
Gender and Reproduction: Embodiment Among the *Kariri-Shoco* of Northeast Brazil

By

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for
Dona Marieta
and
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ABSTRACT

This ethnographic study was conducted among the Kariri-Shoco, an indigenous people of Northeast Brazil, during nine months of field research in 2001. The research focused on the female body, particularly female reproductive processes and bodily fluids as a fundamental way of approaching female embodiment. Kariri-Shoco ethnophysiology and reproductive processes were investigated through examining shamanic specialists' and women's conceptions, experiences, and perceptions of how sexual difference and cure-healing practices are intertwined with Kariri-Shoco knowledge of the body. Kariri-Shoco women's meanings and experiences in relation to reproductive processes, sexual practices and desires were approached as fundamental issues for the understanding of female embodiment.

The investigation of therapeutic methods of cure-healing ritual performances has shown how traditional indigenous medical practices remain contemporary Kariri-Shoco shamanic specialists' medical knowledge. Kariri-Shoco shamanic specialists explain that the body opens during sexual intercourse and when women experience menstrual and post-delivery blood fluxes. Bodily fluids of male and female bodies from sexual intercourse, and menstrual and post-delivery bodily blood fluxes, provide a vulnerability of the body in which shamanic practices become dangerous. I describe three different kinds of Kariri-Shoco cure-healing rituals which have the purpose of closing the patient's body. The *reza* (prayer) ritual is one of the first steps that Kariri-Shoco people take towards cure-healing processes. Kariri-Shoco shamanic specialists experience embodiment during cure-healing rituals, when the nature of the patient's health problem is discovered, diagnosed, and treated. I have discussed and demonstrated that Kariri-Shoco knowledge of the body relates to the 'openness' and 'closedness' of the body, which provides basis for sexual differences perceptions and experiences intertwined with gender embodiment.

Data analysed about gender and female embodiment reveal how Kariri-Shoco reproductive women resist male domination. The perspective that Kariri-Shoco shamanism is the fundamental locus for approaching and understanding symbolic aspects of Kariri-Shoco ethnophysiological reproductive concepts and the experiences women have through sexual difference and practices provided the possibility to approach how female embodied subjectivity is produced and experienced within the Kariri-Shoco cultural context.

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CONTENTS

ABSTRACT	i
Acknowledgments	ii
I INTRODUCTION	1
II RESEARCH CONTEXT	9
2.1. Kariri-Shoco History	9
2.2. Ethnography and Literature Review	26
2.3. Kariri-Shoco and Their Neighbors	35
III THEORETICAL CONTEXT	51
3.1. Selective Literature Review	51
3.1.1. Feminist Theory on Female Embodiment	52
3.1.2. The Reproductive Female Body	63
3.1.3. Shamanism as Indigenous Medical Knowledge	67
IV METHODOLOGY	78
4.1. My Plan in the Field	79
4.2. Research Methods: Interviews and Selected Case Studies	85
4.2.1. Indigenous Health Practitioners (shamanic specialists and a midwife) as Case Studies	86
4.2.2. Women as Case Studies	89
4.2.3. Methods for Researching Case Studies	92
4.3. Visual Anthropology	94
4.4. Ethics	98
V KARIRI-SHOCO SHAMANISM: THE FIELD OF CURE-HEALING PRACTICES	101
5.1. Case Studies and Research Methods	105
5.2. Kariri-Shoco Shamanism as a Sociological Domain	120
5.3. Diseases-Illnesses Experiences and Perceptions	141
VI CURE-HEALING RITUAL PERFORMANCES	175
6.1. Reza Rituals Performances	182
6.2. Reza Ritual for “Open Arcs”	212
6.3. Mesa Rituals	221
VII GENDER ASPECTS: KARIRI-SHOCO FEMALE EMBODIMENT	233
7.1. Kariri-Shoco Shamanic Specialists’ Knowledge of the Body: Experiences and Perceptions of Gendered Embodiment	235
VIII KARIRI-SHOCO WOMEN AND EMBODIMENT	260
8.1. Conducting Interviews with Kariri-Shoco Women	261
8.2. “Dor de Mulher,” the “Dona do Corpo,” and Menopause	283
8.3. Kariri-Shoco Women as Case Studies	287

8.3.1. Marriage, Pregnancy, Aborto/Miscarriage, Delivery	291
8.4. Some Observations on Authoritative Knowledge and Medicalization Related to Physiological Reproductive Processes	316
IX CONCLUSION	331
9.1. Embodiment: The Body as Object and/or Subject of Knowledge	331
9.2. Gendered and Female Embodiment: Corporeal, Ontological and Lived Realities	348
APPENDIX A: Semi-Structured Interview Schedule A Conducted Among Twenty-Nine Kariri-Shoco Reproductive Women	359
APPENDIX B: Semi-Structured Interview Schedule B Conducted Among Twenty-One Kariri-Shoco Reproductive Women	360
APPENDIX C: Ethnographic Interview Outline for Researching Shamanic Specialists and the Midwife	361
APPENDIX D: Ethnographic Interview Outline for Researching Women	365
GLOSSARY	369
BIBLIOGRAPHY	374

ILLUSTRATIONS

Maps

1. Indigenous Land Settlements in Northeast Brazil	13
2. Kariri Peoples' Perambulation during the Seventeenth Century	16
3. Kariri-Shoco Traditional Territory	39

Ethnographic Photos (Digital Stills)

1. Kennedy Explaining about the Moment of Silence	194
2. Dona Maria Velha Measuring a Patient's Shoulder	214
3. Dona Maria Velha Measuring a Patient's Breast	214
4. Beginning of the Reza Ritual for "Open Arcs"	215
5. Cross Sign and Bending Head	216
6. Cross-X Signs During the Ritual	216
7. "Raise up Arcs!"	217
8. Dona Maria Velha Embodies Symptom of "Open Arc"	218

TABLES

1. Kariri-Shoco Demographic Data	41
2. Shamanic Specialists Case Studies and Others Shamans Interviewed During Research Process	88
3. Kariri-Shoco Women as Case Studies	91
4. Pregnancy, Aborto/Miscarriage, Contraception, Tubal Ligation and Infant Mortality (Survey 1)	263
5. Menarche, Aborto/Miscarriage, Contraception, Tubal Ligation (Survey 2)	265
6. Frequency of Aborto/Miscarriage, Use of Methods to Avoid Pregnancy/Contraceptives, and Tubal Ligation Among Fifty Kariri-Shoco Women. Survey 1 ($N = 29$) and Survey 2 ($N = 21$)	269
7. In-Depth Questions about "Dor de Mulher" and Knowledge about the "Dona do Corpo" (Survey2)	284

LIST OF ABBREVIATIONS

AL	Alagoas State, Northeast Brazil
ANAI	Indigenous Action National Association- <i>Associação Nacional de Ação Indigenista</i>
AVC	A brain vascular accident, in Portuguese, is called “ <i>Acidente Vascular Cerebral</i> ”)
BA	Bahia State, Northeast Brazil
CE	Ceará State, Northeast Brazil
CIMI	Indigenous Missionary Council- <i>Conselho Indigenista Missionário</i>
CNPq	National Council of Research and Development- <i>Conselho Nacional de Pesquisa e Desenvolvimento</i>
CODEVASF	Development Company of the São Francisco Valley- <i>Companhia do Desenvolvimento do Vale do São Francisco</i>
DSEI	Special Sanitary Indian Districts- <i>Distritos Sanitários Indígenas</i>
FUNASA	The National Health Foundation - <i>Fundação Nacional de Saúde</i>
FUNAI	National Indian Foundation- <i>Fundação Nacional do Índio</i>
NEPE	Studies and Research Ethnicity Nucleus- <i>Núcleo de Estudos e Pesquisa sobre Etnicidade</i>
PB	Paraíba State, Northeast Brazil
PE	Pernambuco State, Northeast Brazil
PI	Piauí State, Northeast Brazil
PNDS	National Research on Demography and Health- <i>Pesquisa Nacional de Demografia e Saúde</i>
RN	Rio Grande do Norte State, Northeast Brazil
SE	Sergipe State, Northeast Brazil
SPI	Indian Protection Service- <i>Serviço de Proteção aos Índios</i>
SUS	Unique Health System- <i>Sistema Único de Saúde</i>
UTI	Therapeutical Intensive Unity- <i>Unidade de Terapia Intensiva</i>

CHAPTER I

INTRODUCTION

The general objective of this qualitative research project was to explore how specific characteristics of the female body are perceived and experienced by the Kariri-Shoco. The study was conducted among the Kariri-Shoco, an indigenous people of Northeast Brazil, during nine months of field research in 2001. This investigation examines how cure-healing practices and sexual difference relate to female embodiment. As such, it is a research project located within the fields of medical anthropology and feminist theory. My concern during field research was to discover how Kariri-Shoco shamanism provides a way of being-in-the-world from which female embodiment and female reproductive processes are perceived by shamanic specialists and reproductive women as lived experiences.

The use of theoretical feminist frameworks helped to guide the investigation by recognition that the gendered body can be researched from its materiality, considering phenomenological, symbolic, political, and cultural contexts. The study of the reproductive body, particularly female reproductive processes and bodily fluids, is a fundamental way of approaching the female body. Although the body is undetermined, its materiality shows embodiment through cultural codifications (Grosz 1994).

The concept of embodiment and its use is fundamental to contemporary theorizing in anthropology (Csordas 1990, 1994; Lock 1993; Scheper-Hughes and Lock 1987; Strathern 1999). This approach on embodiment combines the abstract and

concrete senses of the body, where I have proposed focusing on the female reproductive body by researching Kariri-Shoco shamanic specialists and reproductive women's experiences, meanings, knowledge, and practices in Kariri-Shoco historical and cultural context.

The concept of embodiment has been considered in relation to gender as sexually differentiated bodies engender. In order to approach Kariri-Shoco female embodiment related to reproductive processes (pregnancy, childbirth and the menstrual cycle), it was necessary to understand ethnophysiological concepts and implicit gender notions contained in their reproductive logic and behaviour, as Browner and Sargent (1990) have suggested. In this sense, bodily fluids are related to the biological body's permeability, boundaries, and marginalities, which involve sex differentiated bodies and in which the differences are culturally, socially, and symbolically constructed (Grosz 1994).

As a biological event, the menstrual cycle and reproductive processes have been part of ethnographic descriptions, which include events that cover biological facts related to women's experiences during the life-cycle, such as menarche, coitus, conception, pregnancy, delivery, contraceptive methods, and menopause (Browner and Sargent 1990), all of which relate to Western conceptions of the biological or physiological procreation process. This ethnographic study has focused on Kariri-Shoco ethnophysiology and reproductive processes investigating how their conceptions, perceptions, and practices relate to sexual difference and cure-healing practices. Thus, the Kariri-Shoco shamanic specialists' knowledge of the body and Kariri-Shoco women's meanings and experiences in relation to reproductive

processes, sexual practices and desires are considered fundamental issues for the understanding of female embodiment.

This study builds on the perspective that Kariri-Shoco shamanism is the fundamental locus for approaching and understanding symbolic Kariri-Shoco ethnophysiological reproductive concepts and the experiences women have through sexual difference and practices. Thus, this investigation has approached Kariri-Shoco shamanism as matrix of symbols of embodiment concepts, perceptions, and experiences related to both their concepts of sexual difference and medical practices.

The purpose of this qualitative research is to describe and analyze how female embodiment, as gendered embodiment, is intertwined with sexual difference, reproductive physiological processes and shamanism. This provides the possibility to approach how female embodied subjectivity is produced and experienced within the Kariri-Shoco cultural context. In addition, the interrelation between indigenous and non-indigenous medical practices was approached. The plural medical context (indigenous, biomedical, and Afro-Brazilian religious) was considered through Kariri-Shoco shamanic specialists' perceptions and experiences with cure-healing practices and through experiences that Kariri-Shoco women have with reproductive processes.

In Chapter II, historical and ethnographic data about the Kariri-Shoco is presented as a way to describe the research context. Different official policies established during colonial history, Kariri-Shoco contemporary history, and an ethnological and anthropological literature review of studies about northeastern Brazilian indigenous peoples (including the Kariri-Shoco) serve as foci. In the first

section, the history of indigenous people in Northeast Brazil is approached to show how indigenous people were submitted to Catholic missionary actions and to different governmental tutelage systems throughout the historical process of colonial domination and oppression. In the second section, ethnological historical accounts, particularly about Kariri people, are described based on the work of historians and ethnologists who have organized the limited ethnographic data provided in historical chronicles, documents and reports about indigenous peoples in Northeast Brazil. A literature review focuses on anthropological studies discusses the theoretical and methodological orientations of these studies about northeastern indigenous people. It is in the last section of this chapter that the Kariri-Shoco contemporary context and their struggle for territorial rights are described focusing on governmental agency assistance.

Chapter III presents the theoretical frameworks utilized for analysis and elaboration of the ethnography about Kariri-Shoco female embodiment, Kariri-Shoco female reproductive body, and Kariri-Shoco shamanism as indigenous medical knowledge and practice. In the field of feminist theory, I discuss different trends and explain why and how I utilized in my research the group of feminists who suggest that sexual difference is a fundamental reference for female embodiment and the production of female embodied subjectivity. Theorists such as Butler (1990, 1992) and Grosz (1994) provide theoretical and methodological considerations of the body, from which gender is approached within representations, experiences, and meanings in cultural context. In the field of medical anthropology, I point out how the female reproductive body has been the object of wide fields of knowledge in contemporary

studies, among which medicalization of reproduction (Browner and Sargent 1990; Lock and Kaufert 1998, etc.) and authoritative knowledge (Jordan 1978) are important concepts regarding the relationship between biomedical and indigenous knowledge associated with female reproductive processes. It is also in this third chapter where I explain how this qualitative research builds on the theoretical perspective that Kariri-Shoco shamanism constitutes form of a medical knowledge. It is following researchers, such as Csordas and Kleinmen (1990) and Good (1994) that Kariri-Shoco cure-healing rituals and practices are considered within their cultural context where cultural meanings cohere and define indigenous concepts of sicknesses. In this section, I describe how anthropologists have researched shamanism as a focus of knowledge or as a matter of cultural beliefs, and I also discuss anthropological studies about South American shamanisms.

Chapter IV focuses on how Kariri-Shoco ethnographic research was realized and which methods were utilized during field research. It is explained how shamanic specialists were selected for ethnographic interviews with the use of the DRS method (Spradley 1979). It also describes the methodological procedures adopted for researching Kariri-Shoco reproductive women, when structured interviews were conducted during the first months of field research. Two different structured interview schedules were used with opportunistic samples that guided the selection of Kariri-Shoco reproductive women as case studies. These methods provided ways of quantitative and qualitative ethnographic data collection. This chapter also explains how visual anthropology became a method from which Kariri-Shoco cure-healing rituals was video recorded and selected as digital stills in order to illustrate Kariri-

Shoco shamanic specialists' embodied experiences and knowledge. The video recording of ethnographic interviews enriched ethnographic descriptions since dialogues, gestures, and expressions are often part of the ethnography. In the last section of this chapter, I discuss how ethical issues were considered during the field research and in the writing of this ethnography.

In Chapter V, I begin by describing selected shamans and the research methods utilized for ethnographic description of Kariri-Shoco shamanism as the locus of a sociological and medical knowledge domain. The second section focuses upon Kariri-Shoco shamanism as a sociological domain from which different shamanic specialists occupy positions and have different roles. In the third section, Kariri-Shoco perceptions and experiences with diseases-illnesses are described and analyzed as aspects of different medical regimens. This section also presents ethnographic data about Kariri-Shoco perceptions of how different medical practices -- indigenous, biomedical and Afro-Brazilian -- are ethnically demarcated regarding health problems and cure-healing practices.

Then, in Chapter VI, three different kinds of cure-healing rituals are described in order to show how Kariri-Shoco shamanic specialists communicate with spiritual beings and experience embodiment when they discover and diagnose the patient's health problems during these ritual performances. The focus on Kariri-Shoco shamanism as a locus of knowledge and medical practice implying embodiment is described and discussed. Digital video footages recorded during these ethnographic interviews and cure-healing ritual practices are described to illustrate ethnographic data and analysis. The translations of several quotations from digitally

recorded ethnographic interviews are also used to show how shamans describe and explain their experiences.

Chapter VII presents ethnographic data on Kariri-Shoco female embodiment to show how sexual difference is culturally coded. In the first section, Kariri-Shoco shamanic specialists knowledge of the body, particularly about ethnophysiology (including bodily fluids) and reproductive processes, are described and analysed. It is in this section where I show how Kariri-Shoco knowledge of the body is intertwined with gendered embodiment from which their knowledge of reproductive processes and ethnophysiology produce concepts and meanings for female embodied subjectivity which characterize the female body.

Chapter VIII focuses on how Kariri-Shoco women experience reproductive processes. It presents and analyses quantitative data from semi-structured interviews conducted among fifty Kariri-Shoco women, where information on their experiences with pregnancy, pregnancy loss (miscarriage and abortion), contraceptive use, delivery and menopause are discussed. It also describes information that Kariri-Shoco reproductive women case studies reported about their experiences with conjugal relationships, pregnancy, pregnancy loss and delivery. It is in the last section that authoritative knowledge and medicalization are discussed and where ethnographic data presented shows how indigenous knowledge have been utilized in the context of biomedical interventions. Thus, ethnographic descriptions on Kariri-Shoco female reproductive bodies discuss what underlies sexual differences and reproductive processes through Kariri-Shoco shamanic specialists' knowledge of the body and

cure-healing practices and Kariri-Shoco reproductive women's experiences and perceptions.

In Chapter IX, a conclusion summarizes analysis from previous chapters about Kariri-Shoco shamanism as medical knowledge and practice and, also, Kariri-Shoco gendered and female embodiment. The significance and theoretical contribution of this research conducted among the Kariri-Shoco is also discussed. Thus, while the first chapters (II, III, IV) focus on the research context and process of developing and conducting ethnographic research among the Kariri-Shoco, the last ones (chapter V, VI, VII and VIII) present ethnographic data collected, registered, recorded, and analyzed during the research process.

CHAPTER II

RESEARCH CONTEXT

This chapter is organized into sections that focus upon Kariri-Shoco historical and cultural contexts. In the first section, Kariri-Shoco history is presented primarily based on different official policies established during colonial history. This is a discussion of Brazilian history in which the Kariri-Shoco constituted an indigenous group. In the second section, a review of ethnological and anthropological literature explores theoretical approaches in studies on northeastern Brazilian indigenous groups, including the Kariri-Shoco. In the third section, Kariri-Shoco twentieth-century history is considered, particularly focusing upon their struggle for indigenous rights.

2.1. Kariri-Shoco History

The history of indigenous peoples in Brazil is a sad history of the extinction of several peoples and their cultures. Ribeiro (1995, 141) estimates an Indian population of about five million in the territory of modern Brazil in 1500 which, after three centuries of colonization, decreased to about one million. In 1957 this population was estimated at 99,700 (Ribeiro 1970, 261) and a 1995 survey found 325,652 individuals (FUNAI 1999).

According to Ribeiro (1978) Brazilian people is characterized “at an ethnic level” by what he analyses on the Brazilian cultural formation from origins based on the mixture of “different ethnic matrixes from Iberian colonizer, tribal indigenous peoples and African slaves... [as] product of European colonizer expansion that joined... the matrixes which have formed” an “*species-novae*” (Ribeiro 1978, 70). Thus, in Northeast Brazil, indigenous and non-indigenous regional population is a product of the mixture of what Ribeiro (1978) analyses from contributions that each ethnic matrix provided:

The indigenous contributed, principally, with the quality of the genetic matrix and as the cultural agent transmitting their experience of ecological adaptation for the new recent land conquered. The black, also as genetic matrix,[contributed] ...principally in the quality of labor force, which generated mostly the goods produced and the wealth that was accumulated and exported... The white had the role of promoting the colonization, of reproducing... [and] implementing the institutional order of social life, and as the agent of cultural expansion...” (Ribeiro 1978, 72)

In Brazil, indigenous peoples have experienced different cultural historical situations, under specific regulated policies. For example, the contemporary constitutional rights for indigenous peoples expressed in the Constitution of 1988 (title VIII, Of the Social Order, and Chapter VIII, Of Indigenous Peoples) marked innovative and important changes for indigenous rights if compared to prior constitutions. Since February of 1991, a revision of the Indian Statute (a law that rules Indian affairs according to prior the constitution) remains to be amended and made law by the Congress into the Statute of Indigenous Societies. This revision is necessary in order to adapt old legislation into the terms of the new Brazilian Constitution of 1988.

The Indian Statute, which prior to amendment, remains to be reviewed, explicitly establishes “the purpose to preserve [indigenous] culture and integrate [indigenous peoples] progressively and harmoniously into the national communion” (Article 1, Law number 6001/1973; Lobo 1996, 119). The Constitution of 1988 emphasizes that indigenous cultural and linguistic differences must be respected through the recognition of indigenous “social organization, costumes, languages, beliefs and traditions, and primordial rights over their traditional land occupations” (Article 231; Lobo 1996,114). While the Statute of Indigenous Societies has not been passed yet in the Brazilian Congress, Law number 6001 of 1973 (Indian Statute) still rules and defines indigenous affairs.

Thus, the term Indian refers today to a forensic historical cultural definition, which will be altered into changes in regulations according to the new Brazilian Constitution.¹ Contemporary policies of the Statute of Indigenous Societies may emphasize the collective character and rights of these peoples. The changes may also recognize the differences among indigenous peoples and also their differences from the national society through the recognition that indigenous peoples’ rights over their lands are linked to the concept of original rights from the historical recognition that indigenous peoples were occupants of Brazil prior to the pre-Colombian period.

¹ The Indian Statute establishes that “Indian” means “...all individuals of pre-Colombian origin and ancestral lineage who identifies himself[/herself] and is identified as belonging to an ethnic group which cultural characteristics distinguish him[/her] from national society” (Article 3, Section I), and that “Indigenous Community” or “Tribal Group” is “the total of families or Indians, who live in isolation from other sectors of the national communion, or in intermittent or permanent contact, without being integrated” (Article 3, Section II; Lobo 1996, 120).

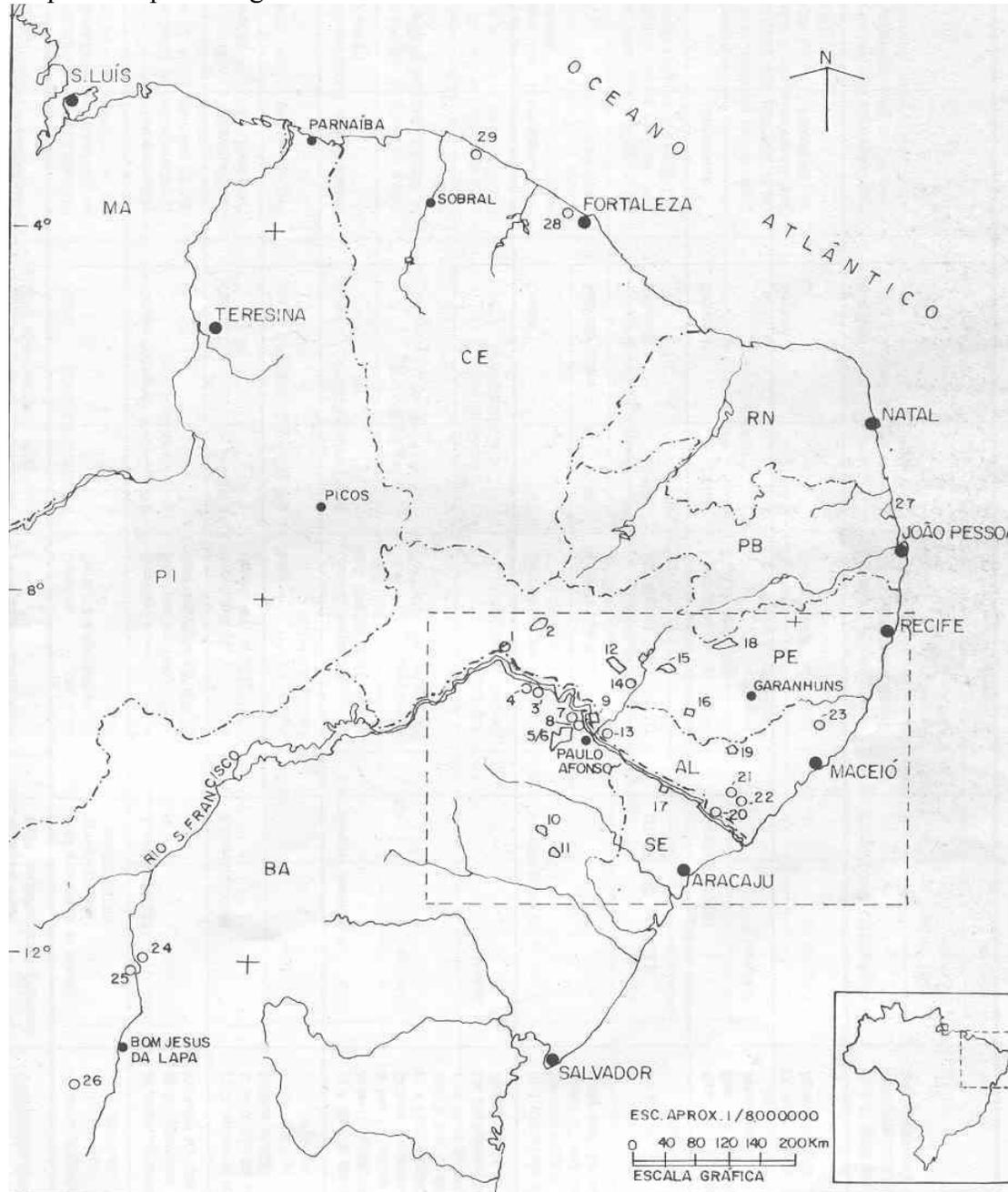
In northeastern Brazil, there is a total indigenous population estimated in 1993 at 31,600, divided into twenty-seven ethnic groups (see Map 1). In this region there is a process of revitalization of indigenous cultures that started at the beginning of the twentieth century and continues today, where several groups that were considered extinct have re-emerged and have fought for indigenous identity rights.

Sampaio (1986) differentiates groups that have been traditionally recognized during history (such as the Kariri-Shoco, Pankararu, and Fulni-ô) from groups that only recently have been identified and have fought for indigenous identity rights; these Sampaio (1986) classifies as emergent groups (such as the Kapinawá, Tingüi-Botó, and several others). The Kariri-Shoco, with the majority of these ethnic groups, live in places where Catholic missions were established in the first centuries of the Portuguese occupation.

The Portuguese Crown's colonial strategy from the sixteenth century included massive grants of land, usually to military men. These landowners, who were called *donatários*, received from the king hereditary parcels of land (passing from father to son) known as *capitanias*. Portuguese men inside the *capitanias* received large plots of land called *sesmarias*. A lucrative sugar industry developed near the coast during the sixteenth and seventeenth centuries using African slave labor.² The occupation of the interior started in the seventeenth century when cattle farms were established as a colonizing economic frontier for expansion into hinterlands.

² It is estimated that in 1810 2.5 million Africans had been brought to Brazil, which contributed to the fact that “two-thirds of the entire Brazilian population in the early nineteenth century was of partial or total black ancestry” (Skidmore and Smith 1984, 24-27).

Map 1: "Map of Indigenous Lands Settlements in Northeast Brazil"



- | | | |
|-----------------------------------|-------------------------------|-------------------|
| 1. Truká | 12. Kambiá | 21. Tingui-Botó |
| 2. Atikum | 13. Geripancó | 22. Karapotó |
| 3/4. Nova Rodelas/Riacho do Bento | 14. Tuxá de Inajá | 23. Wassu-Cocal |
| 5/6. Pankararé/Brejo do Burgo | 15. Kapinawá | 24. Ibotirama |
| 7. Kantaruré | 16. Fulni-ô | 25. Barra |
| 8. Quixaba | 17. Caiçara/Ilha de São Pedro | 26. Vargem Alegre |
| 9. Pankararu | 18. Xucuru | 27. Potiguara |
| 10. Massacará | 19. Xukuru-Kariri | 28. Tapeba |
| 11. Kiriri | 20. Kariri-Xocó | 29. Tremembé |

Source: Atlas (1993:xv).

In the sixteenth and seventeenth century, two terminologies, Tupi and Tapuia, were used by different colonial conquerors (Portuguese, French, and Dutch) to denote indigenous peoples who occupied the coastal (Tupi) and interior (Tapuia) lands (from Rio Grande do Norte to the Bahia states). In the seventeenth century, the Portuguese, who had expelled the French, already dominated the coast, and most of the Tupi peoples who occupied the north to south coast were dead (Hemming 1978, 283).³ Tapuia was used as a generic term to refer to non-Tupi indigenous peoples who occupied a wide region into the hinterlands and were often identified as Kariri tribes (Pinto 1935). Ferrari (1957, 18) produced a map that shows the region of Kariri people's perambulation (see Map 2), and Nimuendaju (1981) also produced a map about indigenous peoples in Brazil where the terminologies used for tribes appear related to territorial occupation and conflicts.

According to language classification, while the term Tupi per se is recognized as a language family, different authors have considered Kariri as a specific language. Lowie (1946) and Nimuendaju (1981), based on grammatical accounts from Capuchin missionaries during the seventeenth century, have the same opinion that Kariri was used as a common language by different groups through four dialects: Kipéa, Sabuja, Kamuru, and Dzubukuá. According to the geographic location, Dzubukuá was recognized as the dialect that people used in the region where Kariri-

³ Nowadays only two groups in the Brazilian coast are descendants from Tupi peoples: the Potiguara (in Northeast) and the Tupiniquim (Southeast).

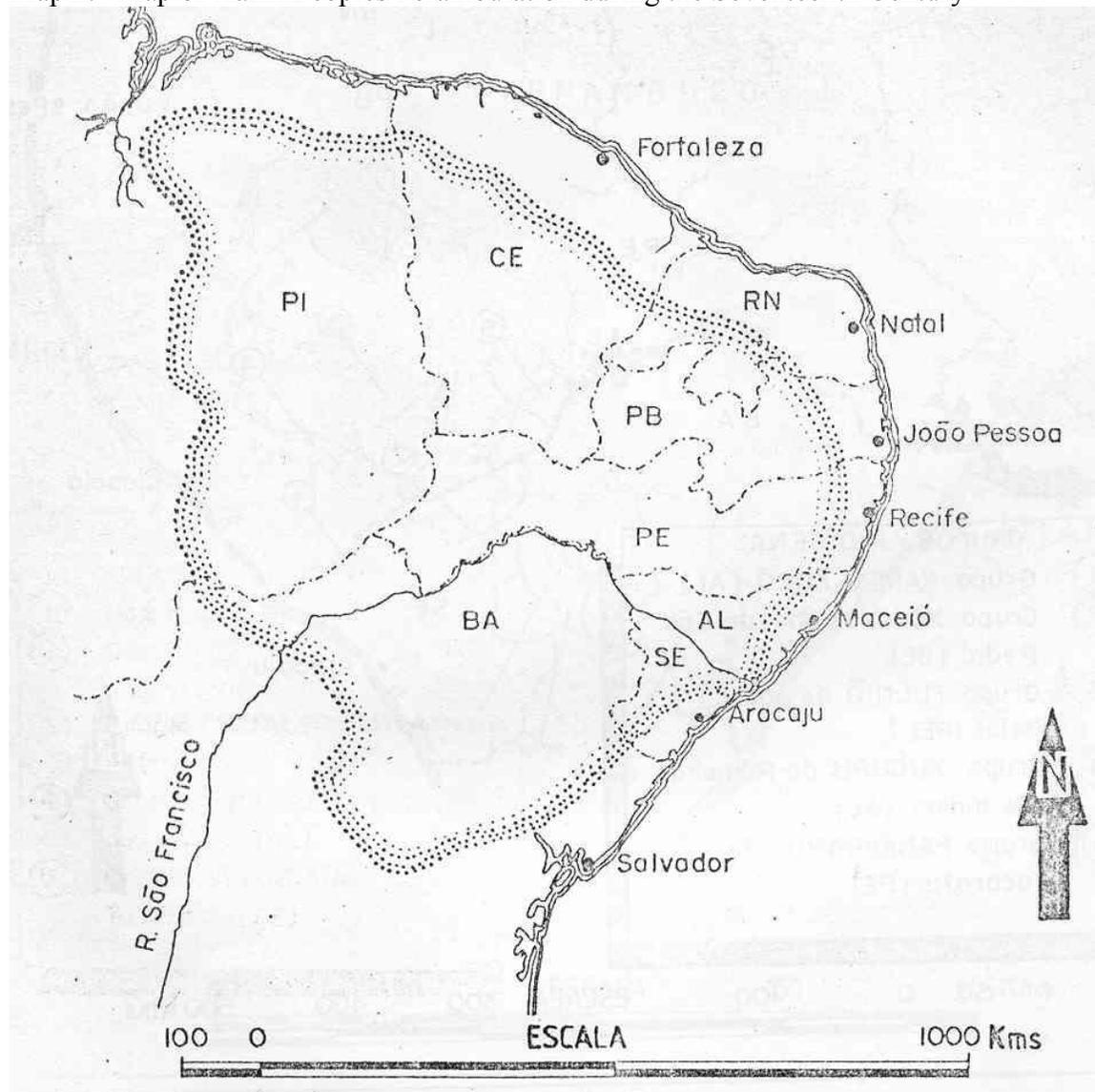
Shoco live today. Rodrigues (1986, 49) identifies Kariri as a language that belongs to the Macro-Gê language family.⁴

All dialects of Kariri language have disappeared. Portuguese colonial laws prohibited the use of indigenous languages. For example, the *Alvara* (Decree) dated May 8 of 1758 determined Portuguese as the official language and prohibited the use of native languages such as Nheengatu, which was a general Tupi language widely spoken throughout Brazil in the sixteenth until the early eighteenth century.⁵ The colonization process not only contributed to cultural disruptions but also to the extinction of several languages. Northeastern indigenous groups in Brazil today are mostly monolingual in Portuguese, including the Kariri-Shoco.

⁴ According to language classifications, Tupi, Arawak, Carib, and Macro-Gê are considered the principal indigenous language families in Brazil (Rodrigues 1986).

⁵ Ribeiro (1970) mentions that Nheengatu was a general language widely diffused for communication, first between Europeans and Tupinamba peoples from the coast. It then became the “language of civilization” (Ribeiro 1970, 122) spoken by colonialists, missionaries, and neo-Brazilians (mixed racial population formed in the first centuries of colonization process).

Map 2: “Map of Kariri Peoples Perambulation during the Seventeenth Century”⁶



Source: Ferrari (1957, 18).

Portuguese colonial strategies during the seventeenth and eighteenth centuries also included the use of natives for military actions. For example, missionary indigenous villages were established for the expulsion of indigenous peoples considered “enemy Indians.” Natives also fought for the Portuguese Crown against

⁶ Abbreviations for northeastern States are: PI, Piauí; CE, Ceará; RN, Rio Grande do Norte; PB, Paraíba; PE, Pernambuco; AL, Alagoas; SE Sergipe; BA Bahia.

African slave rebels, contributing to the extinction of *Quilombos* (African refugee settlements), and usually indigenous villages were established in strategic locations to guarantee Portuguese domination (Costa 1983).

The Dutch established a colony in northeast Brazil for about 30 years in the early seventeenth century. They allied with indigenous groups, such as the Potiguar (one of the Tupi language groups) and Kariri, who fought against other Kariri allied with the Portuguese against the Dutch. The history of occupation and conquest of Brazil (not only by the Portuguese but also by the French and Dutch) involved also the division of indigenous populations among different European colonialists and the enslavement of those who rebelled against the Portuguese colonial enterprise. The colonizers also utilized wars among native peoples for their colonizing purposes.

In the mid-seventeenth and beginning of the eighteenth century, the War of the Barbarians (*Guerra dos Barbaros*) was considered the symbol of resistance against cattle-farm colonial expansion into northeastern hinterland Brazil. This war was also known as the Confederation of Kariri (*Confederação dos Kariri*) because several indigenous peoples who were generically called Tapuias, and identified mostly as *Kariri*, were the principal peoples who fought in this war. This indigenous resistance covered a wide northeast area from Bahia up to Maranhão states, and Tupi peoples joined the Portuguese fighting against Tapuias (Pires 1990).

The history of native peoples in northeast Brazil is linked to this colonial history of conquest, which relates to their extinction or submission to different historical tutelage practices, domination, and expropriation of lands. All these facts interconnect, for tutelage systems are not only methods of domination, but

historically have often considerably changed cultures, and facilitated invasion of indigenous land, or reduced significantly indigenous territorial occupation by implementing reserve systems.

According to Oliveira Filho (1988), there is an ideological paradox in tutelage practices, because it implies different forms of domination, since the relation is founded upon the recognition of unquestionable superiority of one group and the obligation to provide assistance with the purpose of controlling behavior according to the dominant society. Dallari (1982), analyzing different tutelage systems in Brazil since the eighteenth century, mentions that tutelage practices have always entailed a kind of control, from which follows that governmental or state interests determine and relate to powerful control over individuals considered not capable of responding for themselves.

Indigenous peoples in Northeast Brazil were under tutelage control, first from missionary actions, followed by four different governmental tutelage systems throughout their history. During the eighteenth and nineteenth centuries, the *Diretorio dos Índios* (Indian Directory) and, after 1845, the *Diretoria Geral dos Indios* (Indian Affairs General Directory) were agencies responsible for administering indigenous missionary villages. In the twentieth century, two different agencies, *Serviço de Proteção aos Índios*—Indian Protection Service (SPI) and *Fundação Nacional do Índio*—National Indian Foundation (FUNAI), after 1967, were responsible for protecting and assisting indigenous peoples through economic and political control within reserve systems. Thus, in Northeast Brazil, where colonial history took place since the beginning of European invasions, indigenous peoples have experienced

different tutelage systems at different times. These peoples have even experienced the governmental attempt to complete their extermination, when in 1872 they were officially considered extinct.

It is exactly the term “reduced” (“*reduzidos*”), according to Duarte (1969, 121), that was used to refer to Indians who were brought under Catholic Jesuit missionary villages and then considered pacified (*pacificados*). From 1692 to 1759 the *Junta das Missões* (Union of Missions) in Portugal was responsible for controlling, organizing and setting up different congregations of Catholic missions (such as Jesuits, Capuchins, Franciscans, Benedictines). Jesuits established missionary villages in the eighteenth century in the lower São Francisco River region, where several indigenous groups, including the Kariri-Shoco, still live. The missionary control exercised over indigenous populations relates to cultural disruption processes when different indigenous groups were gathered into the same villages to be Christianized and civilized to serve better the colonial enterprise (Lindoso 1983).

The fundamental role of missionaries contributed to the colonization process, which in the eighteenth century related to the establishment and expansion of cattle farms into hinterlands. Jesuit missions had a “structured enterprise model” (Mata 1989, 32), which exploited indigenous peoples as labor workers and settled farm disputes with Portuguese colonizers involving commercially useful indigenous territories (Mata 1989).

A governor of Pernambuco Province in 1708 donated a parcel of land for indigenous peoples’ settlement at a Jesuit mission where today the Kariri-Shoco live.

The Jesuit missionaries in Porto Real do Colégio administered mostly cattle raising and rice horticulture (Mata 1987, 34). This donation of land was fundamental to the development of Kariri-Shoco consciousness so that their traditional territorial concepts are linked to this missionary settlement (Mata 1987).

Pinto (1956, 48-60), based on Couto (1904) and two other important documents dated 1749 and 1760, organized a scheme that shows fifty-five indigenous missionary villages in Northeast Brazil in the eighteenth century. It is mentioned that Porto Real do Colégio mission was linked to another (São Brás), where Cariri and Porge Indians were settled.

Pinto (1956) observes that there is not much evidence to show whether tribal terminologies used in historical accounts are related to peoples who were significantly diverse in terms of cultures and languages, or if some terminologies refer to particular groups that were politically autonomous, but affiliated culturally and linguistically to a wider group. The Kariri-Shoco missionary village followed a model of missionary settlements where, throughout history, the Kariri had been identified as one of the groups which formed part of this mission in Porto Real do Colegio.

In 1759, the Jesuits were expelled from Brazil and the Union of Missions was replaced by the *Diretorio dos Índios* (Indian Directory), established during the colonial Portuguese regime, and later replaced in 1845 by another agency called *Diretoria Geral dos Indios* (Indian Affairs General Directory), which directed governmental policies for the administration of Indians' villages.

Since the beginning of colonization, official policies were directed to deal with indigenous affairs, but only after 1758 did the jurisdiction of the Indian peoples become the exclusive responsibility of the Portuguese colonial government through *Diretorios*, which consisted of regulations to facilitate the colonization or urbanization of areas where indigenous populations lived in missions. The indigenous peoples were then considered orphans under Portuguese tutelage, and missionary villages became administered by a “spiritual assistant,” a magistrate, or an “Indian captain,” whichever was considered appropriate (Mata 1989, 43), who would mainly be responsible to mediate relations between indigenous peoples and the *Diretorio dos Índios*.

While documents from this time mention conflicts, they do not discuss indigenous cultures. There is a reference that in 1763, Crotópós and Cariris Indians were gathered to develop agriculture in *Freguesia de Nossa Senhora da Conceição do Porto Real* and that the land of this *Freguesia* belonged to the Indians (Biblioteca Nacional 1923, 225). In 1840, a director of Colégio village states that this indigenous village had a population of 102 men and 98 women, and calls attention to the need for demarcation of their territory because several conflicts between invaders and Indians were happening, “aggravated by indigenous [sic] misconducts” (Antunes 1984, 90).

The engineer Manoel Lourenço da Silveira wrote a report in 1862 where he mentions eight indigenous villages in the Province of Alagoas, and that Colégio village had a population estimated at 193 Indians, who belonged to Coropotó, Cariri, and Acunan tribes (Antunes 1984). Hohenthal (1960a) mentions a document dated 1852 which reports that 258 individuals composed the indigenous population in

Colégio, and lived by fishing, harvesting manioc, and selling pottery made by women. Hohenthal (1960a) also points out that this report from 1852 could have been written in 1952, because he witnessed that the Indians were living under similar circumstances of poverty.

Several documents provide data on general conflictive situations between indigenous and non-indigenous peoples in Alagoas Province during the nineteenth century, where indigenous peoples are described as vagabonds, lazy, and disturbers of the order (Antunes 1984; Mata 1989). According to Mata (1989), this shows that discrimination was used as justification for the invasion of indigenous territories. In 1872, several indigenous ethnic groups, including those located in Colégio village, were declared extinct by the Brazilian government. This contributed directly to northeastern indigenous groups' loss of territories when indigenous villages became considered 'public lands' and could be occupied by non-Indians.

According to Mata (1989), the politics of extinction was the result of the expansion of the national society overrunning indigenous villages, different from the first centuries of colonial conquest when the expansion extended over indigenous territories. Mata (1989) also mentions that while at the first moment of colonization *caboclo* was a term used to describe Indians who submitted to villages in order to be civilized, later it was used as a prejudicial term to ignore the existence of Indians who were mixed with non-indigenous population. Thus, the indigenous loss of territorial rights was based principally on racist criteria (Mata 1989).

Dantas (1980a; 1980b) describes violent conflicts in Sergipe Province as the result of this politics of extinction. In the late nineteenth century, several Shoco

Indians found refuge among the Kariri in Porto Real do Colégio. The Shoco, who had been settled in a village on São Pedro Island, were expelled from their territory by brutal persecutions of Colonel João Fernandes de Brito, a powerful landowner and politician in the region, who took over indigenous land. Several Shoco families, including the political leader, joined the Kariri in Colégio village. Others remained under the landowner's farm that had expanded over indigenous land. Dantas (1980a, 1980b) mentions that thirty Shoco Indians (who had moved to Colégio) tried to return to São Pedro Island territory in 1930, but once again these Shoco were expelled, this time by the police force. The invasion of their land was based on official recognition that no indigenous population existed there. Political mobilization during the twentieth century, including the participation of the Kariri-Shoco from Colégio, led to governmental recognition of Shoco indigenous identity in the 1970s, and of their territorial rights in 1991, when Decree n. 401 finally legalized their territory in Sergipe state (Atlas 1993, 6).

Several ethnologists register the presence of Shoco Indians during the twentieth century in Porto Real do Colégio. In 1937, Oliveira (1943) observed 180 Shoco Indians living there. Hohenthal (1960b, 98) observed that Shoco groups were located in Colégio and Olho d'Água do Meio (where the Tingui-Boto live at the present time) in Alagoas state, and that another group was on São Pedro Island, Sergipe state. Hohenthal (1960b) mentions that these three groups had no essential differences and were gathered together at a place close to Colégio to celebrate their annual Ouricuri ritual or "period of sacred ceremonies" (Hohenthal 1960b, 99).

According to Dantas (1980b, 178-9), Shoco (Ceocoses, Ciocó, Chocó, etc.) have been mentioned in historical accounts since the seventeenth century, and since their territorial occupation included several indigenous villages in São Francisco River valley there are wide possibilities for Shoco cultural and linguistic affiliations. Nascimento (2000, 17) mentions that probably Shoco Indians were present in Colégio village from the beginning, since historical accounts always noted their presence. Indigenous groups along the São Francisco valley have always maintained interethnic contacts, traveling to each other's villages and sharing cultural traits.

Mota (1997, 1987) and Mata (1989) explain that Kariri and Shoco shared cultural background and kinship from which they became Kariri-Shoco: "a complex nation of people, at once united and divided" (Mota 1997, 15). Several individuals from other indigenous groups, such as from contemporary Pankararu, Fulni-o, Carapotó, and Shucuru-Kariri, have also joined and shaped the Kariri-Shoco as an ethnic, northeastern Brazilian group, particularly through kinship bonds from intermarriage. During my field research, descendants of these groups, including Shoco, explained how their ancestors came to Porto Real do Colégio and gathered together forming the contemporary Kariri-Shoco. They also provided explanations on conflicts between Kariri and Shoco themselves, which revealed that although they have much intermarriage and most people are both Kariri and Shoco (united), they were divided by conflicts and political disputes, which they described as being part of different peoples.

The historical process that indigenous peoples have experienced in northeast Brazil relates to the greater history of Brazil, where Portuguese, African, and

indigenous populations have joined and exchanged cultural traits. These indigenous peoples share the same socially inferior condition under the Brazilian cultural capitalistic system in which they are immersed, although they have a distinct relation to the state and neighbors marked by ethnic identity differences that are officially recognized by the Brazilian government. One could mention that despite colonial history, indigenous peoples have emerged throughout history resisting adaptation to this capitalist system. The Kariri-Shoco have not easily engaged in productive enterprises, nor followed a dominant social order. They have fought for recognition as differentiated peoples and have actually been different, particularly in their shamanistic knowledge and cure-healing practices.

Although customs and technology have been widely shared throughout generations during history in this region, whether among indigenous groups themselves or through contacts with regional populations (Oliveira Filho 1993), the Kariri-Shoco and other groups have resisted political and economic constraints. These peoples have been situated under actions, or the absence of actions (when they were considered extinct), of governmental tutelage systems where domination and submission have taken place. Their resistance resides mainly through the maintenance of their shamanistic knowledge, which is exercised and practiced in their daily life. Kariri-Shoco shamanism as a medical practice has been a way through which Kariri-Shoco people exercise a power to cure-heal indigenous and non-indigenous peoples.

The colonization process, which characterizes Kariri-Shoco history, provided similar shared situations and experiences for other northeastern Brazilian indigenous groups, where state and religion have exercised a power through tutelage systems,

which have maintained these peoples under surveillance. In the following section, an ethnological and anthropological literature review about these peoples is presented.

2.2. Ethnography and Literature Review

Historical accounts (chronicles, documents, reports, and so on) about Northeast Brazilian indigenous peoples provide limited ethnographic data related to their origins, language affiliations or cultural characteristics. These indigenous peoples who have experienced similar histories of missionary actions and colonial conquest also share similar system of beliefs. In this section, a literature review about these indigenous peoples is conducted focusing mostly on historians' and ethnologists' attempts to organize information, particularly concerning Kariri peoples ethnographic data.

It is known that when the Portuguese arrived, Tupi and Tapuias (or Kariri) were disputing territorial occupation along the seacoast, and Tupiniquim had already driven Kariri peoples into the Northeast Brazil interior (Garcia 1922). Pinto (1935) elaborated a classification based on bibliographic and documentary, linguistic and historical literature that included fifteen different *Carirís* groups (among them *Chocós*, *Aconãs*, *Sucurús*) according to the geographic locations they occupied. This ethnologist asserts that Carirí were not only one of the principal peoples that occupied Northeast Brazil, but also that Cariri, per se, represented a language family (Pinto 1935; 1956).

Meader (1978) edited a publication of the Summer Institute of Linguistics about the remaining linguistic aspects of fifteen northeastern indigenous groups,

which also contained ethnographic data on Kariri dance and Aticum indigenous group religious ceremony. Meader (1978, 57-58) also included a list of the indigenous vocabulary investigated among eleven different groups, including Kariri-Shoco (referred as Xucuru-Kariri) from whom Meader (1978) registered twenty-four words of their native language that the religious leader remembered. As was already mentioned in the previous section, Rodrigues (1986), after analyzing grammars registered by missionaries, considered Kariri a language belonging to one of the principal indigenous language families of Brazil, the Macro-Gê.⁷

Siqueira (1978) mentions that several authors have offered different explanations about the Kariri people's origins. When Hohenthal (1960a) investigated the historical bibliographic literature related to northeast indigenous peoples, he discovered that the term Cariri had been widely applied to several different tribes without certainty, and that contemporary use of this tribal terminology by some indigenous groups did not necessarily imply an ancestral root link with Cariri during the first centuries of the colonization process. Hohenthal (1960a, 1960b) researched indigenous groups from the mid and lower São Francisco River, and also conducted an ethnographic study on Shucuru Indians from Pernambuco (Hohenthal 1958).

Garcia (1922), using missionaries' accounts from the seventeenth century, observed that Cariri peoples believed that they had come from an enchanted lake in the north of the continent (which he thought could be the Amazon region) and that

⁷ Rodrigues (1986, 51-52) investigated grammars, dictionaries, and languages of the Macro-Gê language family, and makes several references to the Kariri language, such as those from missionaries like Mamiani ([1699] 1942) on Kipéa dialect and Nantes ([1709] 1979) on Dzubukuá dialect. Rodrigues (1986) also mentions a study that he wrote about Kariri kinship (Rodrigues 1948) and a Master's thesis on the Kipéa dialect (Azevedo 1965).

they had migrated down along the seacoast, from where they had been expelled by Tupi peoples in the countryside. In the northeast hinterlands they were identified in different areas they have occupied as Old Cariris and New Cariris (Garcia 1922). Sobrinho (1929; 1950) wrote about the Kariri people's language and origin before the conquest and Ferrari (1957) described Kariri as a people without history.

During history different contact agents, including missionaries, colonizers, naturalists, historians, ethnologists and others, have differently used tribal terminologies, leading sometimes to ambiguity or uncertainty about exactly which people were involved. Both Kariri and Shoco terminologies are present throughout Northeast Brazil according to Nimuendaju's (1981) cultural and geographic map, which he compiled from this historical literature. The term also are written in different ways, like *Kariri*, *Cariri*, *Cariry*, *Caririuazes*, *Quiriri*, *Kiriri*, and also *Xoco*, *Shoco*, *Chocos*, which means that different European colonizers, missionaries and others have used different words to refer to various indigenous peoples. For example, Herckman (1886) in the seventeenth century described reported contacts between the Dutch and *Tapuia-Cariry*, from which he identified three branches as *Cariry*, *Caririuazes*, and *Cariry-jouos*.

Anthropologists have followed and traced these tribal terms as 'ethnic-names' in order to make an effort to trace historical contacts and references for understanding contemporary groups. In Northeast Brazil, the variations in tribal terminologies also relate to transcriptions of documents when colonizers and missionaries who were speakers of different European languages registered and used different terms (Dantas 1980b).

Garcia (1922) explains that the term Kariri is a Tupi language word for silent which, according to him, characterizes ethnographically Kariri peoples. Siqueira (1978), who compiled several reports from historical references, affirms that Kariri peoples from the São Francisco River region during the seventeenth century lived by hunting, fishing, and had more developed agriculture of cassava, corn, pumpkin, and beans, which were the basic foods of these peoples. The missionary Mamiani ([1699] 1942), in the seventeenth century, described Kariri peoples as also having more cultural developed agriculture and that woman made cotton hammocks and rudimentary ceramics (clay pots) which, according to him, distinguished them from their neighboring tribes. The Kariri-Shoco to this day continue to make utilitarian pottery; this is a female activity and also an economic means for subsistence.

Mata (1989) recognizes that Kariri-Shoco today are symbolically descendants of Kariri peoples, including Shoco as one of the Kariri tribes. Mota (1989), from historical and ethnohistorical research, demonstrates that there is not much reliable information to confirm evidence on either linguistic or culturally shared traits among these peoples described in chronicles and documents. Mota (1987) suggests that it is through shared myths and beliefs that today Kariri peoples can be traced to cultural affinities among indigenous groups in Northeast Brazil.

It is interesting to observe that several historical references describe cure-healing practices related to witchcraft, which resemble situations that I have found during fieldwork. For example, in 1706 the Capuchin missionary Martinho de Nantes ([1706] 1979) published a report of his experience of working in missions in the São Francisco River islands and mentioned that the religion of Cariri included the worship

of several gods, for agriculture, hunting, and fishing. Father Martinho de Nantes ([1706] 1979) also reported that several witches exercised divinatory practices about future happenings and that they also cured diseases when these same witches did not provoke them. They used to make extensive use of tobacco and prayers to heal, and sang songs that could not be understood (Nantes [1706] 1979). Not only are divinatory practices very much a presence in Kariri-Shoco shamanistic knowledge currently, but also healing practices are exercised with tobacco and other herbs, where prayers and rituals, which involve songs, are very frequently used.

The Kariri-Shoco, and several other indigenous groups in northeastern Brazil, practice a shamanism related to Ouricuri ritual which is associated with health-illness and cure-healing practices.⁸ The Kariri-Shoco maintain interrelationships with other indigenous ethnic groups in this region: including Shucuru-Kariri, Tingui-Boto and Karapoto in Alagoas state (these last two peoples claim they are descended from the Kariri-Shoco), Fulni-ô in Pernambuco state, and Shoco in Sergipe state. All these groups practice and participate in the Ouricuri ritual in each other's territories, but the only group allowed to participate in the Ouricuri of the Fulni-ô (which is the only group in this region to maintain their native language—Yatê) is the Kariri-Shoco.

According to Nascimento (1994), who researched northeastern indigenous ritual practices and their ritualized use of Jurema plant, although there is uncertainty in historical accounts about the Northeast indigenous peoples' cultural aspects,

⁸ The Ouricuri is the principal Kariri-Shoco ritual. It is in the village called Ouricuri, in a forest inside the reserve, where the Kariri-Shoco gather twice a month (during three or four days) for shamanistic ritual celebrations and cure-healing ritual practices. The longest Ouricuri ritual is happens annually during fifteen days in the month of January.

contemporary data indicate that several of these indigenous peoples shared cultural similarities, especially religious practices that today these groups still have. Nascimento (1994) also recognizes that shared cultural traits may have happened through cultural exchanges which took place in more recent history, such as the establishment of missionary settlements and the colonial conquest, which contributed to the imposition of colonial and national cultural patterns.

A few researchers have focused upon symbolic aspects of these indigenous peoples. For example, Barbosa (1991) investigated Kambiwá's handicraft commercialization and production and their utilitarian ritual objects as visual signs, while analyzing symbolic elaboration of the Kambiwá as an ethnic group. Ribeiro (1992) demonstrates a symbolic universe where space and the society of enchanted spirits guarantee Pankararu ethnic identity and unity, and constitutes Pankararu imagery.

Contemporary studies about indigenous peoples from Northeast Brazil indicate that ethnicity is the key factor for differentiation between these groups and the national society. In this way, Mata (1989) remarks that contrasting identities function as a political instrument for Kariri-Shoco articulation and mobilization; Amorim (1970-71; 1975) elaborates a definition of indigenous peasantry where 'ethnicism' is the specific variable for this peasantry model. Dantas (1980a, 1980b) investigates the ethnohistory of indigenous groups from Sergipe state; Soares (1977) recognizes that the differences between the Pankarare and their Brazilian neighbors are in their indigenous consciousness of being part of a differentiated ethnicity having lived through a conflictive situation. Carvalho (1984) observes that the terminologies

used by these indigenous groups work as a distinctive sign and that ethnicity is related to the nationality, origins and ritual practices of these groups.

The authors mentioned above followed Oliveira's (1972a, 1972b; 1976) ethnic relations theoretical perspective, through the use of analytical terms such as "interethnic friction" (Soares 1977, Carvalho 1984) and "potential of integration" (Amorim 1970-71; 1975). They also focus on opposed relations between these groups and the national society (Mata 1989) or during history (Dantas 1980a; 1980b) from which different interests characterize interethnic relations. For indigenous groups when considered through this perspective, the focus is on the "tribal order" versus "national order," or "indigenous subsystem" versus "national subsystem" (Oliveira 1972a; 1972b; 1976). These approaches focus on political and economic conflict and opposed interests between indigenous groups and the national society.

According to Oliveira Filho (1988), this "theory of interethnic friction," as formulated by Oliveira (1972a; 1972b; 1976), builds on the perspective that conflicts and continuous interactions are structural components of the contact, from which the interethnic contact is approached as an accidental happening, with a disruptive character. In this way it is predicted that the destiny of indigenous groups is marked by a "progressive loss of culture while they are integrated into the regional economy" (Oliveira 1972, 129). This theoretical perspective leads to considering indigenous groups from Northeast Brazil as being on the edge of the process of integration into the national society. In a cultural perspective, they are considered as those who "maintain minimal conditions to continue being Indians, as they have forgotten their tribal language and the major part of their ancestral culture" (Ribeiro 1970, 56).

Oliveira Filho (1998) calls attention to the fact that in these visions, these ethnic groups suffer from the lack of everything including culture, thus they are perceived as part of a “population recognized as not very culturally distinct” (Oliveira Filho 1998, 48), they are “culturally mixed,” and “negative attributes disqualify and differentiate them from the pure Indians of the past” (Oliveira Filho 1998, 52).

Several studies from the 1990s follow Oliveira Filho’s (1988) theoretical perspective on interethnic relations. This author proposes that interethnic contact must be approached as a situation of interaction, which involves aspects of conflict and interdependency, and that the unity of this situation must be considered a concrete process of social interaction in which different groups (ethnic and others) are contextually articulated (Oliveira Filho 1988, 58). Secundino (2000), for example, focused on how the Fulni-ô have been associated politically with regional power structures, where political and economic dynamics demarcate antagonisms and complicities among Indians and non-Indians.

Medical anthropological research about the health of these peoples is practically nonexistent. Among the academic studies in anthropology (Arruti 1996; Azevedo 1986; Barbosa 1991; Barreto 1992; Batista 1992; Brasileiro 1995; Diaz 1983; Foti 1991; Grünewald 1991, 1999; Martins 1984, 1994; Mata 1989; Messeder 1995; Mota 1987; Nascimento 1994; Ribeiro 1992; Secundino 2000; Silva 2003, Souza 1992; Souza 1998; Valle 1993), only Mota’s (1987) doctoral dissertation and Silva (2003) master’s thesis, belong to medical anthropology. Mota’s (1987) investigation deals with medicinal plants related to Kariri-Shoco animism, shamanism

and healing practices. Silva (2003) researched Kariri-Shoco treatments and healing practices.

Mota (1987; 1996; 1997) observed that Western and indigenous medical systems differ since Kariri-Shoco medicine “comes from sacralized grounds, obtained through occult work and divine inspiration” (Mota 1987, 240). I found that suffering, diseases-illnesses (embodied health problems in general), as well cure-healing events involve mystical experiences for the Kariri-Shoco. These experiences are directly associated with Kariri-Shoco knowledge of the body and their shamanism as a medical knowledge and practice. Among the Kariri-Shoco, different medical knowledge (Western and indigenous) have a distinct and complementary relationship (Mota 1987, 1997), which reflects a complex context of plural medical practices.

The shamanism practiced and shared by indigenous groups in northeastern Brazil, particularly through its characteristic as a legitimate and powerful medical knowledge, is a channel through which Kariri-Shoco (and other ethnic groups) exercise their power as a focus of their ethnicity. Kariri-Shoco history has shown that while at the first moment, their shamanistic knowledge was a target for missionary actions, later on it was transformed into a shield of resistance against colonial domination. In the following section the Kariri-Shoco history of the twentieth century is approached, with the focus on the Kariri-Shoco’s struggle for indigenous rights in contemporary situations.

2.3. Kariri-Shoco and Their Neighbors

The twentieth century for the Kariri-Shoco, and several other indigenous groups in Northeast Brazil, has been characterized by political mobilization toward indigenous identity recognition and territorial rights claims. Most of northeastern indigenous groups that had been considered extinct at the end of the nineteenth century started to fight for their official recognition by the SPI, which was the agency that the Brazilian government organized in 1910 to protect and assist indigenous groups.

In 1944, after the Kariri-Shoco had struggled for indigenous rights for decades, the SPI recognized the Kariri-Shoco as an indigenous ethnic group. The SPI had several regional offices throughout Brazil and the Fourth Regional Division located in Recife was responsible to assist eight different indigenous groups in the Northeast during the 1940s (Pinto 1956, 20). The SPI Post located in Porto Real do Colégio registered a population estimated at 173 of “Natu, Shoco, Carapoto, and maybe ‘Pratio,’ and Naconã, ‘which some were Cariri’” Indians (Pinto 1956, 22; Oliveira 1943).

These several tribal terminologies registered in SPI archives, and mentioned by Pinto (1956) and Oliveira (1943), show how descendants of different indigenous peoples continued to be present in Porto Real do Colégio, as concrete witnesses of earlier occupation established during the seventeenth and eighteenth centuries when different indigenous groups were gathered into the same missionary village there. Although diverse tribal terminologies have been used during history for indigenous

groups in Porto Real do Colégio village, information has always confirmed the presence of Kariri peoples.

Mata (1989, 96) mentions a report dated 1945, in which the head of the local Indian Protection Service (SPI) Post in Colégio describes that 166 Indians were assisted and living in 67 poor houses in the Street of the Caboclos in Porto Real do Colégio town, under great poverty and without economic means for subsistence. In this report, the SPI employee requested from the Fourth Regional SPI headquarters a solution related to land that could be used by the Kariri-Shoco for agricultural purposes. In 1948, the Kariri-Shoco received 54.50 ha., which they called Colônia. In 1950, the construction of a railroad that crossed this land reduced the dimension of this area to 35 ha. This parcel of land was not only insufficient for the Kariri-Shoco, but since it was located a 3 km distance from the river course, it was difficult for agriculture, including rice horticulture, particularly during times of drought (Mata 1989).

The Northeast Brazilian area of Porto Real do Colegio County has seasonal droughts and periods of heavy rain which cause floods of the São Francisco River. Several hydroelectric projects have been built since the 1940s in the São Francisco River course, which have contributed to radical ecological changes, particularly seasonal river floods. This has affected enormously the indigenous and regional non-indigenous population is economy and social organization, since the principal economic activity of subsistence agriculture has practically ceased (Mata 1989, Nascimento 2000). Poor regional populations, including the indigenous peoples,

subsisted working on landowners' rice plantation grown on flat lands (called *vazantes*) on land bordering the São Francisco River.

CODEVASF has managed to provide for this regional population alternatives for economic usage of different areas distant from the river land bordering. Mata (1989) and Nascimento (2000) calls attention to the fact that governmental interest assisting these populations were more related to pressure from international banks, which were financing huge hydroelectric projects, than to effective concern to provide assistance.

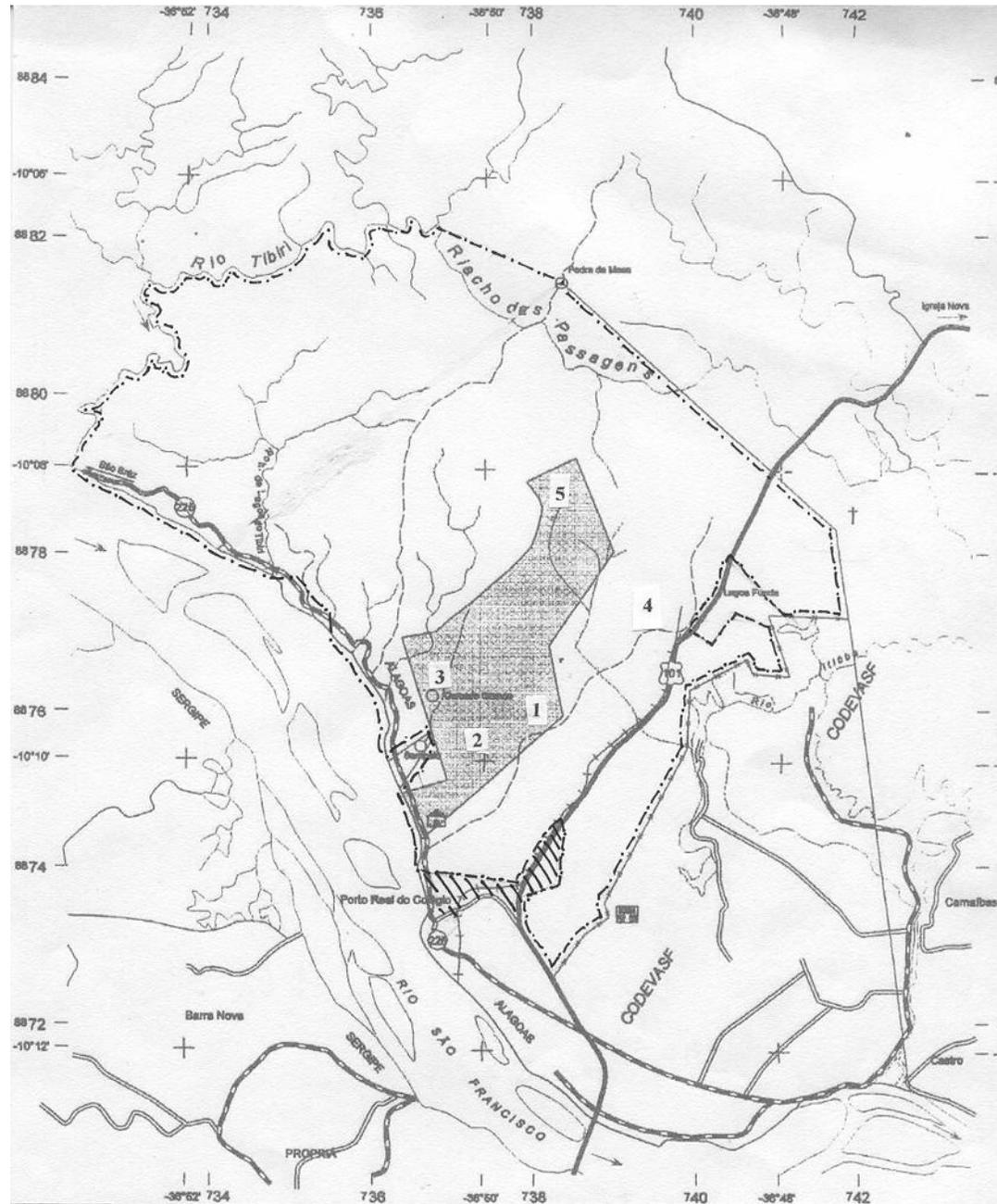
In 1978, after an Ouricuri ritual, 700 Kariri-Shoco occupied an area that they considered ancestral land and reclaimed it as part of their territory. This parcel of land called Sementeira (428 ha) was under management of CODEVASF. Part of this Sementeira area had been occupied since 1957 by *posseiros* (squatters) who were mostly poor regional *sem-terra* (dispossessed of land) non-indigenous population. These *posseiros* took over 220 ha. of land in 1957, which was called Cercado Grande. Thus, from the Sementeira area which the Kariri-Shoco considered ancestral land, only the Fazenda Modelo with an area of 225 ha was actually occupied by them in 1978 (see Map 3).

CODEVASF was a governmental agency established in 1970 for promoting economic development projects directed at populations who were living under the consequences of hydroelectric projects built in the São Francisco River course. This Sementeira land had been used for different economic projects, such as cattle raising combined with agriculture and, later, fish farming (Mata 1989; Nascimento 2000). Since 1976, fish farming has been inactive, which also contributed to the Kariri-

Shoco decision to occupy this land in 1978 (Mata 1989; Nascimento 2000). In 1978, the Kariri-Shoco invaded the Fazenda Modelo (225 ha) and in 1993 the government expelled the posseiros from the Cercado Grande area (220 ha). Conflicts between Indians and non-Indians were aggravated when Kariri-Shoco land claims over the whole Sementeira (445 ha.) area were officially validated in 1993 (Atlas 1993; Mata 1989; Nascimento 2000).

It is estimated that around 150 Kariri-Shoco families made the Sementeira-Fazenda Modelo area their habitat in 1978, leaving behind their poor houses in the “Street of the Caboclos,” where they had lived at least since the 1940s. These Kariri-Shoco families occupied CODEVASF buildings that Nascimento (2000) estimated to be “20m² per family” and “lived in unsanitary conditions” (Nascimento 2000, 39), since the buildings were not meant for human habitation. In eighteen constructed areas, only nine contained houses. In 1981 the Canadian Embassy, after an employee visited the area, financed the construction of sixty houses (each having a dining room, a kitchen and two bedrooms) for families who were living in the worst conditions (Mata 1989). Nascimento (2000) registered 172 houses in the year 2000, where 446 Kariri-Shoco families lived, data that according to him reveals “new married couples continued living with one spouse’s parents after marriage” (Nascimento 2000, 41).

Map 3: Kariri-Shoco Traditional Territory



Source: FUNAI (2000).

1-Sementeira 2-Fazenda Modelo 3-Cercado Grande 4-Colônia 5-Ouricuri

-  Porto Real do Colégio Town
-  Kariri-Shoco Traditional Territorial Land Claims
-  Kariri-Shoco Reserve (699,35 ha.)

Throughout history, there are 100 ha. of forest that has always been under Kariri-Shoco people's use and control for Ouricuri ritual practices. The Kariri-Shoco consider this area of forest a sacred land which they also use for collecting medicinal plants for ritual and cure-healing purposes. Several anthropologists agree that the secrecy involved in Ouricuri ritual practices has been fundamental to the Kariri-Shoco's maintenance of their indigenous identity (Mata 1989; Mota 1987, 1997; Nascimento 2000; Silva 1999), particularly over the time they had been considered an extinct group and had no governmental assistance or guarantee of indigenous rights.

In 1993, the Brazilian government finally recognized and officially regulated the Kariri-Shoco territorial dimension as this 699.35 ha. (Atlas 1993), which included the three areas mentioned above: Colônia, Sementeira (including both Fazenda Modelo and Cercado Grande areas), and the Ouricuri forest. These 699.35 ha. compose the Kariri-Shoco reserve. Porto Real do Colégio County has a population estimated at 18,351, where 5,961 people live in the Porto Real do Colégio town, while 12,390 live in the rural region (IBGE 2001).

According to a Census taken in 2001 by FUNAI (2001), the Kariri-Shoco are an estimated population of 1,732 Indians, from which 1,312 live inside the reserve area, while 504 Indians live in Porto Real do Colégio town (Table 1). Nascimento (2000, 41) estimates that about 300 to 400 Kariri-Shoco live outside Porto Real do Colégio County. Thus the Kariri-Shoco population can be estimated at a total of approximately 2,132 Indians, considering these data.

Table 1: Kariri-Shoco Demographic Data:

Age Range	Sex		Living in the Reserve		Indian		Total
	Male	Female	Yes	No	Yes	No	
0- 05	62	50	81	31	112	-	112
06- 10	142	113	185	70	255	-	255
11-15	131	129	201	59	260	-	260
16-20	125	128	184	69	252	01	253
21-30	187	191	269	109	354	24	378
31-40	115	100	151	64	198	17	215
41-50	71	87	99	59	139	19	158
51-60	42	45	68	19	75	12	87
+ de 60	47	51	74	24	87	11	98
Total	922	894	1.312	504	1.732	84	1.816

Source: FUNAI (2001).

The FUNAI census (Table 1) estimates that 84 individuals, who are not indigenous people, according to their age ranges they are situated above age 16, which indicates that they are non-indigenous people engaged in conjugal relationships with Kariri-Shoco Indians. It interesting to note that non-Indian population of 84 individuals is included in the total estimated total population of 1,816 people. Also, there is no children or adolescent under the age of 15 considered non-Indian, which demonstrates that children from mixed marriages are considered Indians by consanguineal descent.⁹

⁹ As it was already explained in footnote 2, the Indian Statute establishes “Indian” as “...all individuals of pre-Colombian origin and ancestral lineage who identifies himself/[herself] and is identified as belonging to an ethnic group” (Article 3, Section I). In cases of mixed marriages between indigenous and non-indigenous peoples, the Indian’s identity of the non-indigenous spouse depends in what the ethnic group establishes to incorporate or not the non-indigenous spouse. For example, I found among the Kariri-Shoco those who do not participate in the Ouricuri ritual living outside the reserve (in Porto Real do Colégio town), and were considered Kariri-Shoco Indians because of consanguineal descent. On the other hand, there are non-indigenous spouses who are living inside the reserve and they are not considered Indians. Legal rights for a non-indigenous to be considered Indian follow how the ethnic group incorporate non-indigenous individuals in their community, which in the case of the Kariri-Shoco, according to my observations, the consanguineal descent is

During the twentieth century, the Kariri-Shoco population has greatly increased demographically. Nascimento (2000) made a chart about the evolution of Kariri-Shoco population, where he organizes demographic data from 1840 when it registered a total of 200 Indians. Nascimento (2000) explains that the high rate of demographic growth, which has recently increased by 300% (from 1978 to the year 2000) relates to the return of those who had traveled to other places and decided to return after the acquisition of Fazenda Modelo (225 ha.) in 1978. Nascimento (2000) also mentions that better control of endemic diseases (through vaccines and medical assistance provided by SPI and later FUNAI), the decreased rate of infant mortality, traditional early marriages, and the prestige of large families have also contributed to demographic growth.

Mata (1989) calls attention to how the events of 1978 have influenced and revitalized indigenous subjectivity. They not only provided for a return of dispersed relatives to the reserve but this was also when mixed marriages became beneficial, particularly because they are in a region where there is scarcity of land. In the census taken by FUNAI in 2001, a population of 84 non-Indians was registered living in the reserve married with Kariri-Shoco individuals. Warren (2001, 102) analyzes Indian resurgence in Brazil and mentions that in the Kariri-Shoco's case, for example, "a cultural orientation of Indianness (as opposed to whitening) was intensified" (Warren 2001, 102), making individuals "embrace a Kariri-Shoco identity or ancestry" (Warren 2001, 102), when Indian identity and land claims had concomitantly been validated. Warren (2001) does not consider that the Kariri-Shoco population growth

the most important criteria. The children of those mixed marriages are legally recognized as descendants, therefore, Indians.

is directly associated to Kairi-Shoco consanguineal relatives who were living in other cities and very often used to come to Ouricuri rituals.¹⁰ Thus, when land claims started to be validated (since 1978) many of those Kariri-Shoco individuals who were living far-away, decided to come back or start to live within Kariri-Shoco reserve. Several of these cases are Kariri-Shoco individuals who had already married non-indigenous.

On the other hand, indigenous rights' recognition through the recent Kariri-Shoco land acquisition (after 1978) have led to even more tense and conflictive situations between Indians and non-Indians regional populations, particularly after 1993 when several posseiros (squatters) were expelled by the government from Cercado Grande (220 ha.) for Kariri-Shoco occupation (Nascimento 2000). At the same time, this governmental recognition of the Kariri-Shoco's rights have shown that Kariri-Shoco identity or ancestry, which can always be claimed by those who have even distant kinship bonds, has provided not only economic advantages including access to land, but also special services provided by governmental assistance (through agencies like FUNAI and, for healthcare, the National Health Foundation (FUNASA).

There is an ambiguous and complex relationship between Indian and non-Indian local populations, where intermarriage still very often occurs. Among the Shucuru-Kariri from Palmeira dos Índios County, intermarriage with non-Indians was the preferential marriage during the twentieth century (Martins 1994). Among the

¹⁰ Several case studies are examples of these individuals as Kariri-Shoco consanguineal relatives who used to live outside Porto Real do Colegio town, like Vanda, who is a midwife among the Kariri-Shoco, Dona Marieta, the oldest shamanic specialist, and Christie, a woman case study, and several others.

Kariri-Shoco, although several recent cases of intermarriage between Indians and non-Indians can be observed, very often member of younger and older generations explain the importance of exclusively indigenous intermarriages as the best option for them. Even a person who had married a non-Indian may share this opinion. Most of the Kariri-Shoco explain that since non-Indians are not allowed to participate in the Ouricuri ritual, it is often problematic to the non-Indian spouse to stay by himself or herself during these ceremonies. There is a thin boundary between identities-subjectivities when kinship relations are established through intermarriage, but shamanistic practices have maintained borders.

The Kariri-Shoco often use the expression *cabeça-seca* (dry-head) when they refer to non-Indians, which is a term that seems to mean those who do not know indigenous knowledge and sacred secrets. Also, very often Kariri-Shoco healers refer to those who practice African Brazilian religions as being *malfeitosos* (dreadful ones) who practice black magic. Thus, strong ethnic boundaries are established through religious ritual and also medical practices which relate to indigenous shamanistic knowledge.

The general regional context of poverty that has been aggravated by ecological changes, which have affected mainly agricultural usage of the river's edge, as well as resulting in the lack of fishing (Mata 1989; Mota 1987; Nascimento 2000). According to Sampaio (1995), eighty-five percent of the indigenous population in Northeast Brazil "live regularly with hunger and malnutrition" (Sampaio 1995, 31) and the Kariri-Shoco, located in the semi-arid area (called *Agreste*), do not have sufficient productive land for agriculture. This is the principal cause of their poverty

and hunger (Sampaio 1995). The Kariri-Shoco situation of scarcity is less related pre-existing lack of productive land than to Kariri-Shoco and poor regional population impoverishment as consequences of state interventions in the São Francisco valley.

The ecological changes have affected Kariri-Shoco basic subsistence activities of horticulture or farming and fishing, which have been mostly male activities. It is from the 1970s, after several hydroelectric projects were built through the São Francisco River course, that Kariri-Shoco and other regional populations from the São Francisco River valley were harmed. The economic consequences of ecological changes have affected traditional ways of subsistence, which, for the Kariri-Shoco, relates basically to the work in rice plantations where they were hired and paid as daily workers (Mata 1989; Nascimento 2000). The rice plantations, which were the main resource of remunerated work, could not be cultivated anymore in the flat lands where the river floods had previously irrigated and fertilized the river's edge, maintaining the traditional economic activities linked to ecological rhythm (Mata 1989; Nascimento 2000). Thus, an extensive impoverishment occurred in the whole São Francisco valley, affecting mainly the poor regional population's means of subsistence.

The making of pottery (a female activity) and also the production of bricks and tiles (a male activity) have been the income activities least affected by these ecological changes. Usually made during summer, pottery has been considered throughout their history as the most important economic activity for Kariri-Shoco subsistence. Hohenthal (1960b, 79) registered that Kariri-Shoco women produced 15,500 units of earthenware pottery in 1951. The Kariri-Shoco male activity of the

making bricks and tiles has some limitation since non-Indians also make these and compete with them for selling.

The Kariri-Shoco are under the assistance of FUNAI, which is the agency that succeeded SPI in 1967. Under the Ministry of Justice, FUNAI has a central administration in Brasilia, and is organized into 47 different “Regional Administrations” throughout Brazil that are responsible for coordinating assistance using employees who also work directly on the reserves and who can be Indian persons themselves. It is in Maceio City, the capital of Alagoas state, where the FUNAI Regional Administration assists Kariri-Shoco and other groups located in Alagoas and Sergipe states.

The assistance on the reserves relates to different roles employees assume. In the Kariri-Shoco reserve, employees are mostly Kariri-Shoco Indians. For example, the Kariri-Shoco chief of the FUNAI Post, who coordinates the work of other FUNAI local employees, has held this position for several years. Of five teachers who worked in the elementary school placed in Sementeira area, only one was non-Indian. Also as local FUNAI employees, two technicians in agriculture (one Shucuru-Kariri and the other Kariri-Shoco) worked in agriculture, such as planning, for example, the tractor’s use on agricultural plantations.

According to Oliveira Filho (1988), Indian ethnic groups in Brazil live in this reserve system with considerable variety in terms of territorial dimensions, contact with Brazilian national society, ecological environments, and the cultural specificity of each group, but they are all characterized by a situation of domination through the tutelage system. From what I have observed among the Kariri-Shoco (and also the

Shucuru-Kariri), this domination relates to political and economic interdependencies established between Indians themselves and non-Indians under the actions of tutelage organs during history; both SPI and FUNAI have had similar practices. These agencies have maintained political and economic control of the reserved areas. For example, the role of the Cacique indigenous political leader has been legitimated by the FUNAI as the one who mediates economic and political relations between Indians and the organization.

Throughout history indigenous groups have experienced domination as a social process from which inter-ethnic relations have been characterized. For example, the reserve system that the SPI model maintained directed political and economic means through activities managed by employees in order to make Kariri-Shoco become productive rural workers. The FUNAI assistance, even today, supplies the Kariri-Shoco with seeds, fuel for and maintenance of the tractor (which belongs to the “Indian post”), chemical fertilizers, pesticides, tools for agriculture (axes, etc.), and other materials, upon which they depend for subsistence agriculture on parcel of lands which Kariri-Shoco people use within the reserve. Oliveira Filho (1988) explains that domination has been established through historical interdependencies throughout history from which indigenous institutions have been articulated within tutelage systems’ models.

Nascimento (2000) calls attention to the fact that although the Kariri-Shoco currently have available land for economic usage, they depend on FUNAI’s assistance more than ever to sustain their agriculture for subsistence, where “the lack of a native model for economic resource exploitation aggravates even more their

situation” (Nascimento 2000, 45). Nascimento (2000) argues that since the traditional regional economic structure has been affected by state interventions in the region, which have interfered directly with subsistence means for working on non-Indian properties, the Kariri-Shoco have less access to food and autonomy than before. Thus, paradoxically, although Kariri-Shoco have had land claims rights recognition, they have been impoverished and have become even more vulnerable and dependent on the tutelage system’s assistance (Nascimento 2000).

The tutelage system is also extended to biomedical healthcare assistance. The contemporary model of health and health services for Indian ethnic groups determines that the administration of Indian healthcare is the responsibility of both FUNAI, which works directly with Indian rights, and *Fundação Nacional de Saúde*-The National Health Foundation (FUNASA). The biomedical health services are provided by the public health system through local municipal and state healthcare assistance, linked to the Unique Health System-*Sistema Único de Saúde* (SUS), which is part of the Ministry of Health. The local biomedical assistance, which FUNASA is responsible for) is part of the government system: Indigenous Health System-*Sistema de Saúde Indígena* that coordinates thirty-four Special Sanitary Indian Districts-*Distritos Sanitários Indígenas* (DSEI) throughout Brazil. The DSEI for Indian ethnic groups in Alagoas and Sergipe states is located in Maceio city (Brasil 2000). The health services are provided through local (municipal) and regional (state) public health systems.

An ethnoepidemiological study conducted by medical and other anthropologists (Accioly, de Carvalho, and Ferreira 1998), on the Pankararu from

Northeast Brazil reflects the new policy of the Brazilian government on health services for Indian ethnic groups. Although the authors based their suggestions on “ethno-epidemiological diagnoses” (Accioly, Carvalho and Ferreira 1998, 196) that utilize both the Western biomedical system and traditional medical systems, these authors were unable, during their research, to perceive a shamanistic knowledge among the Pankararu that would constitute their traditional medical practice (Martins 2000). This example shows that the biomedical one will probably continue to be the only medical system considered useful by government health services for indigenous groups in northeastern Brazil.

The Kariri-Shoco receive biomedical assistance through a health clinic in the reserve Sementeira area which offers primary healthcare, and where a medical doctor, a dentist, a psychologist, a nurse, five nursing assistants, and two health assistants compose the FUNASA healthcare team. During my fieldwork, the psychologist and the dentist were transferred to another indigenous area and the nurse position remained unfilled. The two health assistants, who are Kariri-Shoco individuals, work directly with the people; their activities include visiting families to ask about health problems and to schedule appointments with the local medical doctor. Among the nursing assistants, only one was non-indigenous and lived in Porto Real do Colegio town. It is after the Sementeira health clinic medical doctor’s diagnosis that a Kariri-Shoco may be sent to necessary specialized biomedical assistance. The Kariri-Shoco who need to have medical exams to be prepared for surgery and or be assisted by a specialized medical doctor have to travel to Penedo or Maceio cities, where FUNASA has formal affiliations with hospitals to provide necessary specialized biomedical

healthcare. Kariri-Shoco patients are transferred to these hospitals by ambulance available in the Sementeira health clinic, particularly in an emergency or if surgery is necessary. Several studies have shown that populations located in poor regions receive public health services of precarious quality (Accioly and Carvalho 1998; Citele, Souza and Portella 1998; Perpétuo 2000; Sanematsu 1998; Scheper-Hughes 1985, 1992; Tanaka 2000).

Kariri-Shoco shamanism as a medical knowledge and a system of beliefs has constituted a way of resistance to colonial constraints throughout history (Mota 1987). The Kariri-Shoco and several other northeastern Brazilian cross-cultural contexts, like in the Pankararu's case, have exercised a power related to their knowledge, which involve cure-healing practices directed at indigenous peoples and non-indigenous. It is through this strong channel that the Kariri-Shoco have empowered their ethnic boundaries.

This chapter considered Kariri-Shoco history, the contemporary context, and cultural characteristics of the Kariri-Shoco and other northeastern indigenous peoples. It observed that contemporary indigenous groups in Northeast Brazil are resultants of the colonial process, from which, despite political, economic, and cultural constraints, these peoples continue to be empowered by their knowledge.

CHAPTER III

THEORETICAL CONTEXT

The research that I have conducted among the Kariri-Shoco has focused on gendered and female embodiment, on reproduction, and on the indigenous medical knowledge and practice. The objective here is to present fundamental theoretical perspectives utilized for understanding diverse ethnographic data from the field research, which will be described in Chapters V-VIII. In the present chapter, a literature review focuses on theoretical perspectives and key concepts that were used for the field research, as well as for further data analysis.

3.1. Selective Literature Review

[Biology] is an open materiality, a set of (possibly infinite) tendencies and potentialities which may be developed, yet whose development will necessarily hinder or induce other developments and other trajectories... they are more like bodily styles, habits, practices, whose logic entails that one preference, one modality excludes or make difficult other possibilities (Grosz 1994, 83).

The main theoretical fields from which I have conducted ethnographic research among the Kariri-Shoco relate to female embodiment, reproduction, and shamanism. While female embodiment has been explored within feminist theory as the major research background, the reproductive female body and shamanism are considered inside medical anthropological grounds.

3.1.1. Feminist Theory on Female Embodiment

The notions of gender in feminist thought and the discussion on differences that demarcate and inscribe female and male bodies have been fundamental themes of feminist concerns. These theoretical perspectives reveal understandings from the focus on how the female body has been the site of power relations in gendered relationships or representations (Alcoff 1994; de Beauvoir 1974; O'Brien 1981; Ortner 1996; Rich 1976, 1983; Scott 1996, 1999; Yanakisako and Collier 1987) to how the sexual corporeal differences demarcate the interwoven characteristics of the body through systems of meanings and representations (Butler 1990, 1993; Grosz 1994; Irigaray 1974, 1977; Young 1990). Although feminist ideas are not homogeneous, what is shared among different trends is the focus on power, and on the discussion of the asymmetry/inequality with/within the gender dichotomy/difference. Contemporary feminist concerns are related to discussions on sexual differences, which are sources of social control and objects of gendered inscriptions in male and female bodies.

It is important to mention that the notions of phallogocentrism and patriarchy are two central concepts that have been present in feminist theories. They are both related to historical Western capitalist contexts where sexual and social-political characteristics of male power have been maintained. While the notion of phallogocentrism is related to the construction of sexuality “in terms of heterosexual and phallic cultural conventions” through “discourse and power” (Butler 1990, 30), patriarchy in a broad sense consists of a “familial-social, ideological, political system

of male domination in which by force, direct pressure, or through ritual, tradition, law, language, customs, etiquette, education, and the division of labor, determines and maintains female oppression through social and gendered inequality” (Rich 1983, 57). These notions, which have been constructed and experienced within Western societies, demonstrate that much of the feminist theory has been formulated through Western concepts and problems. Feminist anthropologists and philosophers have had a fundamental role in developing critiques in order to universalize, particularize, or relativize female oppression in Western and non-Western cultural contexts. Although I do not directly discuss and analyze how phallogocentrism and patriarchy constitute factors for female oppression among the Kariri-Shoco, I consider the concept of patriarchy a useful reference for reflections about Kariri-Shoco contemporary cultural context.

Elizabeth Grosz (1994, 15-19) describes the “egalitarian[/essentialist] feminism,” the “social constructionist,” and the “sexual difference” approaches as three different groups of feminist theory on female embodiment (and subjectivity). According to Grosz (1994) these three groups of feminist theory demarcate diverse theoretical and methodological considerations of the body. Thus, the conceptualization of gender has been the subject of different perspectives in feminist theorizing where the discussions on female embodied subjectivity have been considered.

The research conducted among the Kariri-Shoco focused basically on shamanic specialists’ and women’s own reproductive experiences and perceptions of sexual differences. The interrelation between Kariri-Shoco shamanism (as indigenous

cure-healing practices) and Kariri-Shoco knowledge on sexual differences are fundamental themes researched. Thus, the theoretical perspectives useful for the research topics about gender belong to the author's ideas from the body of feminist theory where sexual difference has been the mainstream for approaching female embodiment. I consider that understanding of these the three groups of feminist theory, about female embodiment mentioned by Grosz (1994), is important in order to clarify my identification and use of the third group's ideas as the feminist theoretical orientation for this research. This explanation is also important regarding relating theoretical perspectives on the female body to perspectives utilized by medical anthropologists when researching women, and also by ethnologists when approaching gender in studies about shamanism as a medical knowledge.

The egalitarian group, which could be represented as ideas of essentialist feminism (de Beauvoir 1974; Rich 1976, 1983; O'Brien 1981), have developed studies analyzing how biological reproductive aspects characterize the female body from which they point out that these have been a source for male domination. In these works, the term woman is used through the assumption that it denotes a common identity and that the female body is the focus of a gender-differentiated subjectivity. In some sense, these authors develop a biologism or naturalism perspective since they are all interpreting the biological specificity of reproduction as characteristic of the female body subjectivity (Grosz 1994).

The "second-wave" of feminism, which came after the essentialists, also reproduced a perception of the body as "ahistorical," "biologically determined," "prehistorical," "fixed," and as "raw materials" subjected to enculturation (Grosz

1994, 16-17; Butler 1990). Since the 1980s critics have moved to point out how problematic the essentialist perspective is. They argue that gender must be considered in terms of its different historical contexts and its intersections with racial, class, ethnic, sexual, and specific identities.

The split between biological sex and gender, which characterized 'social constructionism', was a fundamental step in order to consider that female subjectivity is characterized by historical, cultural, social, political, and other domains that demarcate differences within the category of woman (Butler 1990). From this perspective, feminists began to propose analytical methods in order to approach gender through its cultural and political meaning constructions. They started working with the vision that inequalities are not produced from the female body, nor are they related or restricted to generalized Western notions of oppression through male-female relationships (as the essentialists conceived), but that social, racial, and ethnic differences or inequalities have characterized female oppression in specific cultural, social, and political contexts.

Yanakisako and Collier (1987), Ortner (1996), Alcoff (1994), and Scott (1996), are representative of this new framework. They propose analysis of gender from its particular context and investigation on how political inequalities reflect the place of women in social hierarchy. In this sense, gender becomes understood as a social identity (Scott, 1996; Ortner, 1996), "a posit or construct" (Alcoff, 1994). These authors focus on subjectivity through conceptual positions from which gender is approached through its non-unitary character and its social and historical production through signification. In this view, power relations and systematic

reproduction of difference provide the basis for the understanding of gendered embodiment.

Joan Scott's (1996) definition of gender has largely influenced studies in this field in Brazil. She formulates a notion of gender inside an analytical proposal, which has two basic propositions and elements of investigation: "gender is a constitutive element of social relationships based on perceived differences between the sexes" (Scott 1996, 167), where four interrelated elements are involved, including "cultural symbols," "normative concepts," a "notion of politics" implicit in institutions and organizations, and the "subjective identity" as "enculturated transformation of the biological sex" (Scott 1996, 167-169). Scott (1996) explains that her analytical proposal "approaches the process of constructing gendered relationships through class, race, ethnicity, or, any social process" (Scott 1996, 168). She calls attention to the notion that gender is the "primary field within which or by means of which power is articulated" (Scott 1996, 169) and she also mentions that "gender is constructed through kinship, but not exclusively" (Scott 1996, 168), since it is also interrelated with economic and political domains and constructs.

Scott's (1996) proposal has been particularly significant because several sociologists and anthropologists have utilized or mentioned her ideas in studies of gender in Brazil. For example, the anthropologist Claudia Fonseca (1996, 16) discusses changes in the conceptualization of gender and mentions a new tradition in these studies within the academic environment in which Scott's (1996) contribution has been influential in the way in which the political element is articulated in the definition of gender. The sociologist Mary Castro (1996) discusses the importance of

a gender perspective in analyses of women and work in Latin America. She mentions that Scott's (1996) concept of gender as a construct is useful in order to investigate the "demarcation of power relationships" (Castro 1996, 66), and also that it is a new reference to "the understanding of the place of women and men within culturally legitimated experiences in the logic of power" (Castro 1996, 66).

Another sociologist, Noëlle Lechat (1996), who conducted research on gender relationships within a peasant political movement for land claims in southern Brazil, finds in Scott's (1996) ideas support to explain that the study of the subjective experience and role of women in a political movement is to inscribe women into history. Lechat (1996) mentions that she follows Scott (1996) who redefines and enlarges the traditional notions of what is historically important through personal and subjective experiences of women in public and political activities.

As a South American country, Brazil is characterized by cultural diversity and by racism (DaMatta 1985; Ribeiro 2000), with impoverished and marginalized conditions for women's lives (Citele, Souza and Portella 1998; Lechat 1996; Perpétuo 2000; Sanematsu 1998; Scheper-Hughes 1985, 1988, 1992; Tanaka 2000). Thus, gender, race, and class relations have been articulated and considered for analysis of gendered social and political relationships. These 'social constructionist' studies in Brazil have had a fundamental role in approaching women in situational contexts, through which the aspiration towards 'equality' between men and women or 'autonomy' (as women's rights to 'self-determination' within differences among them) have been considered relevant matters for intellectual and academic feminist aims and concerns.

Grosz (1994) and Butler (1990, 1994), who are representative of feminists of the third group (“sexual difference” approaches), have formulated critiques on the consideration of gender that “social constructionism” has been utilizing. Grosz (1994, 16) argues that this feminist view, which includes the majority of feminists today (Marxist feminists, psychoanalytic feminists, and others), differs from essentialists who have coded women through the nature-culture dualism; these second-wave feminist theorists have reproduced the mind-body dualism, where the mind is considered “as social, cultural, and historical object, a product of ideology,” and the body as “naturalistic, precultural” (Grosz 1994, 17).

Butler (1990) mentions that the sense of gender as a construct implies a vision that the body is a passive medium for inscriptions of cultural meanings or is considered “the instrument of a will [‘appropriate’ or ‘interpretative’]” (Butler 1990, 8) that “determines a cultural meaning for itself” (Butler 1990, 8). It is exactly through this critique that Butler (1990) formulates a concept of gender as performative, and tries to overlap the mind-body dualism through a notion of gender as a product of “the truth effects of a discourse of primary and stable identity” (Butler 1990, 136) in which “acts, gestures, and desire produce the effect of an internal core of substance” (Butler 1990, 136).

Regarding the view of gender as a “social” or “cultural” construct, Butler (1990) argues that it is culture, not biology (as in the essentialist perspective) that becomes what determines gendered subjects and, in this sense, as Grosz (1994) has observed, the body remains a “raw material,” and “naturalistic.” For Butler (1990), whether conceiving gender as derived from biological sex (an essentialist view) or

gender as a “free-floating artifice” (in a radical independence assumption of sex and gender, in the social constructionism), it is a product of a discursive domain that limits, presupposes and prevents “possible imaginable and realizable gender configurations within a culture” (Butler 1990, 9).

The “truth of sex,” according to Butler (1990) “is produced precisely through the regulatory practices that generate coherent identities through the matrix of coherent gender norms” (Butler 1990, 17). Thus, the intelligibility of genders “institute and maintain relations of coherence and continuity among sex, gender, sexual practice, and desire” (Butler 1990, 17). It is through the formulation of the “heterosexual matrix” concept that Butler (1990) explains that gender identity has become intelligible through “a hegemonic discursive/epistemic model of gender intelligibility that assumes that for bodies to cohere and make sense there must be a stable sex expressed through a stable gender (masculine expresses male, feminine expresses female) that is oppositionally and hierarchically defined through the compulsory practice of heterosexuality” (Butler 1990, 151). This author calls attention that the “heterosexualization of desire requires and institutes the production of discrete and asymmetrical oppositions between ‘feminine’ and ‘masculine’, where these [oppositions] are understood as expressive attributes of ‘male’ and ‘female’” (Butler 1990, 17).

This gender notion pointed out by Butler (1990), based on her critique of the essentialist and social constructionist views, from which she formulates the “heterosexual matrix” concept, is particularly important for my research conducted among the Kariri-Shoco, since Butler (1990) calls attention to discursive domains

where language expresses boundaries of gender possibilities and constraints (through what is imaginable within gender a domain). I consider Butler's (1990) concepts of "heterosexual matrix" and "heterosexualization of desire" is important in order to discuss how Kariri-Shoco reproductive women practice sexual desire related to heterosexuality.

Butler (1990, 1993) transgresses the mind-body dualism, approaching and articulating biological sex and gender from a discursive domain, where she identifies a coherence that makes gender intelligible, and this coherence is itself a mechanism of power. Like Foucault (1983, 1990a, 1990b, 1990c), Butler (1990) explains and moves toward 'analytics' of power, considering what determines or undermines the frameworks in which a "truth of sex" and "mechanisms of power" are produced. For Butler (1990), the biological sex and gendered body are articulated in a discursive dichotomy (between feminine and masculine) that coheres within representations. This theoretical perspective seems actually useful in the way that, in order to approach the notion of gender through Kariri-Shoco women's perceptions and experiences, it was fundamental to the understanding of what underlay logical assumptions through discourses. What is problematic in this view is the emphasis on representation over experiences of everyday life. Thus, a theoretical orientation based more on a phenomenological approach helped to guide the analysis to focus on existential ground.

It was through a phenomenological approach to female embodiment that the barriers and limits of poststructuralist semiotics analysis, which privileges and remains in the representational domain through text and discourse, could be addressed

through an account of lived and existential experiences. Thus, it is through Kariri-Shoco women's lived experiences that an approach to their female embodiment was researched beyond the limits of essentialist, constructivist, and even poststructuralist theoretical views. In the third group of feminist theorists, Grosz (1994) explains that, contrasting with other groups, "the body is par excellence regarded as a historical, political, social, and cultural object" (Grosz 1994, 18).

During my field research among the Kariri-Shoco, the main theoretical approach on the female body related to this perception that the body expresses culture. From this theoretical framework, sexual differences and gender distinctions were examined among the Kariri-Shoco, considering the female body through a phenomenological approach at the individual female experiences level, while gendered embodiment was considered through an approach to Kariri-Shoco shamanistic knowledge and practices. The Kariri-Shoco female body politic was approached through a focus on the medicalization of reproduction and how authoritative knowledge has been deployed among them.

Grosz (1994), who is also representative of the third group of feminist theorists, is more committed to a phenomenological account of the body. She points out, influenced by Merleau-Ponty (1962), that the body is "both object (for others) and a lived reality (for the subject)" (Grosz 1994, 87), but never remains or is restricted to being object or subject. The body, for Grosz (1994), has a dynamic and fluid interaction with objects. At the same time as defining objects as such, in her words, the body "is 'sense-bestowing' and 'form-giving', providing a structure, organization, and ground within which objects are to be situated and against which

the body-subject is positioned” (Grosz 1994, 87). Thus, the relation between the subject and objects is marked not by causality, but is fundamentally “based on sense or meaning” (Grosz 1994, 87). It is through this phenomenological conception of the body, through the articulation of subject-objectified body in experience that I have developed an approach to the body in the Kariri-Shoco cultural context, where the female body is investigated in a being-in-the-world experience perspective.

The dualisms such as body-mind, subject-object, and biology-culture have to be transcended through experience, through bodily corporeality, and through perception (subject-objectified body in experience). At this point, it is not the body as a biological given, but the body in a sense of being, of existing, literally of making sense. For Grosz (1994), although the body and sexual difference are matters of cultural inscription and codification, they are never raw material for these inscriptions. She focuses on the body as “inside out” and “outside in” surfaces, and she argues that its materiality attests to embodiment, corporeality, and alterity (sexual, ethnic, aging) according to cultural specificities. She also suggests that feminist philosophers of the body need to develop an understanding of “embodied subjectivity,” avoiding essentialism, dualism, dichotomy, binary, or singular models for accounting for the body (Grosz 1994, 22).

Grosz (1994) suggests that Merleau-Ponty’s (1962, 166) consideration of sexuality as a “modality of existence” is an important reference point from which to approach embodied subjectivity. According to him, “the theory of the body is already a theory of perception” (Merleau-Ponty 1962, 203). The focus on lived experience and perception can provide a basis for approaching and articulating the mind-body

and subject-object problematic, in which embodied subjectivity can be considered as the perceiving ‘subject + the corporeal subject’, that moves and is moved by the body as acting perceiver, in such a way that embodied subjectivity is approached intrinsically, nondualistically, and fundamentally conditionally, once it is lived within an existential immediacy (Grosz 1994, Csordas 1994).

The theoretical perspectives that I have utilized for data analysis relate to this third group of feminist theoretical perception of sexual difference. Thus, the female body is considered not as a biological given reality, nor as a space where cultural constructs are founded. Theoretical perspectives from which the female body has been researched relate to Butler’s (1990) notion of gender as it belongs to a discursive domain, and Grosz’s (1994) notion, influenced by Merleau-Ponty (1962), that there is an embodied subjectivity based on the ‘open’ materiality of the body, which attests to embodiment, corporeality, and difference.

3.1.2. The Reproductive Female Body:

The female reproductive body has been considered through wide fields of knowledge in contemporary studies in medical anthropology. The “Anthropology of Reproduction” has produced studies that associate cultural, social, and political aspects of reproductive processes (pregnancy, childbirth, and the menstrual cycle) as experienced by the female reproductive body. Different feminist perspectives on female embodiment have influenced these studies. For example, the notion of the female body as the space for cultural inscription, as conceived by feminists from the social constructionist group, has formed most of the background of these studies. It is

through ethnographic and historical studies that researchers have critically considered reproductive processes experienced by women during their life-cycle as socioculturally and politically constructed. Thus, gender politics have been the background and focus for approaching human reproduction and the female body politic.

In order to approach how Kariri-Shoco women perceive and experience reproductive physiological processes (pregnancy, childbirth, and the menstrual cycle) during their life-cycle in the context of plural medical practices, two main theoretical concepts were fundamental: the notion of medicalization of reproduction and the concept of authoritative knowledge. Both of these theoretical concepts relate to body politics where the interplay of biomedical and indigenous knowledge is considered and analyzed.

Theoretical perspectives in anthropology have focused on the controlling gaze of biomedical knowledge over women's bodies. Such studies have pointed out through critical frameworks how pregnancy, childbirth, and the menstrual cycle have been medicalized. They show how physiological reproductive processes have been transformed into biological, medical, pathological or technological matters. Thus, the concept of medicalization is a central issue in these studies that show how women have challenged, resisted and or complied with biomedical practices in the context of their lived experiences (Browner and Sargent 1990; Davis-Floyd 1988, 1990; Ginsburg and Rapp 1991, 1995; Handwerker 1990; Hyatt 1999; Kaufert and O'Neil 1990, 1993; Lock and Kaufert 1998; Lopez 1998).

Another important concept used here to approach the Kariri-Shoco female reproductive body that was formulated in studies about pregnancy and childbirth is the notion of “authoritative knowledge.” Jordan (1978) explains that “for any particular domain, several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand, or because they are associated with a stronger power base” (Jordan 1978, 152). Thus, the notion of authoritative knowledge, according to Jordan (1978), relates to which system comes to carry the most weight, from which the legitimization of one way of knowing as being more valued characterizes an authoritative and more valid knowledge, while others are dismissed or devaluated. This notion helped to focus on the role and interplay of biomedicine in the context of Kariri-Shoco reproductive women’s plural medical practices.

Several studies have described how authoritative knowledge has been produced, displayed, resisted, or challenged in social, clinical, and political interactions (Abel and Browner 1998; Browner and Press 1996; Davis-Floyd 1988, 1990; Davis-Floyd and Davis 1996; Davis-Floyd and Sargent 1996; Fiedler 1996; Georges 1996; Hays 1996; Jordan 1978; Sesia 1996). They call attention to the recent Western production of hegemonies of biomedical modes of birth. For example, that is what Davis-Floyd (1988, 1990) explored through the “technocratic,” “holistic” and “natural” Western models of birth as belief systems and rites of passage women choose in the United States. The ideas behind logical arguments and symbolic issues Davis-Floyd (1988, 1990) describes are related to political recognition of the experiences women have with childbirth, which she relates to sex-domination,

domination related to patriarchy, and to biomedical knowledge through the medicalization process.

The ethnographic research, which I have conducted, has focused on Kariri-Shoco ethnophysiology and reproductive processes by investigating their conceptions, perceptions, and practices related to sexual differences and cure-healing practices. Thus, the Kariri-Shoco women's meanings and experiences with physiological reproductive processes and their ethnophysiological perceptions were considered fundamental paths followed for the understanding of their way of dealing with the reproductive female body. In order to approach Kariri-Shoco female embodiment related to physiological reproductive processes (pregnancy, childbirth and menstrual cycle), it was necessary to understand ethnophysiological concepts and implicit gender notions contained in their reproductive logic and behavior (Browner and Sargent 1990).

Thus, gender was considered as an important element in order to understand how different sexual bodies, and particularly women's menstrual blood, conception and pregnancy, are culturally perceived and embedded with symbolic meanings. In this sense, bodily fluids were related to the biological body's permeability, boundaries, and marginalities, which involve sex differentiated bodies and in which the differences are culturally, socially and symbolically constructed (Grosz 1994).

The theoretical analytic model and conceptions of the third group of feminists who focus on sexual difference, such as Butler (1990) and Grosz (1994), have guided my approach on the Kariri-Shoco female body to a wide and in-depth focus on different levels of experiences. From my understanding, sexual differences permeate

Kariri-Shoco women's experiences related to their reproductive female body, from individual (phenomenological) to socio-politic experiences, while shamanistic knowledge and practices also mark sexual differences.

3.1.3. Shamanism as Indigenous Medical Knowledge:

Medical anthropologists have developed critical views of Western biomedical models and practices, and have examined aspects of medical systems, such as shamanism, religious healing, herbalism, as well as Western biomedicine, and psychotherapy strategies (Csordas and Kleinman 1990). Medical anthropology deals with events related to cure-healing, suffering, disease, sickness, and distress that imply representations, actions, and experiences people have within their bodies.

One of the main research concerns was to focus on the interrelation between Kariri-Shoco shamanism (indigenous cure-healing practices) and Kariri-Shoco sexual differences. Thus, gendered embodiment of Kariri-Shoco shamans' roles on cure-healing practices, and Kariri-Shoco women's use of shamanistic knowledge are important matters for research. Thus, during the field research it was fundamental to the understanding of what was actually identified, defined, and experienced as a gendered and embodied (health) problem, which required diagnosis, treatment, and healing (Csordas and Kleinman 1990), particularly on issues related to the female body. Indigenous healing has been considered as a component of legitimate medical practice in cross-cultural contexts.

Kariri-Shoco historical context required attention to the situation of medical pluralism in which the choices of treatment that people take are both indigenous, and

Western biomedical. Theoretical approaches to the therapeutic processes (people's active responses to illness, disease, and distress) have explained that they can take place in the domain of religious or traditional healing or folk practices, along with therapies used by biomedical models (Brodwin 1996; Crandon-Malamud 1991; Young and Garro 1981). Kariri-Shoco shamanism, as a medical practice, has not only occupied the space for indigenous medical knowledge from which specialized shamans compose an indigenous healthcare system, but also the plural medical practices that take place in a cultural environment where an indigenous medical practice is very often used by Indians and non-Indians. Thus Kariri-Shoco shamanistic knowledge is characterized as a channel from where relationships are established, whether among the Kariri-Shoco themselves or with other indigenous groups from Northeast Brazil, and also through relationships with non-indigenous people.

The theoretical perspective utilized to research Kariri-Shoco shamanism as a medical knowledge was based on researchers who propose a phenomenological method in the medical anthropological field, and who have carried out critical and theoretical approaches on its relation to biomedicine (Good 1994; Good and Good 1993; Hahn 1995; Kleinman 1995; Strathern and Stewart 1999). Good's (1994) notion of illness, which was utilized in dealing with Kariri-Shoco medical issues, contains this phenomenological perspective through his proposal of its investigation as "human experience," where human suffering must be interpreted and focused upon, departing from its constituting role in social processes. This perspective was followed during the field research when my concerns as to focus upon shamanism as

a medical practice in which combined aspects of embodied gendered therapeutic processes take place.

It is very widespread in anthropological studies that medical matters lie within the realm of beliefs. Evans-Pritchard (1937) has been an example that Good (1994) uses to show how medical issues have been conceived and described by anthropologists as matters of cultural beliefs. Good (1994) critically analyzes the empiricist paradigm, and points out how “representation of others’ culture as ‘beliefs’ authorizes the position and knowledge of the anthropologist [as] observer” (Good 1994, 20), and how it is problematic as it contains a “juxtaposition of ‘belief’ and knowledge” (Good 1994, 20). This juxtaposition can be identified in several studies on shamanism, even in those where symbolic anthropology has been applied. Several authors have used, in their ethnographic studies, the notion of belief alternatively with the notion of knowledge, or sometimes, knowledge is not even mentioned or considered by the authors.

Anthropologists have developed approaches that focus on the characteristic of embodiment in South American shamanisms. Langdon (1992b), Illius (1992), Pollock (1996), and McCallum (1996) provide examples of studies that focus on central native shamanistic conceptions, which they consider as metaphors or symbols that are linked with construction and representations of the body.

Langdon (1992b) approaches the Siona shamanism complex by exploring their conceptions of the universe, the forces that make or provide “well-being” or “ill-health,” and the nature and source of shamanic power. It was through investigating the significance of the term *dau* (power) that Langdon (1992b) examined how the

shaman gains and possesses “dau,” which provides him with an ability to “understand and influence the forces responsible for well-being” (Langdon 1992b, 42). She explains that only after they recognize a sickness that the expression “dying from a dau” (Langdon 1992b, 42) is used, an expression which she identifies as having a metaphorical meaning of a supernatural cause, or that a substance (dau) in the patient’s body has to be removed. The interpretation of the illness’s cause (supernatural or substance dau) depends on “the history of the illness and its response to treatment” (Langdon 1992b, 51). She concludes that dau is a key symbol in Siona shamanism which expresses a “general conception of energy or power” and that “the shaman’s knowledge, experience and intentions, or spirits’ intentions provide circumstances for its manifestation, operation and healing practices” (Langdon 1992b, 52). In this analysis, Langdon (1992b) argues that Siona shamanism is the focus of knowledge and power, which is embodied within the shaman’s body and also in individual embodied manifestations of illness.

Illius (1992) analyzes the “*nihue*” concept, which the Shipibo-Conibo of eastern Peru relates to health. Illius (1992, 63) explains that “*nihue*” contains “the individual essence” which causes illness: thus, it is a central concern for medical practitioners (shamans, healers/*vegetalistas*, and “bone-setters”). He identifies fifteen treatments of “*nihue*” according to thirty curing songs, and he also classifies “*nihue*” sources (such as identification of plants, animals, bodily fluids) and properties (consistency, smell, light or colours, motion, and temperatures) according to the *nihue* name and identity. In his approach to Shipibo-Conibo shamanism, Illius (1992) illustrates rituals and techniques used by the shamans who restore health through

curing songs and visions induced by *ayahuasca* (*Banisteriopsis* sp.), from which the shaman identifies, diagnoses, and treats the patient. Illius (1992) credits a Shipibo-Conibo shaman's ability to cure to his knowledge and his understanding of the case history and circumstances of the sickness.

McCallum (1996) departs from a focus on Cashinawa (from Brazil and Peru) epistemology of the body in order to explain their verbal and medical techniques and conceptions that transform their bodies into "the body that knows" (McCallum 1996, 347). She discusses how they conceive that the healthy body is in constant process of "learning through the senses" and how "accumulated knowledge" is expressed in "social action and speech" (McCallum 1996, 347). She suggests that medical anthropologists, when approaching non-Western cultural traditions, as in the case of the Cashinawa, have to investigate and be based on "ethno-epistemology," which constitutes a "medical anthropology per se" (McCallum 1996, 365) of the peoples.

Pollock (1992) approaches the Culina's shamanism of western Brazil with a focus on gender power, and knowledge. He also identifies a central concept ("*dori*"), which the Culina conceive as a substance that shamans acquire through the process of becoming shamans and which makes them able to manipulate it. According to Pollock (1992, 27), Culina shamans are the ones who can transform themselves into spirits and who have the ability to diagnose and treat serious illnesses of mystical origin. He explores Culina shamanism as a form of gendered practice, as both a reflexive discourse on masculinity, and a mutually constituting dialogue between men and women, between the properties that "comprise their innermost differentiation qualities and their public contributions to social life" (Pollock 1992, 25).

It is interesting that, in a later publication, Pollock (1996) approaches the Kulina's ethnomedical beliefs and practices which, according to him, provide conditions for fundamental characteristics of their constructions of personhood and illness. Through a different discourse, Pollock (1996) now describes the Kulina's context of illness as beliefs: he mentions that the Kulina classify as external (on the outside of the body) and internal (within the body, originated from mystical causes) types of illness manifestations. Pollock (1996) articulates the significance of the internal illnesses, which are related to witchcraft and to violations of prohibitions, as languages for Kulina personhood construction.

I do not understand Pollock's move from a perspective in which he presents Culina shamanism as knowledge (Pollock 1992) to an approach on their ethnomedicine as a cultural belief (Pollock 1996), where he does not even explain the interplay between Culina shamanism and Culina ethnomedicine. This latter publication was for the medical anthropological community and Pollock's (1996) interpretation, on which Roseman (1996) positively comments, relates to a whole ethnographic literature, on South American Aboriginal populations from the lowland regions, which focuses on the body as a matrix of symbols and thoughts (see DaMatta 1976; DaMatta, Seeger and Viveiros de Castro 1987; Seeger 1980, 1981; Viveiros de Castro 1986, 1987a, 1987b).

These studies show that besides differences between South American populations' cultural contexts (ecological, organizational and cosmological), a basic element in these cultures is an emphasis on the body. This provides a particularly rich elaboration of the notion of person, where the body is the reference point for the

comprehension of the social organization and cosmology of these societies: thus, the body is “a focal symbolic idiom” (DaMatta, Seeger and Viveiros de Castro 1987, 12).

Although Clarice Mota (1987, 1996, 1997) recognizes the Kariri-Shoco’s botanical knowledge, she considers it placed in a “system of beliefs [which] is translated into a system of magical actions and reactions” (Mota 1987, 147). Other examples illustrate this: “plants are believed to be an intrinsic part of the pursuit for power” (Mota 1987, 149); or “certain uses and practices are directly related to specific beliefs and imply the development of an initiation process” (Mota 1987, 150). In this last statement, she is not explaining how they transmit specific knowledge, but, using a semiotic paradigm, she places Kariri-Shoco shamanism in a “system of beliefs.”

The significance of cure among the Kariri-Shoco, as Mota (1987) points out, has a dual meaning based on the “physical and spiritual aspects of someone’s life: in the first meaning, cure seems to re-establish physical wellness and also to ward off evil, to be blessed to have spiritual strength restored upon one; as a second meaning, a double-edged one, it has both positive (meaning strength, being blessed, having good energy) and negative (meaning that the person has been bewitched) meanings” (Mota 1987, 152). Then bad events (not only a negative physical manifestation) in everyday affairs can mean that a cure (inversed healing) has been perpetrated against that person, and he or she has to take special herbal medicines to be cured (healed) positively.

Mota (1987, 232) explains that the Kariri-Shoco's "animistic theory of the world" is the base to understand their conceptualization of health and illness. According to her, they differentiate dead spirits (souls of the dead persons, which continue to live in forests, villages and places where they used to live when they were alive) from live spirits, "beings who are alive in humans, animals, vegetal" (Mota 1987, 232). She explains that illnesses are caused by "live spiritual beings that enter a person's body, either spontaneously or by responding to someone's will" (Mota 1987, 233). Everyone who participates in Ouricuri's ritual "learns how to utilize nature's power, as everyone becomes empowered by a special plant" (Mota 1987, 239). She also observes that the Kariri-Shoco conceptualize relationships between the "type of healing" and the "type of illness," and there are "spiritually-provoked illness," which cannot be cured by a medical doctor (Mota 1987, 240).

Mota (1987, 1996, 1997) considers that Kariri-Shoco shamanism is a phenomenon that reveals how political minorities resist domination and maintain ethnic consciousness (part of a self-imagery construction); and that Kariri-Shoco shamanism is a social process linked to cultural resistance within a class struggle environment, where the "symbolic significance of botanical medicines is directly related to ethnic preservation and counter-hegemonic strategies against... the national society" (Mota 1987, 12). The utilitarian (economic) and political sense of this knowledge, she relates to the relation of power shamans maintain with non-Indians through the practices of healing at the regional population's request (paid by monetary means) and their powerful secret knowledge, which members of the national Brazilian society fear. I found this interpretation extremely interesting, and

probably this view of shamanism-resistance can contribute to the understanding of several other cross-cultural contexts, such as northeastern Brazilian indigenous peoples.

Among the Kariri-Shoco, different medical knowledge (Western and indigenous), as presented by Mota (1987), have a distinct and complementary relationship, which reflects a context of plural medical practices. She mentions that when the shaman and other healers feel unable to heal, they do not hesitate to send the person to modern medical doctors, and the shaman himself also makes use of those health services. She affirms that the difference between the two systems is that the Kariri-Shoco medicine “comes from sacralized grounds, obtained through occult work and divine inspiration” (Mota 1987, 240).

As presented in the fifth chapter, Kariri-Shoco shamanic specialists conceive that they are able to cure-heal biomedically diagnosed diseases. Mota’s (1987, 272-361; 1997, 107-122) classification of Kariri-Shoco medicinal plants according to illness and remedies, illustrates this, as it contains information on Kariri-Shoco use of medicinal plants that address health problems and that do not come exclusively from ‘sacralized grounds’.

Mota’s study (1987, 1996, 1997) gives a dimension of how Kariri-Shoco shamanism is the focus of a medical system, ethnobotanical knowledge-belief, and animism-cosmology, which she relates to theories of health and illness, and reflects on their values and power (in ethnic and interethnic domains). She builds on a theoretical perspective that the Kariri-Shoco conceptions of cure, which contain

positive (healing) and negative (inversed healing) meanings, are part of their comprehension and manipulation of the world (Mota 1987).

The theoretical orientation followed during the research about Kariri-Shoco shamanism presented here departs from the perspective that shamanic (ritual) healing involves experiences which, more than beliefs, are related to knowledge (Good 1994). In the case of shamanism, it is interesting to note that the shamans are the ones who diagnose and treat disease-illness, and they can also be the ones who provoke or send a disease-illness upon someone. Since knowledge involves power, shamans have been identified as the ones who hold a power related to their knowledge (Langdon 1992a).

According to Langdon (1992a), although South American shamanisms differ, it is possible to generalize about them as a sociological institution. She calls attention to the fact that South American shamanisms share characteristics of power, social roles, ecstasy techniques and experiences, the idea of a “multilayered cosmos[/universe]” (Langdon 1994a, 13) as a unity, and a vision of human and extrahuman composed realities. These characteristics pointed out by Langdon (1992a) can be found in several contemporary ethnographies on South American shamanism. In these studies the authors have considered shamanism as a focus of knowledge (Langdon 1992b, Illius 1992; McCallum 1996; Perrin 1992; Pollock 1992), as a matter of cultural beliefs (Baer 1992; Pollock 1996), or as both knowledge and belief (Mota 1987, 1996, 1997). Anthropologists have described shamanism, whether focusing on the role and the social construction of the shaman (Baer 1992; Perrin 1992), on political and social characteristics of shamanism as a symbolic system (Langdon 1992b; Illius 1992; Mota 1987, 1996, 1997; Taussig 1987), or on the

performance of shamanistic (ritual) healing (Briggs 1996; Desjarlais 1996; Laderman 1996; Roseman 1996). It is evident that, in cross-cultural contexts where shamanism is manifested, it involves meaningful and experienced dimensions of knowledge. The research concerns regarding Kariri-Shoco gendered embodiment related to their shamanistic knowledge have enriched the understanding of the gendered domain of cure-healing practices. The interrelation between gendered embodiment and shamanism provides the possibility of observing how Kariri-Shoco specialized knowledge relates to gendered embodiment and female embodied subjectivity.

CHAPTER IV

METHODOLOGY

By focusing on how ethnographic knowledge about how individuals experience reality is produced, through the intersubjectivity between researchers and their research contexts, we may arrive at a closer understanding of the worlds that other people live in (Pink 200, 20).

Ethnographic research serves as a "process of creating and representing knowledge" (Pink 2001, 18), where interpretation and representation of the cultural context is based upon ethnographers' own experiences. During this research process among the Kariri-Shoco, information was collected relating to the research topics as a basic procedure for doing ethnography. At the same time, a fundamental position during the fieldwork was the recognition of "the centrality of [my] subjectivity [as a] researcher to the production and representation of ethnographic knowledge" (Pink 2001, 19) about the Kariri-Shoco.

I depart from the perspective that reflexivity is an essential way of balancing the realism of research data collection, while subjectivity (as my own experience and perception) and intersubjectivities (as the shared experiences and perceptions between peoples that I researched and me) guided the whole research process from which ethnographic knowledge was created. Thus, the knowledge, interpretation, and representation produced through ethnography about the Kariri-Shoco are based on reflexivity considering research contexts, relationships established during research, and my own subjective experiences.

The present chapter is organized into sections which provide a description of the ethnographic research and the methods utilized during field research among the

Kariri-Shoco. I begin with a brief account of my first contacts with the Kariri-Shoco people and my daily life in Porto Real do Colegio; I also explain how data were registered and recorded, gathered, and organized as planned and realized during my field research. Then in the following section, I discuss how I conducted surveys from which selected case studies were chosen as the principal method of qualitative data collection. In the third section, I describe and explain how visual anthropology became a method for recording Kariri-Shoco 'ethnographicness', while in the last section I discuss the ethical issues research, particularly in relation to sensitive topics investigated.

4.1. My Plan in the Field

It is not solely the subjectivity of the researcher that may 'shade' his or her understanding of 'reality', but the relationship between the subjectivities of researcher and informants that produces a negotiated version of reality (Pink 2001, 20).

The first contact I had with Kariri-Shoco peoples happened when I conducted field research among Shucuru-Kariri (from Palmeira dos Índios, Alagoas state) in 1993. At that time I learned that the Kariri-Shoco had taught the Shucuru-Kariri the practices of the Ouricuri ritual.¹¹ That was the reason why Kariri-Shoco peoples would very often come to visit and participate in the Ouricuri ritual among the Shucuru-Kariri, sharing, as they did, religious rituals and knowledge related to

¹¹ In Chapter VIII, I explain how the Shucuru-Kariri from Mata da Cafurna started to participate in the Kariri-Shoco Ouricuri ritual.

shamanism. The Ouricuri ritual involves sacred secrets from which cure-healing practices derive.

The first time I visited the Kariri-Shoco reserve in Porto Real do Colegio, it was in the month of April, 2001, when I contacted both the Pajé Júlio and the Cacique Cícero. I told them about my intention to conduct field research among the Kariri-Shoco. Pajé Júlio was very receptive to the research, but Cacique Cícero asked me questions about FUNAI's authorization and about research procedures regarding Kariri-Shoco secret knowledge. I explained to both of them how I would proceed in developing ethnographic research about Kariri-Shoco women's experiences and perceptions regarding gender, reproductive processes, and shamanism as a medical knowledge. This procedure marked a fundamental step in obtaining official consent to start the ethnographic research. The political and religious leaders' approvals were required to achieve the official authorization of FUNAI (the agency responsible for Indians' rights). It was after FUNAI consulted both the *Conselho Nacional de Pesquisa e Desenvolvimento*-National Council of Research and Development (CNPq) analysis of my research proposal and Kariri-Shoco leaders (who gave their approval for the research) that I received FUNAI's permission to conduct the ethnographic research among the Kariri-Shoco.

It is important to note that other anthropologists have already conducted ethnographic studies among the Kariri-Shoco. Mata (1989), Mota (1987, 1997), Nascimento (2000), and Silva (1999) are contemporary examples. I did not feel, however, that these previous experiences that the Kariri-Shoco had from contacts with other anthropologists had facilitated their understanding of my ethnographic

research. As my research was within a new field of knowledge (on medical anthropology and reproductive women), it characterized a whole new experience, particularly for female shamanic specialists and reproductive women, who had never been the main subjects of any research conducted among the Kariri-Shoco.

During my first visit to the Kariri-Shoco reserve, I met one of the oldest shamanic specialists, with whom I was already familiar from Mota's (1987, 1997) and Silva's (1999; 2003) writings. Dona Marieta was living with one of her daughters and received me, and I was one of many people who came to be blessed by her when they sought cure-healing practices. Although I had explained to her my intention to conduct field research about Kariri-Shoco women, Dona Marieta needed to accomplish what she knew how to do so well: she prayed on me. This gesture made me experience and discover from the beginning how “*reza*” (“prayer”) rituals, like the one that she performed on me, were a fundamental source of embodied knowledge, manifested through words.

I realized later that reza rituals performed by shamanic specialists had a power and purpose not limited to cure-healing. Among the Kariri-Shoco, it is from reza rituals that shamanic specialists can diagnose and find out what is causing suffering or health problems. During cure-healing sessions, shamanic specialists are able to feel through the body what is the cause of suffering. From my experience, I understood that Dona Marieta had the intention to make sure that I did not have any health problem. She performed ritualized prayers, which also had the purpose of providing me with protection through ‘closing’ my body. When I told her that she would get tired of my presence, since I was moving to Porto Real do Colégio and would be in

contact with her constantly, she told me that she never got tired of kindness. From this first contact we were very much attached through a strong and affective bond.

The field research involved personal life changes, which not only I experienced. I have my family (my husband, a seven year-old daughter and five year-old son) close to me. The whole process of taking my doctoral degree has provided all of us with experiences with different peoples. We have learned to make different cities like Winnipeg, where the University of Manitoba is located, and Porto Real do Colégio, where the Kariri-Shoco live, as places for our homes. My personal life was attached to the fieldwork, since my family and I were part of the whole research process and were interacting with Kariri-Shoco neighbors and friends daily. I learned a great deal by observing my children and their friends.

From May, 2001, we lived in a rented house in Porto Real do Colegio on the street of the Caboclos, where approximately fifteen Kariri-Shoco families also live. My children were registered in a Catholic private school in Propria City (in Sergipe state, across the São Francisco River from Porto Real do Colégio), where a few Kariri-Shoco children also attend this school. My husband and I, in our daily routines, included transporting our children to and from school, having dinner as our biggest daily meal together at noon, and gathering for supper usually at 6 p.m. Thus, my daily life included a routine for my private life while interacting with Kariri-Shoco people as a married woman who was the mother of two children. The fact that I had my family with me during field research earned me respect, since I was considered to be a responsible person, and also provided a sense that I was living a regular life there.

On the other hand, as an outsider, I realized that I occupied a particular status that made Kariri-Shoco people in general treat me with respect that seemed more related to their sense that I occupied a hierarchic position in relation to them. I became aware that their respect reflected an implicit power attribution. For example, even older people used to address me as *senhora* (ma'm, Mrs.) and call me “*Dona Silvia*,” which were terms that younger people use for older ones. Within the context of poverty that surrounds people from Porto Real do Colégio County in general, and particularly the Kariri-Shoco, as an outsider, I was often seen not as a middle-class but as a rich person. I believe that this characterized the relationships established with Kariri-Shoco people as power relations during the whole fieldwork, despite my effort to explain to Kariri-Shoco people my work and role in the field during research.

Facts that contributed to make them value my work and me were that I was an anthropologist and professor from the Federal University of Alagoas, and had come from a foreign country to conduct field research among them. Sometimes I had the feeling that they saw my research as a matter of honor for them, because locally they had been recognized and valued through an outsider's research.

It was mostly during mornings and afternoons that I conducted fieldwork in the reserve area, which was, located about 1 kilometer away from the street of Caboclos. On the evenings I often stayed at home to organize and analyze data gathered during the day, and to write my journal. Sometimes during the evenings I also visited or chatted with next-door neighbors, while watching my children play on the street with their friends.

Throughout nine months of ethnographic fieldwork, qualitative data were collected, gathered, and analyzed through different and complementary research techniques, such as writing a journal, taking notes of informal conversations, experiencing participant observation, making ethnographic interviews, making audio and or video digital recordings, and having closer relationships with selected case studies. As case studies were selected, I started to visit them regularly in order to conduct ethnographic interviews. The ethnographic experience not only involved observing realities on embodiment related to sexual difference, shamanism (as a medical practice), and the historical context of plural medical practices, but also entailed reflexivity and visual anthropology as methods which provided wide and in-depth information for the research topics.

The ethnographic fieldwork conducted during the first three months (April to June, 2001) had the purpose of contacting the two main groups who compose the research case studies: (1) indigenous health practitioners (male and female shamanic specialists and a midwife) and (2) Kariri-Shoco women. It was also during these first months of fieldwork that I explored different areas (within the reserve and in Porto Real do Colégio town) and conducted a survey using different semi-structured interview schedules (Appendices A and B) from which women case studies were selected.

In the following months (from July, 2001) the research focused mainly on taking ethnographic interviews (Appendices C and D) with case studies organized into folders through chronological interviews in my laptop computer. I made an effort to organize data in a way that information from shamanic specialists and a midwife

could also complement topics researched among women, particularly about female embodiment, gynecological and obstetric health problems, cure-healing processes, and ethnophysiology. In the following section, I discuss the research case studies.

A qualitative study implies the use of methods which research subjects' perspectives and experiences, and the development of theoretically driven field research (Silverman 1993). The topics researched required a development of qualitative research, where the subjects' perceptions and experiences were privileged as fundamental information to be registered in order to approach theoretical concerns on embodiment related to sexual difference and shamanism.

4.2. Research Methods: Interviews and Selected Case Studies

As a form of research, case study is defined by interest in individual cases, not by the methods of inquiry (Stake 1994, 236).

The use of case studies as a form of researching individual cases through informants' perceptions was fundamental to collecting qualitative data for analysis. The research topics, such as embodiment related to sexual difference, shamanism, and Kariri-Shoco plural medical practices were focused upon, considering particular and collective dimensions of individual cases. Techniques, such as using samples from surveys, observation (participant observation), informal conversations, and ethnographic interviews were used in order to select and conduct case study research.

Here I intend to explain how individuals were interviewed through surveys from which case studies were selected and how the field research was conducted among these Kariri-Shoco people. I first report about shamanic specialists, then about adult women researched.

4.2.1. Indigenous Health Practitioners (Shamanic Specialists and a Midwife) as Case Studies

The selection of indigenous health practitioners as case studies was based on a survey about who and where Kariri-Shoco shamanic specialists were. Although most of the Kariri-Shoco do not use the term “shaman,” as it will be discussed and described in the following chapter, Kariri-Shoco cure-healing practices do involve shamanistic knowledge and practices.¹² The terms Kariri-Shoco people often use are *rezador* (male prayer shaman) or *rezadeira* (female prayer shaman) and or *curandeiro* (male healer shaman).

I started interviewing Pajé Júlio, and then other indigenous health practitioners, who were those known as Kariri-Shoco *rezador/rezadeira* or *curandeiro*. I conducted informal conversations and open-ended interviews with twenty-three Kariri-Shoco health practitioners, of whom seventeen were shamanic specialists, five worked in the Sementeira health clinic (three were nurse assistants, and two were health assistants), and one was a midwife. Seventeen shamanic specialists were interviewed from people that Pajé Júlio had mentioned that were *rezador*, *rezadeira* and *curandeiro* shamans. The other interviewees were selected because they work in the Sementeira Health clinic. From the month of May 2001, I started to select indigenous shamanic specialists as case studies, and started to conduct and organize ethnographic interviews with them based on ethnographic interview outline (Appendix C), which worked as an important guide to conduct ethnographic,

¹² Pajé Júlio and Frederico were the only shamanic specialists who used the term shaman in ethnographic interviews.

descriptive, and structural questions during interviews, according to Spradley's (1979) method.

The ethnographic field research has the objective of focusing on and describing cultural meanings in their "own terms;" thus, cultural data analysis involves a form of analysis distinct from others used in "social science research" (Spradley 1979, 92). The main purpose of conducting ethnographic interviews was to learn what were the meanings of things and experiences for informants. This method was then used as a research methodological technique, which becomes "an anthropological tool in order to discover, analyze, and describe cultural data" (Spradley 1979, 92).

The interviews conducted with seventeen Kariri-Shoco shamans does not demonstrate an estimated number of Kariri-Shoco shamanic specialists who live on the reserve or who work performing cure-healing practices with indigenous and non-indigenous people. Among the Kariri-Shoco, there are diversified shamanic specialists who assume different roles and practices. All female and male shamanic specialists selected were specialized in cure-healing practices through the use of reza rituals and the making of remedies from medicinal plants and animals (in lesser degree), as I describe in greater detail in the following chapter. I refer to those shamanic specialists as rezador, rezadeira or curandeiro shamans based on their roles as shamanic specialists.

I listed in Table 2 (according to age and marital status) a total of ten female shamanic specialists, and one midwife as case studies selected. I also included six others shamanic specialists with whom I also conducted ethnographic interviews

during my field research. I decided to use their identity based on their consent and also because this procedure is a recognition of their knowledge, which they shared with me. Most of the selected cases studies were individuals older than fifty. The fact that most of the female shamanic specialists were post-menopausal women is particularly significant, since the Kariri-Shoco people conceive female shamans to be more powerful when they do not menstruate.

Table 2: Shamanic Specialists Case Studies and Others Shamans Interviewed During Research Process

Female Shamanic Specialists	Age	Marital Status
Dona Marieta	96	Widow
Dona Zezinha	63	Separated
Dona Maria Velha	53	Married
Baioca	35	Married
Dulcilene	30	Single
Male Shamanic Specialists	Age	Marital Status
Candara	72	Married
Paje Julio	63	Married
Frederico	42	Common Law
Chiquinho	30	Married
Kenedy	24	Common Law
Midwife	Age	Marital Status
Vanda	36	Married
Other Female Shamans Interviewed	Age	Marital Status
Dona Chiquinha	± 75	Married
Dona Ivete	68	Married
Dona Maria Curi	± 75	Widow
Other Male Shamans Interviewed	Age	Marital Status
Mr. Herpidio	± 80	Married
Mr. Zeca	± 55	Married
Mr. Ze Tenorio	± 40	Married

It was from my experience during the first three months of field research (April to June, 2001), based on the survey and contacts established with shamanic

specialists, and learning from information gathered (observational and registered or recorded) about them and their cure-healing practices, that I selected ten case studies of indigenous health practitioners (such as five male shamanic specialists, five female shamanic specialists, and the midwife).

I also considered different generations in selecting individual cases. For example, some shamanic specialists were chosen within the same family, where the mother, son, grandson, and granddaughter were also shamans. This facilitated observing how specialized knowledge was transmitted between generations and how gender and age differences relate to their cure-healing practices and roles. As I plan to describe in the next chapter, shamans as individual cases will be approached through his or her particularity and having his or her own voice.

During the whole process of fieldwork, I also maintained contacts with three other male shamans and three other female shamans, who were not selected as case studies. Through these contacts, I also conducted ethnographic interviews and maintained informal conversations with them as a complementary way of gathering information that was being registered from case studies.

4.2.2. Women as Case Studies

The selection of women as case studies was based on a survey conducted with a total of fifty Kariri-Shoco women from which two opportunistic samples were made by the use of different semi-structured interview schedules (Appendices A and B) utilized during the months of April, May, and June, 2001, when women older than twenty-one years of age were interviewed. I discuss in Chapter VIII quantitative data

based on those different surveys when twenty-nine women were interviewed with semi-structured interview schedule A (Appendix A), while twenty-one others were interviewed with interview schedule B (Appendix B). Those different samples were constructed from Kariri-Shoco adult women who were selected opportunistically and who are mostly ranging in age from twenty-one to fifty years of age. Those interviews were conducted among Kariri-Shoco women who lived in different settings inside the reserve and, also, those who lived in Porto Real do Colégio town.

It is estimated from a census taken in 2001 (Table 1 in Chapter II) that 474 Kariri-Shoco women are older than twenty-one years of age (FUNAI 2001). It was from the total of fifty Kariri-Shoco women interviewed that I have selected case studies. The use of semi-structured interviews provided the opportunity to become familiar with Kariri-Shoco women's lived experiences with reproductive processes. On the other hand, as a qualitative research without concerns about quantitative data, women as case studies were selected considering primarily fertility factors for my research focus on Kariri-Shoco women.

From case studies selected, all twelve Kariri-Shoco women are older than twenty-one years. Table 3 shows the list of individuals selected as women case studies, according to their approximate age and marital status. Although the marital status could provide their identity, the imprecision of the age and omission of number of children guarantee the case studies' anonymity.

Table 3: Kariri-Shoco Women as Cases Studies:

Woman	Age (±)	Marital Status
Ann	±60	Married
Betty	±50	Married
Christie	±45	Married
Diane	±40	Married
Ema	±40	Common Law
Faye	±35	Single
Gilda	±30	Married
Hilda	±25	Common Law
Ina	±25	Common Law
Julie	±20	Single
Lila	±20	Common Law
Marian	±20	Common Law

These twelve case studies of Kariri-Shoco women with diversified reproductive experiences were selected from different settings, including some who live in the city of Porto Real do Colegio. According to what was planned in my research proposal, I selected individual cases of women based on (1) woman's experiences related to female embodiment (from which the research focus was directed to investigate sexuality and sexual difference), and, (2) women with diversified reproductive experiences (from which the focus was the investigation of their reproductive experiences). I focused the investigation on both their gender and female embodiment and their capability of producing offspring as female reproductive bodies.

Among twelve Kariri-Shoco women selected as case studies, two were post-menopausal, four had opted for tubal ligation, one was infertile, one was fertile and not using any contraceptive method, and four were pregnant (or started to experience pregnancy during the fieldwork). Through these case studies, I started to gather information about female embodiment (ethnophysiology, sexuality) and reproductive

processes. I found it more complex to select and research women as case studies, since private and sensitive topics were very often approached.

4.2.3. Methods for Researching Case Studies

The Developmental Research Sequence (DRS) Method, as formulated by Spradley (1979; 1980), was used as an appropriate research technique for researching the case studies, since the research concerns with interpretation of symbols, meanings, experiences, and perceptions related to gender, shamanism (healing practices), ethnophysiology, and reproductive processes entail in-depth organization and analysis of information registered during the fieldwork.

The use of participant observation and ethnographic interviews were fundamental and complementary techniques of data collection and analysis for conducting the case studies, which involved "sequenced tasks" (Spradley 1980, vii; 1979). These tasks I followed through sequential procedures from interviewing informants, making ethnographic records, asking descriptive questions, making domain analysis, analyzing ethnographic interviews, and discovering cultural themes in order to write the ethnography (Spradley 1979).

Since language is the "tool for constructing reality" (Spradley 1979, 17), it has a fundamental role in both "major ethnographic work tasks" of "discovery" and "description" (Spradley 1979, 17). The ethnographic work involves a "dialectic" process through which some data collection is registered, and analysis of this material is done "to make sense out of it," and more data collection is registered, and more analysis is done, in order "to refine interpretation" (Agar 1996, 62). The use of

research techniques with the DRS method covered, in a useful and appropriate way, ethnographic fieldwork as a dialectical process, particularly the ethnographic interviews with selected case studies. In research concerned with symbols, meanings, and experiences through recognition of the importance of language, the ethnographic interview served as a "speech event" (Spradley 1979).

All ethnographic interviews conducted in the case studies with indigenous health practitioners were organized separately to collect-gather-analyze data and discover cultural themes on shamanism as a medical domain (which shapes gendered embodiment). Also, Kariri-Shoco ethnophysiology and shamanic specialists' embodiment related to shamanistic knowledge were investigated through ethnographic interviews.

In addition, I observed and recorded different kinds of cure-healing rituals performed by selected rezador/rezadeira and curandeiro shamans from which ethnographic data is described and analyzed about Kariri-Shoco indigenous medical practices showing indigenous cure-healing processes. These events were observed and registered as a source of data on embodied knowledge and medical practices of male and female shamanic specialists' cure-healing practices, as I describe in the following chapter.

The registration of information about how Kariri-Shoco health practitioners and diverse women perceive and deal with the female reproductive body and how they perceive characteristics of the female body (ethnophysiology, sexual difference) has driven the investigation to link boundaries between the perceptions and experiences related to gendered embodiment.

During the field research, informal conversation, participant observation, and ethnographic interviews through case studies focused also on their perceptions of the plural medical context. The ethnographic research was developed through different methods of collecting and gathering data, by opportunistic samples based on different structured interviews and a selection of shamanic specialists case studies and of women with diverse reproductive experiences, which enabled the collection of information for answering the research problem concerning embodied subjectivity construction.

The ethnography was written based on methodological procedures that provided the research with a better assessment of the validity and generality of the explanations and interpretations, as my conclusions became based on a wide range of diversified data collection procedures and samples in order to approach female embodiment in the Kariri-Shoco cultural context.

4.3. Visual Anthropology

The 'ethnographicness' of any image or representation is contingent on how it is situated, interpreted and used to invoke meaning and knowledge that are of ethnographic interest (Pink 2001, 19).

The uses of visual methods of registering Kariri-Shoco 'ethnographicness' was based not only on recording ethnographic interviews of case studies (which were often digital audio and/or video recorded) but also on visual images recorded that "invoke[d] meaning and knowledge that [were] of ethnographic interest" (Pink 2001, 18), such as cure-healing rituals and practices and experienced embodied knowledge.

The use of digital video and audio recordings as a research method of gathering data during the field research among the Kariri-Shoco enriched even more

the ethnographic data collection. Visual data registered, particularly during ethnographic interviews and cure-healing rituals of Kariri-Shoco shamanic specialists provided material from which the visual anthropological field had to be considered.

The purpose of the use of visual images as a research technique was principally to register cultural settings and cure-healing practices for analysis, following Collier and Collier (1986, 163), who argue that visual data can be a systematic method of observation in which the research is supported by visual technology. The use of this technological resource required that information about local media culture, and also Kariri-Shoco reaction to the use of digital video camcorder should be registered. Very often I showed them the images, and gave printed digital stills as a way of sharing the images registered with them. As intellectual property, I plan to provide to the Kariri-Shoco all the filmic images (video footages) that I have recorded of their images. I also plan to edit ethnographic films following their suggestions.

I made also video footages from recording ethnographic interviews with reproductive women. The confidence established between Kariri-Shoco women and me within a relationship of friendship made possible, by their sincerity, not only let me register audio recordings but also video recordings of their explanations of their experiences related to reproduction and sexuality. I assured them that the research maintains a fundamental concern with the anonymity and confidentiality of their identity and interviews. These digital recorded materials from reproductive women's ethnographic interviews are to be destroyed.

I obtained a formal written consent from Pajé Júlio, authorizing my use of Kariri-Shoco shamanic specialists' digital video footages. Informal consent (verbal, digitally recorded) was given and provided by Kariri-Shoco shamanic specialists during the research process. Although they have authorized the registration and use of their images (for editing film images and digital still photographic images), I plan to provide their images to them and work together on the selection of video footages in order to provide to them possible ethnographic films. The issue of confidentiality and anonymity gained a different characteristic through the registration of the visual data. I learned that it is important for shamanic specialists to be recognized for their knowledge. Kariri-Shoco shamanic specialists' lack of concern with confidentiality and anonymity matters related to the recognition of their knowledge (on cure-healing practices) made me rethink ethical concerns, which I had previously considered in my research proposal, about their anonymity.

I was resistant, particularly in the beginning of the field research, to register visual images during ethnographic interviews and cure-healing ritual performances. Since shamanic specialists seemed comfortable with the digital recordings and also with digital video camcorder, I often video recorded their ethnographic interviews and cultural settings. The frequent use of the camcorder, and also the flexibility and naturalization of its provided the possibility to record rich ethnographic data collection.

I found it important also to observe the cultural visual media that the Kariri-Shoco use. Radio and very often principally television shows (like soap operas and other kinds of popular shows) was watched locally by Kariri-Shoco people. I had the

opportunity to observe a recording of a TV show when a popular soap opera artist came to the Kariri-Shoco reserve with other professionals for shooting a TV series about the Jurema tree.

According to Ilisa Barbash and Lucien Taylor (1997), "...film is a quintessentially phenomenological medium... It has a unique capacity to evoke human experience, what it feels like to actually be-in-the-world, while anthropological texts tend to be equally (although of course by no means exclusively) concerned with nonintuitive abstractions like social structure or population statistics" (Barbash and Taylor 1997, 74-75). I have the intention to use both textual and visual images as a way of discussing and presenting ethnographic knowledge. From this point of departure, the visual data gave support to describe *Kariri-Shoco* 'ethnographicness'. I learned from my experiences of recording images that it is fundamental to assume that "representations are partial, and limited to the perspective adopted during research" (Barbash and Taylor 1997, 59), but it is a powerful tool to illustrate ethnographic data.

Several authors call attention to ethical issues related to image-making during field research, particularly on the characteristic that film and photographic images are very often perceived as 'the truth' and as 'an objective reality' (Barbash and Taylor 1997; Davies 1999). According to Ruby (1988), "the maker of images has the moral obligation to reveal the covert -- to never appear to produce an objective mirror by which the world can see its 'true' image... So long as our images of the world continue to be sold to others as *the* image of the world, we are being unethical" (Ruby 1988, 310). The ethical responsibility is fundamentally based in "contextualizing our

films” (Barbash and Taylor 1997, 60). The experience of filming thirty-eight cure-healing rituals (very often not fully recorded), conducted by few Kariri-Shoco shamanic specialists, provided not only the naturalization of the camcorder and my use, but made me perceive and discover, through analysis, how embodiment is experienced in Kariri-Shoco cure-healing ritual performances. Filmic images recorded are powerful and rich material of ethnographic knowledge.

Thus, the ‘ethnographicness’ presented about Kariri-Shoco through the use of images consider ethical issues where textual and visual are complementary tools for presenting ethnographic data and analysis. My experiences with the use of video recordings enriched considerably my research since very often interviews and cure-healing rituals and practices are described considering the visual and regarding gestures and body expression.

4.4. Ethics

I consider that the Kariri-Shoco constitute a ‘vulnerable population,’ as an indigenous group with a history of colonial oppression, under tutelage assistance through Brazilian governmental agencies, living in a context of poverty, where some individuals are illiterate. I have considered specific procedures to respect and protect Kariri-Shoco interests, according to ethical concerns. Firstly, from the beginning and during all use of research methods (participant observation, ethnographic interviews), I explained and clarified the ethnographic research enterprise, such as my intentions, interests, concerns, and procedures for developing and writing an ethnography about

Kariri-Shoco shamanic specialists and women's experiences and perceptions with gender, reproductive processes, shamanism, and medical practices.

The field research followed ethical principles that regarded not only Kariri-Shoco as individuals who are subjects of research, but ethical concerns were extended to the Kariri-Shoco as an ethnic group. Thus, a fundamental matter is the respect for Kariri-Shoco's rights, from individual to collective levels, according to what is private and confidential that can or cannot be investigated or exposed about individuals and about their culture.

Considering that ethnographic data collection methods involve observation and interview procedures, I made an effort to ensure that my role as an ethnographic observer was understood and that data collected followed respect for their cultural-ethnic standards on sensitive issues when involving research topics about gender, reproduction, and shamanism. Basically, the respect for their individual and ethnic human dignity has guided this ethnographic research, when the result of data analysis was shared, and when I consulted with those who were interviewed.

The focus on embodied subjectivity was investigated as a signification of Kariri-Shoco cultural rationale, which implicitly recognizes their rights to 'autonomy' and 'self-determination' as a political ethnic group in Northeast Brazil in the context of colonial oppression. This research derives from a position that a relevant matter for intellectual academic concern is the recognition of their reproductive rights, which relate basically to health and quality of life, and socio-cultural practices of everyday life that must be guaranteed by the Brazilian government. Thus, this research does not bring harm to the Kariri-Shoco as the approach of embodied subjectivity,

ethnophysiology, and reproductive processes can serve as a source and basis for the guarantee of reproductive health and rights for the Kariri-Shoco themselves.

CHAPTER V

KARIRI-SHOCO SHAMANISM: THE FIELD OF CURE-HEALING PRACTICES

There were among them witches or, better say, impostors, who guessed what they thought. Predicting future things, they cured diseases, when they did not produce them (de Nantes [1706] 1979, 4).¹³

In this chapter Kariri-Shoco shamanism is described as the locus of a sociological institution and of a medical practice from which shamanic specialists emerge and perform cure-healing rituals for embodied health problems. The Kariri-Shoco people experience the medical cultural domain, such as sicknesses and cure-healing processes, as intimately intertwined with their shamanism, despite their use of the biomedical healthcare system. As my research is theory-driven to focus on the shamans' medical practices and cure-healing ritual performances, I did not use the theoretical orientation of religious healing (Csordas 1990, 1994b, 1994c) to approach the religious aspects of Kariri-Shoco shamanism as a medical practice.

Shamanism as a system of beliefs has religious characteristics (Townsend 1997; Langdon 1994a). Kariri-Shoco shamanism is an indigenous system of beliefs, which was influenced by the Roman Catholic Church throughout the history of colonization. As was already discussed in Chapter II, the history of the Kariri-Shoco people is marked by different cultural contacts with colonizers (and African slaves) that provided wide cultural influences. Kariri-Shoco shamanism has remained as a medical knowledge despite this dynamic process of cultural change and influence

¹³ My translation: "*Havia entre eles feiticeiros ou, para dizer melhor, impostores, que adivinhavam o que eles pensavam. Prediziam coisas futuras, curavam doenças, quando não as produziam*" (Nantes [1706]1979, 4).

from which plural cultural aspects compose Kariri-Shoco culture today. I do not intend here to analyze this process of cultural change nor utilize explanations from which the influence of different cultural religious traditions could be traced to explain the development of Kariri-Shoco shamanism as an indigenous tradition. This would mistakenly suggest that Kariri-Shoco shamanism is a result of cultural syncretism, as it converges aspects statically joined from different cultures. I approach Kariri-Shoco shamanism as a contemporary domain in which medical knowledge is integrated into medical practices expressed through religious aspects as a language that allows communication among indigenous and non-indigenous peoples in Northeast Brazil.

I intend to present here an ethnography describing how Kariri-Shoco shamanism is perceived and practiced through lived experiences among the Kariri-Shoco. It is an ethnography realized particularly from my observations of shamanic specialists' practices in cure-healing rituals and from what they explained about those practices. Because an aura of secrecy surrounds their shamanism, and in order to respect Kariri-Shoco cultural-ethnic ethical standards related to collective privacy, no information is provided on Kariri-Shoco shamanism that threatens its secrets. The qualitative research conducted through ethnographic interviews focused on what is experienced daily among the Kariri-Shoco. It investigated the roles that shamanic specialists have and their cure-healing practices.

Kariri-Shoco shamanistic secrets are central to Kariri-Shoco ethnic boundaries as a fundamental way for continuity of their culture. The secrets within Kariri-Shoco shamanism are related to their perceptions of what is opened and what is closed. This perception is reflected in their knowledge of the body through the idea of strength,

from which what is kept closed in secrecy is protected and has strength. This same understanding the Kariri-Shoco have within their knowledge of the body, from which they perceive that when the body is closed it has strength for shamanic ritual practices. An illustrative example about this perception on what is kept secret and what is shown is Pajé Júlio's opinion about the prayers that I have video-recorded during cure-healing rituals. When I asked him if I could include the contents of prayers used in cure-healing rituals that I have recorded, he told me that I could, but he added: "If someone gives you something and you show it, it loses its value." Thus, the strength and power of cure-healing practices, which the Kariri-Shoco receive from spiritual beings through their shamanistic knowledge, is founded on the secrets kept from outsiders. If secrets are revealed, Kariri-Shoco shamanism could be destroyed. When I describe information about Ouricuri rituals, I continue to respect the secrecy that characterizes Kariri-Shoco shamanism.

It is important to point out that rezador, rezadeira and curandeiro are very common throughout Brazil (Priori 1994; Scheper-Hughes 1992; Silva 2002; Souto Maior 2002) and in South American and Central American countries (Bastien 1987; Brodwin 1996; Taussig 1987; Young and Garro 1981). Silva (2002) mentioned, "rezadores... combine Catholic religion mystical practices, magic, and knowledge from popular medicine" (Silva 2002, 11). This author researched twelve rezadores in the city, Serido, in the northeastern state of Rio Grande do Norte. Silva (2002) discussed religious aspects of their practices, particularly on healing *quebranto* (evil eye). Silva (2002) explains that the "rezadores' practices are reminiscence of the miscegenation process from which Catholic, African and indigenous cultures

influenced and formed wide popular medicine practices” (Silva 2002, 11). These practices involve particularly the poor people throughout Brazil since its time as a Portuguese colony. Priori (1994) also explains that “magical practices and witchcraft characterized, along with secularism from the Catholic missionary process, producing multiform healing practices from which Africans, Indians, and ‘*mestiços*’ [racially mixed people] became great healers during Portuguese colonial times” (Priori 1994, 30). Souto Maior (2002) defines a rezador as: “a person who cures diseases [*doenças*] by spoken prayers, gestures, signs, crosses, aspersions in the presence of the sick person” (Souto Maior 2002,n/a). Souto Maior (2002) adds that a “rezador is a very common type” (Souto Maior 2002, n/a) of curandeiros in Northeast Brazil, and defines curandeiros as “*raizeiros*” (“rooters”), who are “people who deal with medicinal plants knowing how to prepare and use them to cure diverse diseases” (Souto Maior 2002,n/a). He explains that “*raizeiros*” are also called “Doctor Root” (“*Doutor Raiz*”) and that they are “a common type found in Northeast open markets” (Souto Maior 2002,n/a) selling medicinal plants.

The Kariri-Shoco have experienced a historical process of colonization within their cultural context. As a result Kariri-Shoco shamans exercise cure-healing practices within a setting where cultural aspects are widely shared among Indians and non-Indians. For example, the notion of evil eye is widely accepted throughout Brazil. Catholicism as a missionary process has influenced several prayers used in the reza rituals. A diverse cultural environment exists when traditions from Christianity, such as saints and prayers, relate to popular medicine practices throughout Northeast Brazil. Another example of this cultural diversity occurs when Kariri-Shoco shamans,

dealing with the spirit possession of non-indigenous patients, identify spirits from Afro-Brazilian religions, such as Maria Padilha and Pomba Gira.¹⁴

In the case of the Kariri-Shoco, although they practice a popular medicine, including the use of some prayers from Catholicism during rituals for healing purposes (compare to the ones from Serido that Silva [2002] described), I argue that among the Kariri-Shoco their shamanism characterizes embodied knowledge that shamanic specialists have and experience during cure-healing ritual performances. By embodied knowledge, I mean the way that shamans experience and sense through their bodies the patient's health problem. Shamanistic knowledge is acquired during life through subjective experiences related to foreseeing, communicating and interacting with spirits. Ethnobotanic knowledge also forms part of Kariri-Shoco shamanic specialists' cure-healing practices (Mota 1979, 1989).

5.1. Case Study and Research Methods:

The research was conducted using ethnographic interviews in order to discover cultural domains related to shamanism as a cultural theme. The use of DRS method helped to discover information about cure-healing rituals and sicknesses. This provided information to analyze experiences and perceptions of how the medical and shamanistic knowledge domains compose a cultural theme. Thus, through information about those fields of knowledge (rituals and sicknesses), ethnographic data was analysed, particularly through the discovery of cultural meanings of

¹⁴ Both Maria Padilha and Pomba Gira are Afro-Brazilian female spirits. They induce sexually driven behavior on the part of those who become possessed or influenced by them.

indigenous medical practice and knowledge. It is through the use of selected ethnographic interviews, where descriptive and structural questions were asked (Appendix E), that I focus on shamanic specialists' discourses and explanations about Kariri-Shoco shamanism. Language is considered the primary tool in order to discover how the reality is constructed as well as to investigate cultural meanings (Spradley 1979). It is through ethnographic descriptions that I often utilize parts of ethnographic interviews, using quotation marks for interviewees' speech throughout the text to explain information gathered and to emphasize interviewees' perceptions. Whenever considered, relevant words, terms, and expressions, are explained to elicit cultural meanings. All translations are mine and I made efforts to provide appropriate meanings of words considering cultural context.

Thus, the ethnographic descriptions concern Kariri-Shoco medical practices. Cultural symbols about the domain of cure-healing rituals and sicknesses relate to shamanistic medical knowledge as a cultural theme. The ethnographic interviews were selected to explain domain analysis, searching for cultural knowledge associated to those domains, which has provided my understanding of Kariri-Shoco shamanism as a medical cultural theme. I consider that the use of DRS method helped to guide my research for in-depth data collection about those domains providing a basis for my understandings of the field of Kariri-Shoco cure-healing and knowledge of the body. Tracking a sequence of tasks using this method in fieldwork, I followed procedures for data collection, which involved mainly the elaboration and use of descriptive and verification questions about what I was observing in Kariri-Shoco indigenous cure-

healing practices. Thus, the research focused on their perceptions and knowledge of the body in order to analyze ethnographic interviews and write this ethnography.

My research among selected Kariri-Shoco shamanic specialists was conducted by considering them as cases studies and focusing on their perceptions, experiences, and knowledge. Thus, I describe each one of them, and throughout the text I present information that they have provided about their experiences and knowledge. As will be evident throughout my ethnography, during this chapter and in the following one, some cases studies, like Pajé Júlio and Chiquinho, provided information about Kariri-Shoco shamanistic medical aspects, which I use mostly for their explanations about those themes. Dona Maria Velha and Frederico provided information about their knowledge of the body, particularly about ethnophysiology and female embodiment, and ethnographic interviews conducted with them are often used in Chapter VII.

There are shamanic specialists selected as case studies on the basis of their kinship ties or their cure-healing ritual practices (Dona Marieta, Candara, Kenedy, Dulcilene, and Dona Maria Velha). I also considered for the selection of case studies the roles and positions that shamanic specialists occupy within Ouricuri ritual practices (Pajé Júlio and his son Chiquinho; Baioca; Dona Zezinha). I intend to describe them individually using aspects of their life histories and household environments.

Dona Marieta, the oldest Kariri-Shoco female shaman, had a life history very different from the other cases studies. She only joined the Kariri-Shoco after she was fourteen years old. Her father was “a true descendent from São Pedro Island” (meaning that she is from where the Shoco came). He moved to Itabaiana city and married a black woman (she explains her black appearance). As her parents died

when she was still a baby, her grandmother “gave” her to her godmother. She explained to me that her grandmother could not raise her because she was too old and poor. Her godmother raised her within the Catholic religion, and when she was fourteen years old her uncle (who was the old Pajé Suíra) invited her to the Ouricuri ritual’s biggest feast, which takes place during fifteen days in January. She told me that she did not want to accept this invitation, but her godmother insisted that she go because her father’s relatives were there, and she would be better among them where she belonged. After she participated in the Ouricuri ritual, she told me that she could not return to Itabaiana City. Dona Marieta said that she discovered such “beauty,” such “pureness” in the Ouricuri that she could not go back to Itabaiana city to live with her godmother anymore. She stayed and lived in her uncle’s house until she moved to live with her husband after marriage.

Dona Marieta told me “a marriage was arranged” for her when she was still fifteen years old. She said she was not willing to marry anyone, but “nobody wants to maintain a luggage” (as she was a load for her uncle’s expenses). Thus, she got married and had five children. Dona Marieta became a widow when she was thirty-two years old. She had a stroke in October of 2001 at age 96, while I was still conducting the field research, and died in the night of January 16, 2002. I was close to Dona Marieta before and during her convalescence. As I have already mentioned, from the first time I met Dona Marieta I found myself very attached to her. She died on the night when I returned to Canada to continue my doctoral work. Later, I describe Dona Marieta’s sickness and the indigenous and biomedical healthcare that her aged body experienced. Since Dona Marieta was a very famous and beloved

Kariri-Shoco rezadeira shaman, her disease-illness was a matter of grief for everybody, indigenous and non-indigenous, who knew her goodness and gentleness. It was difficult to interview Dona Marieta, principally because of her hearing disability. I had to speak and ask questions loudly. After October we could not converse anymore because the consequences of her stroke, when she could not speak, hear, see, or move anymore.

Kariri-Shoco shamanistic knowledge and the shamans' ability to conduct cure-healing practices are related to subjective shamanic specialist experiences through his or her life. In several interviews they explained that they alone learned what they knew. They often explain that it is a matter of "science" ("*ciência*")¹⁵ and "knowledge" ("*sabedoria*"), which "cannot be taught" ("*não pode ser ensinado*"). I understand that shamanic knowledge cannot be taught because, as Pajé Júlio explained, it is a knowledge based on experience from which shamans "concentrate" in order to communicate with spirits.

That was how and why Dona Marieta became a Kariri-Shoco shamanic specialist. She told me that she became a rezadeira very young (when a teenager), when Kariri-Shoco people started to ask her to perform reza (rituals) on babies who were sick. She said she used to tell them, "I do not know how." Because her prayers were effective, others continued to come and ask for her cure-healing assistance.

When I met Dona Marieta she was living with her daughter Tarcisia, because her house, which was besides Tarcisia's house, had fallen down and she did not have

¹⁵ The Kariri-Shoco often use the word science meaning to be conscious and also as knowledge; as a noun in Portuguese it means both to be conscious, and science.

the money to build it again, although she still had the hope to be able to do it one day. Dona Marieta was living in a four-bedroom house, where Tarcisia and her husband, their son, and two adolescent daughters also live. Despite her hearing disability, Dona Marieta used to complain about the noise and the amount of people in Tarcisia's house. Whenever she got bothered she walked by herself and stayed in her granddaughter Tanira's house, who lives in Porto Real do Colégio town. On two occasions this happened during the field research. Tanira was very close to Dona Marieta, as she is Dona Marieta's first granddaughter. Every month Tanira went to the bank to withdraw Dona Marieta's "minimal salary" (minimum wage) from her retirement pension to give to her.¹⁶

Dona Marieta told me that her son Candara learned how to make remedies from his godmother, Maria Martile, who was very famous for her knowledge and power. Maria Martile raised him from five years old. Although Candara recognizes that he learned considerably from his godmother, on several occasions he showed to me medicinal plants that he had "discovered" and started to use with patients for certain health problems. Thus, "vocation" implies a personal journey where "knowledge" and "science" are acquired and developed through a process related to shamanic experiences with spiritual beings.

Kariri-Shoco shamans explain that their "ciência" comes from their "vocation" ("*vocação*"), as "a gift from God" ("*dom de Deus*"). I understand that it is

¹⁶ The "minimal salary" is the basic salary stipulated by the Brazilian government, which is raised every year, and was rated at R\$ 180,00 (one hundred and eighty *reais*, which was close to one hundred Canadian dollars at that time) monthly. Dona Marieta was retired as a rural worker, and like other Kariri-Shoco and non-indigenous people, receive this right from the Brazilian government when they reach 65 years.

obtained and developed through their subjective shamanistic experiences, which relate to their relationship with spiritual beings. This relationship is kept secret. On the other hand, as I have already mentioned, I found out from Kariri-Shoco shamans' case studies that their "vocation" often forms within their families. In Dona Marieta's case, for example, her son Candara and two grandchildren (Dulcilene and Kenedy) perform cure-healing rituals as rezadores. Another son of Dona Marieta, Mr. Zeca, is also a Kariri-Shoco shaman.¹⁷

It was at the end of May that I had the opportunity to meet Candara, who usually travels to Girau do Ponciano, where he stays sometimes for more than a week working as an Indian rezador and curandeiro. Like Dona Marieta, whom I already knew from Mota's (1987, 1997) writings, another anthropologist, Christiano Silva (1999), mentioned Candara.¹⁸

I always admire the dedication that Kariri-Shoco rezador, rezadeira or curandeiro shamans have for those who ask for their services. Candara works hard and is very active with his duties as a rezador-curandeiro. I never witnessed a Kariri-Shoco shamanic specialist give an excuse not to perform a reza ritual. They are always ready to listen and to provide assistance for those who come to them. What the shamans receive as payment for their reza ritual is usually something considered

¹⁷ I had the opportunity to observe a situation where Mr. Zeca's relative asked for his influence through his "prayers" (which I understood relate to his contacts with spiritual beings) and asked him for medicinal plants, in order to cure a disease-illness that she was suffering. Mr. Zeca performed a cure-healing ritual, which I will describe, when he used methods that are not seen in other reza ritual performances.

¹⁸ Christiano Silva was a student from the University of Alagoas who conducted an undergraduate research project about Kariri-Shoco shamanism, and was my advisee for this research during the year 1998. He continues to conduct his research, and is now affiliated to the Graduate Program in Anthropology of the Federal University of Pernambuco.

as an “exchange for the reza [ritual],” however, sometimes they do not receive anything. These payments can be in the form of food, like a package of sugar or rice, or can even be a small amount of money.

Candara is a famous Kariri-Shoco rezador-curandeiro shaman; therefore, he is often busy collecting medicinal plants for making remedies and performing cure-healing practices. Candara and his family live in a small house, although he has a new larger one being built beside the old one. Candara and his wife, Martinha, live in their old two bedroom house that they share with their two sons: Erismo, who is single, and Kenedy, who lives with his wife and two year old daughter. Both Candara and Martinha are retired and each receive minimal wages from their pensions, which help them to support their sons, who do not have jobs or activities from which they receive income. Their sons’ lack of income describes the situation in which many Kariri-Shoco live today. As a consequence of hydroelectric projects that were built throughout Sao Francisco River, the economic and ecological changes provoked a situation preventing rice production within the region.

When I used to visit Candara to conduct ethnographic interviews, I very often met his sons and their families in his house. Kenedy is an indigenous health practitioner like his father, and usually received things that people give to him in exchange for a reza ritual. Erismo helps his parents with several activities, including taking care of animals (a horse, and dogs that they have for hunting) and collecting medicinal plants that Candara needs to make remedies. Erismo and Kenedy also hunt small prey, like birds, or bigger prey, like *teiu* (*T. merianae*) lizard, which is also used for making medicinal remedies. The remedy called “bottled” (“*garrafada*”), is

made from a mixture of several kinds of medicinal plants according to the health problem diagnosed, and is sold to patients when Candara or Kenedy prescribes it. They earn extra money this way. Each bottle was sold for R\$ 10,00 (which was about eight Canadian dollars) at the time of the research. These “bottled” medicines vary according to the kind of health problem diagnosed. Martinha or Kenedy very often prepared them under Candara’s supervision, usually for his patients from Girau do Ponciano city. During one of his travels he carried ten two-litre bottles with him.

I made use of one of these strong remedies that Candara prepared using *Jurubeba*’s fruits mixed with other medicinal plants. All “bottled” remedies he makes contain one kind of Jurema, which is a very sacred plant that is often called as “the remedy of the Indian,” and that several different indigenous peoples from Northeast Brazil use during rituals and for cure-healing purposes.¹⁹

Candara’s daughter, Dulcilene, and his son, Kenedy, are also rezadores shamans. Dulcilene explained that she was very close to her grandmother Dona Chiquinha (Candara’s mother-in-law) who used to be a rezadeira. Thus, in both Dulcilene and her brother Kenedy’s case, their grandmothers (Dona Marieta and Dona Chiquinha) were rezadeira shamans. Dulcilene told me that she learned to be a rezadeira mostly from observing her grandmother, Dona Chiquinha, to whom she was

¹⁹ It is interesting to note that Jurema is also used in Afro-Brazilian religious rituals. Dalva (a “mother of saint”) who lives in Porto Real do Colégio town, prepares two different kinds of beverages that she makes to use in festivities from a plant called Jurema. When I asked her to show me the plant, it was a different one than Kariri-Shoco shamanic specialists have shown me and that they use. In the “night of the Caboclos,” when ancient indigenous spirits are celebrated in her *terreiro* (ceremonial ground), songs are sung referring to Jurema as a spiritual being. Ortiz (1991, 89) registered Cabocla Jurema as being part of *Umbanda* and *Quimbanda* Afro-Brazilian religions.

very attached. Candara's son, Kenedy, also became a rezador and curandeiro learning from his father's cure-healing practices and performances. Both Kenedy and Ducilene have worked like their father, performing cure-healing rituals such as “*reza*” (“prayer”) and “*mesa*” (“table”), which I will describe later. Although the rezadores and curandeiros (and also reza and mesa rituals) are very common throughout Brazil, I will show, when I describe those Kariri-Shoco ritual practices, how indigenous therapeutic methods are used during cure-healing performances. Several cases show how the role of being a rezador, rezadeira or curandeiro shaman, as an indigenous health practitioner among the Kariri-Shoco, relates to a learning process within the family realm, although each shamanic specialist experiences a secret and private development within his/her shamanistic embodied knowledge.

Dona Chiquinha, for example, told me that her grandmother was the one who “discovered for her” that she had this “gift” and told her that she was a rezadeira. “Vocation” is understood as a “gift” that the person has from birth, but the “knowledge” (“*conhecimento*”) and the “*ciência*” that the shaman acquires during his or her life depends on his/her personal growth, and experience in his/her “vocation” to become a rezador, rezadeira or curandeiro to perform cure-healing practices as a daily activity.

Ducilene explained that she “prays” (perform reza rituals) to cure “evil eye,” for “bad will” (“*má vontade*”), and participates in mesa rituals as a “godmother” (“*madrinha*”) when the Pajé Júlio or her father, Candara, asks for her help. She said that since she was a child she “stayed *curiando* [observing with curiosity]” with her grandmother Dona Chiquinha, and learned to become a rezadeira shamanic specialist.

Dona Maria Velha told me that when she was a child she used to observe her father praying for people, and that he used to ask her to bring leaves of *mastruz*, *vassourinha*, or *pinhão-roxo* for him to perform reza rituals on people. She told me that she felt that she could “be a rezadeira too” so she started to practice by herself, hiding from her father. One day when her father arrived and caught her performing a reza on a boy, he said that he did not know that she was a rezadeira. She told him that she was still learning, and from that day forward she continued to pray on people. Thus the role of rezadeira is not necessarily passed down through a same-sex line.

With Dona Maria Velha I had not only the opportunity to conduct ethnographic interviews and watch her perform cure-healing rituals, but I also learned considerably about Kariri-Shoco female embodiment. Dona Maria Velha’s interviews contributed to my comprehension of ethnographic data recorded with reproductive women’s case studies, more than any other rezadeira case studies did. This happened based on our empathy, so I felt more comfortable to converse with her about sensitive issues related to data that I started to record on sexuality and reproduction. I video-recorded several ethnographic interviews, when I used to leave the camcorder on a table when conducting interviews. Several video footages were also recorded when she performed cure-healing rituals and also when we talked while she was making pottery.

Dona Maria Velha had twenty-one pregnancies. Eighteen children were born, of whom only six children survived, and she had three pregnancy losses. She lives in a two-bedroom house with her husband, who is retired and receives the “minimal

salary,” which is their principal source of income. They live with their youngest son (who is fourteen years old), and another single son (twenty-six years old).

Dona Zezinha is another Kariri-Shoco female shaman who works with cure-healing practices as a *rezadeira*. The first time I visited her, she told me about her great-grandfather who was recognized as a “captain” by Don Pedro II (who was the Emperor of Brazil during the nineteenth century) during a trip he made through the São Francisco River valley. Dona Zezinha explained that she became a *rezadeira* learning from her mother and father who also worked as shamanic specialists. She said that her father knew everything about cure-healing: “He knew how to pray, how to make bottled remedies, and how to open a *mesa* [table ritual].”²⁰

Dona Zezinha has seven children, and one of her sons is living in São Paulo, where he works and has bought house. She has two married daughters who teach in the elementary school inside the reserve. She told me that her son and daughters always help her, giving her money every month. Dona Zezinha also said that her oldest daughter is the one who is already a *rezadeira* shaman, and that she will also inherit Dona Zezinha’s “obligations” related to Ouricuri shamanic practices as a “*Avó*” (“Grandmother”).

Baioca lives in a two-bedroom house with her husband. During field research her son was working in São Paulo and her daughter studied in Porto Real do Colegio. When I met Baioca I came with Julie, one of the woman reproductive case studies. Baioca told me that she became a “*Mãe* (“Mother”) among the Kariri-Shoco because her mother occupied this role in the Ouricuri. She showed her mother’s picture and

²⁰ The *mesa* ritual is “opened” by a male shaman who is called “*mestre*” (“master”) as I will describe below.

told me how she misses her and still communicates with her spirit, explaining her goodness and gentleness. Baioca also told me that her father was from the Pankararu and her mother a “natural from the land” (which means that she was born in Porto Real do Colegio). Baioca occupies a very important position within Ouricuri rituals and she is responsible for conducting an annual celebration for Saint Anthony in June.

I met Frederico when he came back from a frustrating trip to Rio de Janeiro. He went to work performing cure-healing practices with other young Kariri-Shoco. The work Frederico conducted in Rio included “individual attendance,” “spiritual orientation,” “medicinal herbs” and “spiritual cleansing of places.” This was advertised on the *Tribo Virtual* (Virtual Tribe) website by Favilla (2001a).

The website group, Tribo Virtual, contains several electronic messages referring to information about a “ceremony” that Frederico was going to perform and that was advertised through this website. This ceremony proposal caused a series of discussions among different members of that web-group. These members, which include anthropologists, addressed emails to each other expressing their opinions about the ceremony. They also discussed the fact that Pajé Júlio was informed about that ceremony and had asked Frederico to come back immediately to the reserve as he was making a mistake by performing the proposed ceremony, where rumors about sacred secrets from Ouricuri ritual could be revealed. Thus, when I met Frederico, he only wanted to talk about this episode. He assured me that he “wouldn’t be crazy to reveal any secret,” and that he knew what he was doing.

I understood from the advertisement on the web that it was not the first time that a ceremony led by a Kariri-Shoco shaman involving the use of Jurema occurred

in Rio de Janeiro. Rogerio Favilha (2001b) reported that the first time it happened was in 1997 with Pajé Júlio's participation. I talked to Pajé Júlio about this and he explained that "the problem" this time was related to the fact that he was not aware that Frederico was going to perform that kind of ritual in Rio de Janeiro, when Frederico was not authorized to perform that ceremony. According to Pajé Júlio, the use of Jurema is "very dangerous." He also explained that Jurema's use could "bring harmful consequences to the ones who participate" and "if secrets from Ouricuri" were revealed, it would affect and could even "destroy the whole Kariri-Shoco community." The Jurema plant has psychotropic properties. In Chapter VI, ethnographic data about Kariri-Shoco use of Jurema in mesa ritual. For now, I continue to describe information about Frederico.

I heard several different opinions about Frederico's return, which spread the rumor of the threat of Kariri-Shoco secrets being revealed. Some shamans thought that Frederico was wrong to propose to perform a ritual using the Ouricuri as reference to a ritual, and the fact that he had to return to the reserve was already a "punishment he was receiving." Dona Maria Velha was very mad because her son, who traveled with Frederico, was also involved in this "misunderstanding" and came back to the reserve. Dona Maria Velha explained that she knew her son and Frederico very well, and that she was sure that they would never reveal any secret from the Ouricuri ritual.

This episode, which involved performing this ceremony in Rio, was a demonstration of how the Kariri-Shoco are concerned with their Ouricuri secrets being protected from outsiders, which are part of their knowledge and practices. It

was also a demonstration of Pajé Júlio's power and control over a shamanic specialist who, according to him, had "passed the limits," particularly because he did not ask for his authorization to perform such ritual using the sacred Jurema remedy. Pajé Júlio was sure, according to what he stated, that Frederico would never reveal Kariri-Shoco sacred secrets.

Pajé Júlio, who is the religious leader, lives in a three-bedroom house with his wife, Vandete, and two teenage children. Pajé Júlio has eight children and, among them, Chiquinho is the one who is going to become a Pajé like his father. When I first met Pajé Júlio he embraced me and gave me all support to conduct my field research. Very often I would come to visit him and we would talk about my research and the information that I was collecting. Thus, I consider him to be an important informant for my research. Two of his sons, Carlinhos and Chiquinho, are FUNASA employees. Chiquinho works as a sanitary technical assistant and is responsible for coordinating FUNASA sanitary actions and projects within the reserve, such as water treatment and garbage control. Carlinhos occupies a position as a health assistant at the Sementeira health clinic. Chiquinho lives in a two-bedroom house with his wife and two children. He is usually busy with his work within the reserve and as a DSEI member he attends monthly meetings in Maceió City.

5.2. Kariri-Shoco Shamanism as a Sociological Domain:

The religious leadership role of Pajé has been passed down through generations within the same family.²¹ In Pajé Júlio's case, not only was his father the previous Pajé, but his son Chiquinho will occupy his father's position in the future. The Pajé's role relates to a responsibility with spiritual issues, which includes coordination of celebrations and of work that shamanic specialists perform in Ouricuri rituals. As he explained:

“A Pajé does not have to be accepted by the community, he has to be accepted by his capacity, which he can only get through the ritual [Ouricuri] and spiritually, where his divination is. There are things that I can teach and the Pajé can only assume the responsibilities based on this [his divination]... Then, those are not things that we can change, because it is from origin, they come from the trunk [*tronco* ' meaning ancestrally]... and as long as it exists, it can only be that.”

The meaning of the word *tronco* stands for the kinship ancestral domain. *Tronco* is also a cover term that refers to roots and to plants. Pajé Julio explained how the political leader *Cacique*'s position and his as Pajé differ:

“The *Cacique*'s work is different; if it doesn't work the community can gather and replace him. It is a different thing. The *Cacique* has nothing to do with what is religious. I respect him, I help, he is a good *Cacique*, everybody supports him, but when he plans something, I have to confirm [through divinatory practices] if it will work. If it won't, I tell that it has to wait; it is not the time yet... That is why my responsibility is ever greater, because my word is the last one.”

Chiquinho's interview illustrates how explanations are usually given about the process of becoming a Kariri-Shoco shaman. Chiquinho told me that most of the

²¹ Diégues Jr. (1975) describing historical characteristics of indigenous peoples in Brazil, defines Pajé as “the religious authority... who... joint functions as priest, healer, and guesser” (my translation, Diégues Jr. 1975, 69). Today all indigenous peoples in Northeast Brazil still have the roles of Pajé, as the religious leader, and *Cacique*, as political leader.

diseases-illnesses that he has treated among the Kariri-Shoco are “spiritual problems that belong to Indians themselves,” which he “cures” with his father. About the process of becoming a shaman, he explained:

“Although I see him [his father] working, I have already received a vocation and I have the power to decide and to do... Among all my brothers, including three older ones, I am the chosen one, and my father knows that... I have a mission to accomplish... Right now we work together, but if he is not present in the reserve, I assume the work. For example, according to my knowledge, sometimes when I am working with my father I can remind him something that is missing.”

Chiquinho said that sometimes when his father forgets something, he tells his father what to do. From these experiences his father recognizes and agrees that he has a “vocation” for that. Chiquinho mentioned:

“These moments happen because my father cannot teach. There are things that cannot be taught... it is why my father thinks to himself: ‘I haven’t taught him about this! Nobody taught him, but he is learning!’”

When I asked Chiquinho if he knew how to make remedies, he said that he knows how to make several remedies, “like everybody,” but right now he is not working with remedies, so he leaves it to his father: “I can make a remedy and it can be validated, but I don’t want to have this duty now... My father makes them as a duty.” This duty relates to how Kariri-Shoco rezadeira and rezador-curandeiro shamans assume daily activities working as shamanic specialists with cure-healing ritual practices and also making remedies for indigenous and non-indigenous people.

Pajé Júlio and Chiquinho’s interviews are examples of how shamans obtain their knowledge and become shamanic specialists. Their shamans’ roles relate to a “Grandfather” position within the shamanistic kinship ties, and also to Pajé, as the religious leader who assumes the leading role in Ouricuri ritual celebrations.

Although all shamans are able to cure-heel, not all of them become indigenous health practitioners as a rezador, rezadeira or curandeiro shamans. Those kinds of shamanic specialist conduct reza and mesa cure-healing rituals and work also making remedies from medicinal plants. Pajé Júlio is also a rezador-curandeiro shaman and his future successor, Chiquinho, will become one.

Pajé Júlio explained that fifteen women and twenty-eight young men are his “helpers” (“*ajudantes*”) who actively participate in the Ouricuri rituals as shamans. About his male “helper” shamans, Pajé Júlio told that he followed his “divination” (vision, prediction) when he decided to “put aside older men” (as retiring them from certain ritualistic practices) who are also shamans, “because they are tired and cannot stand the *repuxo* [hard work]” required in certain Ouricuri ritual practices. Thus, his “helper” male shamans are “young men” who are “the sons of older shamans” who have worked with Pajé Júlio’s father, the old Pajé Suíra. From those young men, he mentioned that only eight are his “helper” shamans during daily life within the reserve. Pajé Júlio explained that those eight “helpers” work as an extension of his “eyes... being aware” and telling him “if something bad or wrong happens within the reserve.” His “helper” male shamans also can “represent” him when he is “absent from the reserve.”

The information that young “helper” male shamans are the sons of older ones demonstrates how male shamanic specialists are formed within families along descent lines. Pajé Júlio explained, “they are from the same houses” of the older ones, and that “although they are young, they are prepared and old about their work... [which]

cannot be diminished [*diminuído*] and neither be advanced [*adiantado*]; it has to be passed from generation to generation.” And he continued explaining:

“Because I have a custom that belongs to God, what God gives you is yours, and that’s what you have, can have, and what is not for you to have you don’t, because God gives the divination [*vidência*]. Your determination is only what God allows to your head. Your head of God is a secret. All are sons of God, everybody could have the same equal deserving [*merecimento*], but doesn’t. Everyone has the way that the person deserves, and also what the person dedicates and trusts. God gives your head for your effort and for the trust.”

When I asked Pajé Júlio about whom those “helpers” shamans were, he said that I would meet them during my research, but he did not tell me their names. I understand that shaman “helpers” identities are kept veiled from outsiders because their roles, activities, and experiences are mainly associated with secret and sacred male and female Ouricuri shamanic ritual practices. Thus, the kinds of shamans that Pajé Júlio calls “helpers” were not researched, although I may have met and interviewed some of them, as he predicted, or even selected some as case studies.

I understand that Kariri-Shoco shamanistic knowledge cannot be taught, but the role of the shamanic specialist relates to a position passed down through generations, like the Pajé and “helper” shamans’ roles. Chiquinho explained that in Pajé’s role it has happened without “knowledge be taught” but as a “vocation” of a “chosen one” through different generations within his family: “For example, my grandfather [Pajé Suíra] never taught my father, who also never taught us. Thus, my father recognizes that it is a vocation that I have and he tells me: ‘You keep this to yourself because later you will need this knowledge.’” When I asked a verification question about his role as shamanic specialist, he answered that according to their traditions:

“... the Pajé is the tribal chief, the spiritual chief ... the Cacique is the warrior chief, but the Pajé is the father of all the tribe. Then I received this function, like I am already managing it, but in the future I will receive it in a spiritual way. This is the function I receive. My vocations make that later, for example, I will have to accept the decisions of few, but there will be a time that everybody, all Kariri-Shoco, will have to accept my decisions, and even those older than me will have to respect my decisions.”

Then I asked: “Will they call you Father?” He answered: “No, they will call me ‘Avô’ [‘Grandfather’] ... My father is the son of a very famous Pajé that everybody called him Avô for his knowledge.”

Chiquinho told me that he has friends who are his same age that are already finding it strange that one day they are going to call him “Avô:” “That is the way they will have to,” he mentioned. Although Chiquinho is going to assume a specific role as a Pajé, also as an “Avô,” and become a rezador-curandeiro shaman, his interview shows an example on how the process of becoming a shaman happens among the Kariri-Shoco. It also reveals what I had already noticed: there is a ritualistic kinship established among the Kariri-Shoco, in which shamanic specialists are recognized and addressed with fictive kinship terms, such as Mãe (Mother), *Pai* (Father), Avó (Grandmother) and Avô (Grandfather). Those are statuses associated with their shamanic relation and association with spiritual beings, which are kept secret from outsiders.

These ritual fictive kinship statuses are positions that shamanic specialists occupy through the roles they assume within Ouricuri rituals from which relationships are established among the Kariri-Shoco ritualistically by these kinship ties. For example, I had the opportunity to interview an eighteen-year-old girl who explained how her “Avó” was important to her in terms of protection by the

shamanistic world. She also explained how her “Avó” regards and is responsible for her shamanistic growth within Kariri-Shoco shamanism. Thus, the ritual kinship bond relates to the initiation process, within Ouricuri rituals, when those shamans occupy a position that becomes responsible for the shamanic initiation of their “rebanho” (herd, flock as neophytes). In the Ouricuri ritual world, those positions follow the mother’s or father’s descent line (according to the shamanic specialist’s gender), and are regarded by the Kariri-Shoco as a ritual kinship system. In the last section of this chapter, I describe how this cognatic ritual kinship system is linked to spirits.

Those who occupy ritual kinship positions are responsible for specific celebrations during Ouricuri rituals throughout the year. When an Avó dies, for example, this position has to be occupied by someone through the female consanguineal line. After Dona Marieta had a serious health problem during the fieldwork, I observed that several of her consanguineal grandchildren were possible candidates to occupy her position. The one chosen would mainly depend on Ouricuri shamanic ritual, where the replacement of Dona Marieta’s position of “Avó” would be decided among her female consanguineal descendents and according to spiritual beings. Pajé Júlio explained that although there is no definition of who inherits this position, it always passes to someone who belongs to the same family through generations. Thus, Dona Marieta’s substitute could be chosen among her female children, granddaughters, or great-granddaughters. It is a position that may be disputed between those who are candidates. Although one of Dona Marieta’s granddaughters was willing to assume this shamanistic role, this would not

necessarily happen because the chosen one among Dona Marieta's female family descendants would fill this position by a decision taken within Ouricuri ritual.

I had information about a dispute over one of these shamanic kinship positions. The one who was chosen to replace the previous one was not a consanguineal descendant. This shamanic specialist died after assuming this shamanic position. Several people suspected that the successor's death related to the power of the shaman who occupies this role at the present. The death of the successor was described as "sudden" and "mysterious." These descriptions were associated with commentaries about the shamanistic power of the actual one who holds this position today. This shamanic specialist explained to me that one inherited this shamanic kinship position from a parent, following consanguineal descent. Thus, the replacement of this position within a shamanic classificatory kinship category is gendered following consanguineal descent.

What is interesting about these ritual kinship statuses is that they reproduce a kinship system that Rodrigues (1948) discovered based on ethnographic data registered in Father Luis Vicêncio Mamiani's ([1699] 1942) book, *Arte de Grammatica da Língua Brasílica da Naçam Kiriri*. Mamiani ([1699] 1942) organized the grammar and catechism of the Kipea language in order to provide better knowledge of those people's language for missionary purposes.²² The indigenous Kariri people that Mamiani ([1699] 1942) observed in the late seventeenth century had a term, *buyó*, to refer to relatives and a term, *buyoidzã*, which means "relative

²² Mamiani ([1699] 1942) registered information about the Kipea language of the Kariri people located in a missionary settlement on the Itapicuru river, in the Northeast of Bahia state.

arrived by consanguinity” (*“parente chegado por consagüinidade”*) that Rodrigues (1948, 202) translates as “true relative” (*“parente verdadeiro”*).

Rodrigues (1948) analyzed information provided from Mamiani’s ([1699] 1942) account of the Kipea language and shows that within this language the kinship system is classificatory:

All relatives from the same generation of ego - whether brothers or cousins (parallel or cross) are classified in the same way, i.e. as “brothers.” ...In the first descendant generation, as in the ascendant, there is no identification of children and nephews. For the children there is only one term, and the distinction of the sex is done with words ‘man’ and ‘woman’: ...”man child” and...”woman child” (Rodrigues 1948, 196).²³

According to Rodrigues (1948):

In the second ascendant generation, the grandparents are only distinguished according to sex, not having difference between fathers’ parents and mother’s parents. In the second descendent generation, in the same way, the grandchildren are distinguished only by sex (Rodrigues 1948, 196).²⁴

Rodrigues (1948) analysis seems to illustrate the Kariri-Shoco ritualistic kinship system today, where they have classificatory kinship terminologies (Mãe, Pai, Avó, Avô) that “systematically class together lineal relatives (father, mother, grandparents) and collateral relatives” (Keesing 1991, 102). This means that the Kariri-Shoco experience within their shamanistic world a kinship system where a social organization is lived and experienced through being relatives. Rodrigues’

²³ My translation: *“Todos os parentes da mesma geração de ego –tanto irmãos como primos (paralelos ou cruzados), são classificados da mesma forma, i. é., como “irmãos.” ...Na primeira geração descendente, não se identificam filhos e sobrinhos. Para os filhos há um só têrmo, e a distinção é feita pelas palavras “homem” e “mulher”:* ...”filho homem,” ...”filha mulher” (Rodrigues 1948, 196).

²⁴ My translation: *“Na segunda geração ascendente, os avós são distinguidos apenas de acôrdo com o sexo, não havendo diferença entre os pais do pai e os pais da mãe. Na segunda geração descendente, da mesma forma, os netos são distinguidos sòmente segundo o sexo”* (Rodrigues 1948, 196).

(1948) analysis provides a basis to consider how an indigenous kinship system remained alive, throughout four centuries of history of oppression, within their shamanistic world. Through this ritual kinship system, recognized among the Kariri-Shoco, kinship ties are established and experienced between those who belong to the same and different generations as being part of a cognatic kinship system.²⁵ This illustrates how Kariri-Shoco shamanism is a form of resistance within a context where extended families, including *sistema de compadrio*, or *compadrazgo* compose and characterize Kariri-Shoco daily social organization today.

According to Keesing (1991), “most tribal societies have *classificatory* kinship terminologies... [which] systematically class together *lineal* relatives (father, mother, grandparents) and *collateral* relatives... Collateral relatives are off to the side, the siblings or cousins of lineal relatives” (Keesing 1991, 102). It is this kinship system, followed by the Kariri-Shoco within Ouricuri rituals, which contrasts with their daily nuclear family domestic groups, where kinship terminologies are used to distinguish lineal (pai, mãe, *tio* [uncle], *tia* [aunt], *sobrinho* [nephew], *sobrinha* [niece], *avô* [grandfather], *avó* [grandmother], *tio avô* [uncle grandfather], *tia avó* [aunt-grandmother]) and collateral relatives (*irmão* [brother], *irmã* [sister], *primo* [male cousin], *prima* [female cousin])²⁶ within an extended family.

²⁵ Cognatic kinship is very widespread among indigenous groups in Brazil. Seeger and Viveiros de Castro (1986) explain that Gê groups and the Bororo from Central Brazil became famous in anthropological studies because those societies, extremely complex, utilize a multiplicity of principles to form groups, and they have a notable social organization” (Seeger and Viveiros de Castro 1986, 46).

²⁶ There is also expressions that distinguish within a collateral relative from the father’s or mother’s side, for example, “male cousin from the father’s part” (“*primo por parte de pai*”), “uncle from the mother’s part” (“*tio por parte de mãe*”), etc.

On the other hand, since classificatory terminologies are used within a shamanistic cognatic ritual kinship status of shamanic specialists' roles, the ones chosen to occupy this status belong to a non-ritual kinship consanguinity and gender-differentiated descent. Those who occupy positions within this ritual kinship system assume responsibilities and affective bonds among themselves and among the Kariri-Shoco people.

There is a practice and experience of a great goodness, "beauty" and "purity," as Dona Marieta described, within Ouricuri village sacred ground. "Avós" experience great happiness on their "travels" ("*viagens*") to the Ouricuri village. Their concerns with obligations are very often related to the food that they have to bring which is shared among "relative[s] by consanguinity" who are "true relative[s]," quoting Rodrigues (1948, 202), when he translated the significance of the Kariri Kipea language terms for relatives. The Kariri-Shoco gather to celebrate divinity and holiness, and also to perform cure-healing practices in Ouricuri rituals. Shamanic specialists who occupy a position through shamanic kinship roles hold wide social and affective bonds among the Kariri-Shoco, where people also experience strong affective ties as 'true relatives'.

Kariri-Shoco shamanic specialists are those who are the "chosen ones" within their families. "Vocation" is a "gift" given by the spiritual world, when "divination" ("*vidência*") is experienced and the person's "dedication," "trust," and "concentration" are part of the shamanic specialist formation and practices. Still, spiritual beings are the ones who choose who will become a shaman. My understanding is that the Kariri-Shoco consider that "live spirits" are spiritual beings

from the cosmological world, which are the ones who choose shamanic specialists within Kariri-Shoco extended families.

Pajé Júlio is responsible for scheduling a series of Kariri-Shoco rituals that relate to the Ouricuri, which take place in the Ouricuri village, two weekends each month (from Fridays to Sundays, and sometimes from Saturdays to Wednesdays) throughout the year. He is also responsible for the biggest celebration that lasts for fifteen days in January, when many Fulni-ô, Carapotó, Shucuru-Kariri and other indigenous peoples, from groups that also practice Ouricuri rituals, come to participate in celebrations. The Kariri-Shoco and other groups in Northeast Brazil experience Ouricuri rituals from which a cognatic kinship system is experienced, gathering to “accomplish obligations” related to individual, familial, and community protection.

The Ouricuri sacred territorial ground is gender demarcated. There is a place where only men gather, where no women can go. The men, however, can go to where women and children gather. This territorial ground is a place of “respect,” where there is no space for disputes nor for sexual desire, where ritual kinship ties link everyone. This gendered territorial ground demarcation does not necessarily illustrate that gendered shamanic practices differ. Those positions of being the Mãe, Pai, and Avó and Avô are gender inherited, when female shamanic specialist’s roles pass through female lineal descent, and the same happens to male shaman’s roles within the Kariri-Shoco shamanistic cognatic ritual kinship system.

Thus, among the Kariri-Shoco rituals, the Ouricuri is the most important one in which only indigenous peoples participate. There are cases of non-indigenous

people who married a Kariri-Shoco woman or man, who were accepted to participate in the Ouricuri rituals. Those cases happened mostly in the past, although there are cases, like a woman who is thirty-six years old and was accepted to be part of the Ouricuri when she married a Kariri-Shoco man ten years ago. Pajé Júlio explained that when his father was already old, he decided that permission for those non-indigenous spouses taking part in this ritual would not be granted anymore. There are also cases of older non-indigenous spouses who, although married to a Kariri-Shoco, were never accepted to take part in the Ouricuri ritual. Thus, for a non-indigenous person to be accepted, or Indians from groups which do not have Ouricuri ritual, it always depends on decisions taken within Ouricuri, where spiritual beings decide.

One example that shows how an indigenous population had access to Kariri-Shoco Ouricuri rituals happened in the 1980s, when a Shucuru-Kariri nurse assistant, who worked for FUNAI in the Kariri-Shoco post, was accepted to gather and be part of this ritual. As she was a midwife, there was a need for this specialized health assistance in the Ouricuri, where women give birth. After this Shucuru-Kariri woman started to be a member within Ouricuri ritual, she also brought her relatives and that is why the Shucuru-Kariri today practice the Ouricuri in their indigenous Mata da Cafurna area.

The Ouricuri represents the maintenance of protection against health problems and bad events for both Kariri-Shoco individuals and the whole community. Pajé Júlio once said: “Our work there [in the Ouricuri] is more of defense. We have to

cover [*cobrir*] ourselves.”²⁷ I observed how busy the Kariri-Shoco are with preparations, or as they say “obligations” (“*obrigações*”) for the Ouricuri rituals. When preparing for specific celebrations some people are responsible for accomplishing “duties,” such as to provide food as offerings to be shared.

During an ethnographic interview, a shamanic specialist explained that all Kariri-Shoco elderly women today are called and treated as “Avó” by those with whom this shamanistic kinship tie is established, but the number of “Avô” is greater. This shaman also explained that this kinship relates to Kariri-Shoco religion (shamanism) and that all Kariri-Shoco “know and respect it” (“*conhece e respeita*”), I found out that there are two Mãe, one Pai, forty-five Avô, and fifteen elderly women who are Avó. I told him and mentioned Baioca whom I had noticed was considered and called “Mãe” by many people. He explained that “both Mãe” do not have the same role-functions in the Ouricuri. This relates to the fact that the Mãe’s role is fundamental for the opening of Ouricuri rituals. There has to be another Mãe, who may practice similar necessary opening activities of Baioca’s role for the Ouricuri ritual, substituting Baioca (when she is menstruating) in order for Ouricuri ritual to be conducted. As I asked about who was considered a Pai among the Kariri-Shoco, he mentioned Mr. Herpidio was the one considered. He also explained that I could observe that even his “morality [referring to the way he conducts himself] is different.”

I told this Kariri-Shoco shaman that I had observed that many people were afraid of Mr. Herpidio. He laughed at my comments and explained that since Mr.

²⁷ The verb *cobrir* (cover) is semantically associated with ideas of secrecy, protection, ‘closedness’, according to domain analysis.

Herpídio was twenty years old “he was already privileged with power... and [since then] he has commanded” (assumed his role in the Ouricuri as the Father). This shaman corrected me by explaining that although I had mentioned the correct word, “fear” (“*medo*”), he would prefer me to say that Mr. Herpídio is “respected” (“*respeitado*”), and that “the respect makes the person fear... the respect is so big, that makes people fear him, and even now when he is already old.”

This ethnographic interview illustrates how Kariri-Shoco shamanism is characterized by different roles that Kariri-Shoco shamanic specialists have through positions that they occupy through ritual kinship ties, which also characterize relationships among Kariri-Shoco people. These roles also relate to the power that shamans have from their knowledge. Since power and knowledge are connected, the shamans are feared and respected.

Once I asked another shaman if these kinship ties were related to their age. He explained that “even the oldest Kariri-Shoco man” at the age his “*bisavô*” (“great-grandfather”) will have to “consider” and call him “my Avô.” He told me this smiling. About the Ouricuri ritual he continued:

“These are things that happen within our communion. There are days that we have to respect and deal with children very carefully, when we have to consider a class related to the celebration [in the Ouricuri]”

I asked: “Does this relate to the obrigações [obligations] within the Ouricuri ritual?” As he bent his head affirmatively, I asked: “Do these duties create the reality of ritual practices for all year round?” He said: “Yes, during the whole year... and it is formed from children to the older ones.” Then, I asked him why the Kariri-Shoco

have several Ouricuri rituals during the year, while among the Fulni-ô rituals happen only during the three last months of the year? He replied:

“It is according to what the old Pajé Suíra used to tell, that his father and father of his father told about these traditions: ‘Those are things that we have already found.’”

Thus, Kariri-Shoco shamanism has social aspects where ritual kinship ties and roles within the Ouricuri ritual are established. These shamanic specialists’ roles also relate to “duties” and specific ritual celebrations throughout the year. The content of these practices has to be kept secret.

Dona Zezinha is a shamanic specialist “Avó,” like Dona Marieta and other older women. Dona Zezinha explained that she has “lots of grandchildren” who call her “Avó” and they always “ask for blessings” during daily life. She also mentioned that several older women have “*Netos*” (“Grandchildren”), who are like a “rebanho.” When I asked to Dona Zezinha if all “Avó” shamans know how to pray and make remedies, she answered that “not all of them know and all know.” She explained that all “Avó” know how to pray and make remedies, but not all of them are rezadeira shamans like herself and others. She explained to me:

“The person has to have a gift to make remedies and to deal with plants. Here there are plants that we all respect, for everything, like velandinho and jurema which ward-off all evil... all our plants are a gift left from God.”

About her work as a rezadeira shaman, Dona Zezinha also told me:

“This is my obligation that I have with my family, with people who come for me, and it is also my way of living. I have my obligation there [in the Ouricuri], I have my responsibility.”

Although shamanic specialists explain, “Knowledge cannot be taught” (“*conhecimento não pode ser ensinado*”) the role of a rezador, rezadeira or curandeiro

shaman is usually learned from observation of someone close. This learning process usually happens early in their lives when they are young, or even as a child. However, it mostly depends on their “vocation” within their family. During my field research, I observed one case of a newborn that was already considered as “having a *cadência* [vocation].” The characteristics of his head and eyes, and also health problems that were affecting him, were pointed out as related to his “vocation.” I was sure that this was an exceptional case, but I also observed that this was a case of a very special child who was a consanguineal descendent of powerful shamanic specialists from both matrilineal and patrilineal ascendants. Thus, “vocation” very often is experienced with suffering and expected through consanguineal descent.

Baioca, who is called “Mãe,” occupies a fundamental position in the Ouricuri rituals. She explained that she has “the keys of the Ouricuri” and for each ritual she goes before the others and works there, in order to “open” the ceremonies. Thus, it is a female shamanic specialist who opens the Ouricuri sacred and secret ritual. Baioca explained:

“All of them depend on me... I have to arrange very early, I cannot go to the city... during four days lot of things pass through my hands... My strength [*força*] is from things discovered with the time, maybe with the planet that I was born with a strong star... I assumed my work after my mother died... and it could not put a wrong person, because it was from my grandmother, who passed to my mother, and [she] passed to me... she died when she was 70 years old.”

The word strength belongs not only to the shamanistic domain. It is often used within the ethnophysiological domain, which I approach in the next chapter. About her role as a “Mãe” shamanic specialist, Baioca told:

“I have to embrace everybody... if there is a president of the Indians and a poor Indian ‘*cachaceiro*’ [drunk], I have to embrace them all... I feel like a

Mãe, I have to bring peace, and I was born for that, although the person suffers.”

Then Baioca explained how she had experienced sufferings as part of the process of her shamanic knowledge related to “discipline”:

“The suffering is part of my *‘sina’* [destiny]... My discipline is different... I have to maintain my faith alive and the spirit pure... then I get what I want, through maintaining the body and spirit pure and not wishing bad to anybody... This is the discipline. There are several disciplines that I have passed through. This husband, I have suffered a lot with him, he used to drink a lot, that suffering was to divide, [it was] to maintain myself pure or to mix myself with him... I used to pray and when he used to arrive drunk, he couldn’t see me... He would arrive and wouldn’t see me... he looked at me and didn’t see... I would stay quiet, then he would find a place and fall asleep. Then I would go to confess to the walls asking why that was happening... and thank God one day he told that he wouldn’t drink anymore. Then it came another one [discipline]... everything that I touched disappeared... then a *‘caboclo’* [Indian] from Aguas Belas told me that I should experience, that I had to pass through this... that I would be a person chosen by God for the community, but I had to leave all my vanity... with clothes, make-up, hair... So today it is very difficult to even drink a soft drink... I live asking forgiveness to the eternal Father [spiritual male being]... and started to do this *‘regime’* [discipline] and all things against me started to go away.”

Baioca described her strength as a shamanic specialist and that her role within Kariri-Shoco shamanism is of great power:

“Because I am a strong person, if there is someone who wants to be more than me, [he/she] has to *‘topar’* [confront] me...there are strong people here, but they do not pass over me, even if they want to be stronger than me, they have to *‘topar’* [confront] me.... Even the oldest one from here is my son.”

Baioca told me that she is still developing her shamanic knowledge as she has a “lot of ground to grow.” She also mentioned that her mother was a widow and she “*amarrou o facão*” (“tied up the big knife,” went through menopause) very early. Because she still has a husband, Baioca prays and makes a “lot of effort.” Her explanation about the fact that she still menstruates and that she still has a husband,

relates to the Kariri-Shoco perception of differences that characterize the female body which affect shamanic performance. She considers that this influences her growth in her shamanistic practices. The way she explains her shamanic specialization demonstrates how powerful she already is, and the fundamental role she has, when she is the one who has “the keys for the Ouricuri” ritual.

Thus, like the Pajé religious leader’s role, I understand that among the Kariri-Shoco the shamanic specialist’s role has also been passed down through generations within families. Shamans are those who work protecting their families, protecting the ones who are ritually affiliated to them, and assisting the ones who come for their help. Although not all Kariri-Shoco shamans become rezador, rezadeira or curandeiro, who perform reza and mesa cure-healing rituals and make remedies for indigenous and non-indigenous people as indigenous health practitioners, all shamans are able to cure-heal because it is a power and strength they have through their communication with spiritual beings.

Pajé Júlio explained to me that the difference between rezador, rezadeira and curandeiro is in their ability to heal different health problems. The rezador and rezadeira shamans are those who conduct reza rituals when they are able to treat “light things” (as minor health problems), while curandeiro shamans are those who treat dangerous health problems caused by evil spirits. He mentioned that curandeiros are called “*mestres*” (“masters”) those who open mesa rituals. He also explained and considers that all Kariri-Shoco rezadeira, rezador and curandeiro are shamans. I asked a verification question to Pajé Júlio if those rezadeira and rezador, whom I have researched, could be considered rezadeira/rezador-curandeiro, since I observed that

they were all able to “attract” something evil, including an evil spirit through reza rituals. He answered that although they are all able to treat “minor things,” only the “mestres” (curandeiro shamans) are able through mesa rituals to “cure from spirits” (“*curar de espíritos*”). Shamanic roles are gender demarcated, since no women perform mesa rituals as mestres by opening it. This reflects shamanic specialists’ perceptions that men have more “*força*” (“strength”) than women. Still, the one who “opens” the most important Kariri-Shoco ritual, the Ouricuri, is a female shamanic specialist.

Thus, among the Kariri-Shoco there are shamans who occupy classificatory kinship status. There are also rezador, rezadeira and curandeiro (master) shamans who perform different cure-healing rituals as shamanic specialists. Female shamans, like Dona Marieta, Dona Zezinha, Dona Maria Velha and Dulcilene, are specialized in reza rituals; they do not “open” mesa rituals, although they participate as “godmothers” (“*madrinhas*”). Female rezadeiras specialize in health problems considered minor ones, such as evil eye or other kinds not related to evil spirits. Curandeiros also perform reza rituals, like Candara, Kenedy, Frederico and Pajé Júlio, and they are mestres who treat minor and dangerous health problems related to evil spirits. Still, there are those who are not specialized in performing reza rituals or mesa rituals as mestres, but are able to perform cure-healings practices, like Mr. Zeca and others.

Dona Maria Velha’s brother, Mr Ze Tenorio, is an example, like Mr. Zeca, of a shamanic specialist who works mainly inside the reserve. Mr. Ze Tenorio explained that he “takes care of his family... [and] more of the Indians,” and that he has “often

helped Pajé Júlio in mesa rituals” as a “godfather” (“padrinho”). He also told me about non-indigenous peoples who came to ask for his help and he assisted them, although he is not known as a rezador or curandeiro, and does not perform those kinds of cure-healing rituals. Mr. Ze Tenorio also explained that he “learned a lot from the old Pajé Suíra,” but the “learning,” which he defined as a “calling” (“um chamado”) and an “*obrigação*” (“obligation”/“duty”) to follow, involves “suffering” (“*sofrimento*”) as “discipline” (“*disciplina*”).

I believe that among Pajé Júlio’s ajudantes there are some shamans who are rezador/rezadeira and curandeiro. Kariri-Shoco rezador/rezadeira and curandeiro shamans are the ones who work with cure-healing ritual practices, attending indigenous and non-indigenous people. Chiquinho, for example, in the future will be like his father, a rezador-curandeiro shaman, a Grandfather, and will work with outsiders. He said that in time he would start “to work” (“*trabalhar*”) with these cure-healing practices (as a rezador-curandeiro shaman), but for now he is only “working with Indians.” Although Chiquinho recognizes that his father has “a deeper knowledge,” he knows that he will eventually learn, and help even more his father. He told me that he is “preserving” (“*se preservando*”) himself now; that he used to “fool around” (“*farrear*”) but today he cannot. Thus, the role that shamanic specialists assume involves a different way of proceeding during daily life. This process implies some restrictions related to changes in behavior in order to grow in their shamanistic knowledge. Pajé Júlio, Chiquinho, and Baioca’s discourses exemplify this argument, when their “responsibilities” (“*responsabilidades*”) and “obligations” are taken seriously.

During an ethnographic interview when I asked Pajé Júlio a descriptive question about his work, he explained his shamanic experiences and practices:

“It is [a work with] divination [*vidência*] and knowledge. I can see things that come through dreams, and they can come also through spirits... It is like you're there, if you are a *vidente* (diviner) and you have contact with some spirit, he passes there and you see... he is there and you see, you observe him, you're sitting there. For you to have contact with the spiritual area you can have it being awake or asleep. You need to have the gift [*dom*] and concentration [meditation, *concentração*]. The concentration is principal. The person who concentrates with spirits has to be a person very concentrated on certain areas.”

In this explanation, he uses the word *vidência* regarding vision, the ability to see, the ability of predicting the future. In the context of the research, *vidência* is a cover term semantically associated to foresighted, which means the one who guesses, predicts things. This is the reason why in the next sentences he says: “I can see... through dreams... through spirits... being awake or asleep.” Both words, *concentração* and *dom*, are fundamental properties as ability and as attributes of being and of becoming a shaman. They are words often used in the cultural domain of shamanistic knowledge, related to experiences shamans have with communication with spirits. I understand that *concentração* means meditation, which is often explained as the moment through which the shamanic specialists focuses through concentration in the communication with spiritual beings, which enables him/her to see things and to cure-heal. It is also the moment that a trance or a light trance happens.

Thus, among the Kariri-Shoco, there is not one kind of shaman, but various shamanic specialists who have different roles and practices, and who perform different gendered roles in cure-healing rituals. As already explained, there are Kariri-

Shoco shamanic specialists who work as Pajé Júlio's helpers during Ouricuri rituals and within the reserve. There are shamans who are called "Mãe," "Pai," "Avô," and "Avó," with whom shamanistic ritual kinship status is recognized among the Kariri-Shoco. There are also shamanic specialists who are female rezadeiras or male rezadores or male curandeiros, who during daily life perform and practice cure-healing rituals as indigenous health practitioners. These roles may intersect, since male curandeiro shamans can be also rezadores and helpers; Avôs can be rezadores/curandeiros; Avós can be rezadeiras and helpers. What characterizes their cure-healing ritual practices is the gendered and demarcated character of the nature of the health problem involved. Kariri-Shoco rezador/rezadeira and curandeiro shamanic specialists practice cure-healing rituals through the use of words in prayers, the use of spiritual plants, and also by communication and interaction with spiritual beings.

Thus, among Kariri-Shoco shamans there are those who become specialized as female rezadeiras or as male curandeiros (mestres), which I have considered as indigenous health practitioners, who mostly work performing cure-healing rituals for indigenous and non-indigenous peoples. It is in the following section that I focus on disease-illness perceptions and continue to describe information on how the evil is perceived and experienced as embodied health problems.

5.3. Diseases-Illnesses Experiences and Perceptions:

Medical anthropologists have redefined contrasting concepts, such as disease-illness, curing-healing, and the mind-body relationship. I consider and utilize such concepts regarding Kariri-Shoco shamanism. The notion of disease-illness is interrelated to both domains of disease, which means biological or biochemical

malfunction, and of illness, which relates to the patient's cultural perception and experience of sickness (Fabrega 1974; Kleinman 1980; Finkler 1985). The second concept, curing-healing, also refers to interrelated domains: while curing relates to successful results of treatment, healing has a broader context of both physical and abstract components of the "curing" process (Hahn 1995; Strathern and Stewart 1999). The mind-body distinction, basic to biomedical science, has been considered here as phenomenologists propose, as a concept better understood in terms of embodiment, in which comprehension of thoughts, experiences, and perceptions transcend the dichotomist character implicit in mind-body concepts (Csordas 1994; McCallum 1996; Strathern and Stewart 1999). Thus, the ethnography about the Kariri-Shoco considers that domains of disease-illness, cure-healing, and mind-body relate to both subjective and objective realities experienced non-dualistically by shamanic specialists who use medical knowledge and by those with health problems who use indigenous medical practice.

There is only one word in Portuguese, *doença* (disease), which can have the similar meanings of disease, illness, and sickness. Thus, considering those different English terminologies as intersected domains from which medical practice treats individuals who experience health problems, I decided to use the word *doença*, meaning the compound key concept of disease-illness, which refers to material (disease) and conceptual (illness) manifestation of bodily suffering among the Kariri-Shoco, when a health problem is experienced through embodiment.

Before approaching how some *doenças* (diseases) are perceived and experienced by the Kariri-Shoco, I intend to describe information on how Kariri-

Shoco's concepts of different kinds of diseases-illnesses demarcate their own shamanistic medical practices from others such as biomedical and Afro-Brazilian religious. Then, I focus on how Kariri-Shoco's concepts of evil or evil eye interrelate within the field of cure-healing processes and in diseases-illnesses perceptions, which are cured-healed through indigenous medical practices.

I found out that perceptions of diseases-illnesses are closely related to differentiated ethnic medical boundaries from which their ideas of "white man's disease" ("*doença de branco*") and "Indian's disease" ("*doença de índio*") demarcate Kariri-Shoco shamanism as a different medical practice and knowledge from Western biomedicine. The "Indian's diseases" are those health problems which can only be treated and cured-healed through Kariri-Shoco or other ethnic indigenous northeastern groups' shamanistic medical practices.

Diseases-illnesses that are caused by evil that enters someone's body have also a contextual ethnic dimensions among the Kariri-Shoco. Health problems caused by evil spirits, which happens to non-indigenous people, Kariri-Shoco shamans often relate to the work of Afro-Brazilian religious practitioners, which they refer to "white man's disease," since it is a problem that affects non-indigenous people. Kariri-Shoco shamanic specialists very often identify evil spirits on non-indigenous patients from works of the *malfeitores* (those who make evilness), which they attribute to Afro-Brazilian religious practitioners. Thus, Kariri-Shoco indigenous medical practice is also demarcated by an ethnic medical boundary from which Afro-Brazilian practitioners are perceived as those responsible for health problems related to evil spirits that can affect non-indigenous peoples. On the other hand, Kariri-Shoco people

are very secure about the power that their shamanism has, since no indigenous people are harmed by Afro-Brazilian witchcraft practices, and Kariri-Shoco shamanic specialists are able to cure-heal those non-indigenous people who come for health assistance. The “table” ritual performed on a non-indigenous woman, described in the previous section, illustrates their medical practice and perceptions. Thus, for Kariri-Shoco people, their shamanism is powerful and they are protected from any evilness of Afro-Brazilian practitioners’ work.

I had the opportunity to register in my journal, during field research among the Pankararu, their ideas of “Indian’s disease” and “white man’s disease,” which I find similar to Kariri-Shoco perceptions. Acciolly and Carvalho (1998, 7-8) consider that Pankararu notions on “white man’s disease” are those which the Pankararu have historically learned from Western ideas, through the “official [governmental] health system,” while “Indian’s diseases” are those which are caused by “spiritual determinants.” I recognize that the Kariri-Shoco have historically learned a wide range of terminologies used by biomedicine to refer to diseases-illnesses. This is illustrated through how shamanic specialists very often use biomedical terminologies when they refer to *doenças*. However, my account of Kariri-Shoco perception of diseases-illnesses, which they may classify as “white man’s disease” or “Indian’s disease,” slightly differs from Acciolly and Carvalho’s (1998) explanation.

When Acciolly and Carvalho (1998) explain that Pankararu’s notions are related to *doenças* of different natures, for example as biomedical diagnosed ones (“white man’s diseases”) and those with spiritually related cause (“Indian’s diseases”), they do not consider how diseases-illnesses are actually experienced as

embodied health problems from which indigenous shamanistic medical knowledge diagnoses and treats them (whether biomedical or indigenous). The use among the Kariri-Shoco of those different ideas demarcates indigenous shamanistic knowledge as a powerful medical practice for “Indian’s diseases” which cannot be diagnosed and effectively treated by the biomedical healthcare system. On the other hand, biomedical diagnosed diseases-illnesses are very often treated by Kariri-Shoco shamanic specialists and, according to their perceptions, even more powerful medical practice.

One example is Dona Chiquinha’s cervical cancer. I was informed that when it was already considered incurable by medical doctors, Kariri-Shoco shamanic specialists were able to effectively cure-heal it. I talked with several people who were directly or indirectly involved in Dona Chiquinha cure-healing process. Dulcilene was the first one who informed me about Dona Chiquinha’s health problem when I asked her about women’s disease-illness. Dulcilene told me that a terrible disease had affected her grandmother and that she had almost died from it. When she explained that it had been cervical cancer, I asked about how she was treated by indigenous medical knowledge. Dulcilene told me that Candara was the one who decided on remedies and how to treat Dona Chiquinha. She said that it was a problem already of an advanced cancer and that by the door of Dona Chiquinha’s house could be smelled “a bad scent from her inflammation.”

I had the opportunity to interview Juarez, who is Dona Chiquinha's son.²⁸ Juarez explained that he brought Dona Chiquinha to the hospital, where the doctors tried to treat her, but when they discovered that she had a very dangerous disease, from the exam results they did not want to try any surgical procedure, because it would not be effective. He said that after Dona Chiquinha came back home from the hospital, they tried to use only treatments with "bush" remedies to treat her health problem. Juarez also told me that after Dona Chiquinha was treated, he decided to bring her to the same hospital and doctor, in order to make them take tests and confirm her recovery. He told me very proudly that after the doctor completed her "check up," he was impressed and asked him how did they treat her. Juarez told him that she was cured by their religion. Then, the doctor mentioned to him, "with admiration" that "the Indians have two Gods: One from the whites and one of their own!" This idea that the Kariri-Shoco have "two Gods" became very popular among them, since I often heard Kariri-Shoco individuals mention it, when they talked about their power to cure-heal health problems as something told by a medical doctor.

I also talked to Candara about Dona Chiquinha's health problem and recovery. He is her son-in-law. He explained that when he "prayed" ("*rezou*") on her, he discovered that she had cancer. Then he talked to Juarez and told him what they had to do. Several plants were prescribed over several months, through daily treatments of baths and drinking, which he told me that provided Dona Chiquinha's recovery.

²⁸ He lives in Karapoto indigenous reserve in Alagoas, and is the Cacique of the Karapoto. The Karapoto are affiliated to the Kariri-Shoco, and come to join Kariri-Shoco Ouricuri rituals.

Candara also said that it happened with the help of all her daughters, who took care of Dona Chiquinha's health treatments daily.

Another case, happened with a younger reproductive women who also had a case of cancer that the biomedical system diagnosed and that, according to her description, was effectively treated through indigenous medical practice. When I interviewed this woman about her experience with this gynecological health problem, she was five months pregnant. She explained that she took different exams in Arcajú city, where the doctor told her that she had “a grown womb” (“*útero crescido*”) where “flesh had been formed and it was infected” (“*uma carne cresceu e estava inflamada*”) and that she needed to undergo surgery. She told me that the doctor informed her family members, who learned that her health problem was cancer. She said they did not want to tell her about it which could make her suffer even more. She told me that the “Foundation” (FUNASA) had to cover the expenses of the surgery, but she was informed that no financial support was available for her surgery at that time. Therefore, she had to wait while her partner, who is an Indian from another indigenous area, decided to bring her for health treatment among the indigenous group where he belongs. She decided to stay there during the treatment, since there was no option for surgery soon. Thus, it was her partner who prepared the remedies. He would make it and leave on a pan in the morning and she drank it two or three times daily for seventeen days. She said that she also douched and washed her lower belly with the rest of the remedy during the treatment. When I asked her if someone prayed on her, she said that a woman from there “prayed” on her three times.

This happened in the year 2000. This woman explained that a few months ago she noticed she was missing her period. She suspected that she was “getting into menopause.” When she told this to the Sementeira health clinic medical doctor, she prescribed an exam to check if it was pregnancy. As she had a positive result from the exam, she explained to me that her pregnancy was the “confirmation” that she was “cured.”

Thus, Kariri-Shoco shamanic specialists perceive that they are able to treat by performing cure-healing rituals (such as reza and mesa rituals) and with the use of their ethnobotanical knowledge, different kinds of doenças from other medical boundaries (“white man’s disease” and those from Afro-Brazilian religious practitioners). For example, they use medicinal plants for health problems such as diarrhea, constipation, gastritis, hemorrhoids, menstrual hemorrhage, amenorrhoea, asthma, colds, sore throat, pneumonia, bronchitis, fever, stroke, and others that Mota (1987, 1997) registered, and that I have observed (and experienced treatments) during the fieldwork, when shamanic specialists perform ritual healings and prescribe treatments to patients. The Kariri-Shoco and shamanic specialists from other indigenous groups diagnose and treat several kinds of diseases-illnesses caused by spirits or evilness that non-indigenous people “catch” (“white man’s disease,” evil eye).

Still, there are health problems related to “Indian’s disease” that can only be treated by Kariri-Shoco shamanic specialists themselves, like Dona Marieta’s health problem, which intersected with biomedical knowledge. But it is within this domain of “Indian’s disease,” that there are health problems that Kariri-Shoco shamanic

specialists are not able to cure-heal. Only a shamanic specialist from other indigenous northeastern groups, who also have a shamanic Ouricuri ritual system, can treat these cases, which relate to witchcraft.

I found several examples that can illustrate how bad events or disease-illness might occur as a consequence of somebody's will. Dona Maria Velha explained that she had fallen down and seriously injured her right arm. She mentioned several times during this conversation that it was the arm that she uses to pray. Because it was not the left arm, it was still a "not dangerous thing that came" to her, "to affect" her. After I asked her if she knew who could have sent that to her, she explained that she knew who the person was. She told me that the young woman she knew that was responsible for that would receive "something back," that she would have "what she deserves." When I asked Dona Maria Velha if she was going to make a spell against that person, she told me that it would not be necessary because she knew that something would happen. Dona Maria Velha was taking care of her arm with remedies and prayers.

Dona Zezinha told me about a case of a non-indigenous woman who came to ask for help because her son was in trouble because of crime. Dona Zezinha explained that she arranged the cost with this woman for the work that she was going to do with prayers and remedies. She told me that she charges a certain amount of money depending on the client's ability to afford it. In this case, she charged an amount of money that the woman would pay monthly. As she did the work, the woman's son started to recover from the troubled situation - since his boss hired a lawyer for his case and he was already out of jail and continuing his work. The

woman stopped paying Dona Zezinha the amount she owed her, and Dona Zezinha explained that bad events continued to happen with the woman's son, and she came again to ask for Dona Zezinha's help, bringing the amount of money to pay her debt. I asked Dona Zezinha if she had done something as a punishment to the woman. She explained that she did not, that the problems that were happening again with the woman's son were a punishment that was sent by those who protect Dona Zezinha's work, because the woman did not respect the agreement. Thus I understood that a punishment is sent by spiritual beings who protect the shaman's interests and works. That is why Dona Maria Velha was so sure that the young woman would receive "something back."

This perception that shamanic specialists have is very recurrent on their idea that spiritual beings with whom they communicate also care about them and protect them by punishing whoever makes something against them. In ethnographic interviews they express this idea. For example, when I was talking to Dona Maria Velha about her communication with spiritual beings she explained:

"Behind the cure [reza ritual] the person who is curing has a body guard, who comes already from our grandparents, from our fathers. As you know we are Indians, we live with our worship, we have to have our protector behind."

During ethnographic interviews conducted with shamanic specialists, I investigated the double meaning of the term cure (*cura*) that Mota (1987) described in her thesis.²⁹ Although Pajé Júlio confirmed that the notion of cure among the Kariri-Shoco has a double meaning, which can be understood as the recovery of well-being

²⁹ I have described Mota's (1987) observations about Kariri-Shoco ideas of cure in Chapter III.

(in a sense of being healed), or when something negative is sent upon someone (as an inversed healing, as a witchcraft), I always found difficulties in getting interviewees to understand my questions and their confirmation in this inversed healing sense. After I asked about cases that I had found about women who reported their experiences with “Indian’s disease” which, according to what I found, meant they had to be cured-healed under health care from other indigenous groups’ shamanic specialists, Pajé Júlio explained:

“There are cures that we [shamans] can cure...it is for the person to get well... There are cures that we try, but we can’t. Then, instead of curing the person, you harm the person because sometimes the person has to pay for what has done, we cannot uncover that... but when it is something normal, something light, we cure and the person gets well... I mean about our part as Indians [curing-healing Indians].”

Then I asked Pajé Júlio to explain if a person could be ‘cured’ (inversed healing sense) by their religion (shamanism) and why it happens. He gave this explanation:

“This happens, the religion cures and it is very defined [clear], we are already used to it! And it depends on the person’s procedure [behavior], because if the person has goodness, it is definitive... and has to maintain, that is what cures the person... The religion [shamanism] has its own way. It has the scheme like we have to survive with [/through] it... We have this knowledge and it is a need... It is difficult to catch something bad, but if the person knows the schema and facilitates [taking risks], it means that what the person deserves is discipline. If the person disrespect a support that values the person and everybody else... and for the person is diminishing [devaluating]. Then it is not a religion from outside, it is something different. We have that knowledge, we cure and we don’t cure, do you understand? The person cannot keep, preserve that... even myself can be harmed! Do you understand?”

I felt intrigued by Pajé Júlio’s explanation of those cases about health problems provoked by shamanic specialists’ willpower. I could only understand that he meant, if someone receives something evil, it relates to a “punishment” that the

person deserves to receive, when it is an “Indian’s disease.” I insisted on asking him why those were problems that Kariri-Shoco shamanic specialists were not able to cure-heal. According to him, when the nature of the health problem is investigated, shamanic specialists do discover who is responsible for the embodied health problem. What happens is that Kariri-Shoco shamanic specialists “cannot undo what another shaman makes” (“*não pode desfazer o que o outro xamã faz*”). Thus, he said one of the procedures in those cases is to go to the shamanic specialist “who sent that punishment to that creature and ask him the forgiveness for that person.” I understood that Pajé Júlio’s perception is that when it happens that a shamanic specialist perpetrates a “punishment” towards someone, this shaman is actually provoking a “cure” for that person, who deserves it. Thus, the notion of the suffering experienced by the victim has a cure-healing sense through an inversed-healing experienced. Still, this is my point of view on this issue, which is complicated considering, for example, three cases of young women, who reported that had suffered from “Indian’s disease” as victims, according to what they said, from the evil work of powerful shamanic specialists.

I asked shamanic specialist case studies, if the meaning for the term cure was used in a similar way. Usually they explained that the person could receive something negative because she or he deserves it. Thus, I started to conclude that the notion of cure (as inversed healing), like Pajé Júlio’s explanation, has a meaning more related to a punitive sense, from which the person who receives it deserves it. Still, I realized that I had never heard the word cure in a sense of inversed healing, or in a sense that a person had been bewitched, as Mota (1987) had found out. Explanations about

something evil that can be sent to someone were never explained by the use of the word “cure.”

Most of the Kariri-Shoco people that I have interviewed do not say that witchcraft (*feitiçaria*) exists among them or that they know how to harm or to “make an evilness” (“*fazer uma maldade*”) against someone, although there are cases where shamanic specialists discover that an evilness, which can be associated with a disease-illness, was sent upon someone. Three women who told me about their “Indian’s disease” are examples.

I perceived that Kariri-Shoco people do not like to recognize that they know how to practice witchcraft because their shamanism is mainly characterized by healing purposes, from which it guarantees what Langdon (1992a) pointed out as the purpose of shamanism; the “well being of society and its individuals” (Langdon 1992a, 13). According to Langdon (1992a) shamanism “in its broadest sense... is preoccupied... with social harmony, and with growth and reproduction of the entire universe” (Langdon 1992a, 13).

Kariri-Shoco shamans very often criticize the Afro-Brazilians’ religious practices, because, according to their understandings, they are responsible for sending evil upon people who then become their patients. I realized that Kariri-Shoco shamanic specialists’ refusal to recognize their knowledge about witchcraft practices is due to their assuredness that they work with goodness. This is also a way that Kariri-Shoco people distinguish their indigenous shamanistic practices from Afro-Brazilians religious magical practices; it is a way to establish ethnic boundaries. I have already mentioned that I heard very often from Kariri-Shoco indigenous

rezador/rezadeira and curandeiro shamans about their experience with cure-healing non-indigenous peoples, who were “bewitched” (“*enfeitados*”) by the “*malfeitores*” (those who make evilness), referring to Afro-Brazilian religion practitioners.

I had the opportunity to interview Frederico about his notion of “witchcraft,” and also about the fear that some Kariri-Shoco felt for him. He explained that he knew several people who thought he was a “sorcerer,” but he said, “Witchcraft is something created in the person’s mind, invoked by a weak guardian angel of that person, because the person is weak on everything.” He added:

“In this world it is one against the other... it is worse for the weakest ones, in their lost illusion for knowledge. I am a guardian, I am an adviser, and I work for peace and harmony... I will never destroy a person.”

This can be illustrated in an ethnographic interview, conducted with Baioca when she explained about how she provides protection for her son who is traveling away:

“In my work I have to be prepared to help people, like my son who is abroad. He can ask me to prepare him wherever he is. From here he receives there. For example, maybe somebody here wants to dominate him saying things that shouldn’t say, here I feel, right? I feel that concern and say: ‘My son traveled, my God, what is happening?’ I go to my backyard; I look at the stars, the light of the Moon. Then I ask God for the help, then in the words of prayers, depending on the reaction of my body, crying, I ask for him [her son]. Then he calls, then he tells me that he is fine.”

Thus, there is an idea on evil or evilness as something that people can manipulate and send to another, against which protection can be provided or acquire. Rodrigues (1948) explains that in the Kipea language that Mamiani ([1699] 1979) registered, there is a word which means “devil” (*nhewó*) and also a word to define “witch or guessers” called “*bidzamú buré*” meaning “evil witch or guesser” (Rodrigues 1948, 195). Rodrigues (1948) supposes that there was also the expression

“*bidzamú canghi*,” which would mean “good witch or guesser” (Rodrigues 1948, 195) that was not registered by Mamiani ([1699] 1979).³⁰ Rodrigues (1948) argues that in this way there would exist, among Kipea-speaking Kariri people, the “doctor” (good healer, the one who cures the sick with blows, words, or songs) and the “witch” (evil witch or guesser) as the one who sends witchcraft to kill others (Rodrigues 1948, 195). This author considers this similar to what Tessman (1930) registered describing the Omágua and Kokama from Northeast Peru (Rodrigues 1948). Independent of the existence or not of different kinds of shamans (good and evil) among the Kariri peoples, Rodrigues’ (1948) analysis reveals evidence that existed already in pre-Colombian Kariri peoples in Northeast Brazil: the notions of evil and good was already there within their culture. Pajé Júlio’s interview is an illustration of how those ideas are still present among the Kariri-Shoco culture. I believe that they were probably reinforced and mixed with Catholic missionary ideology.

During an ethnographic interview with Pajé Júlio, when I asked him a verification question about which spirits Kariri-Shoco shamans work with, he explained that “each shaman has his own spirit which is part of only one chain [*corrente*] of spirits.” When I asked him another verification question about how those spirits interrelate, he answered me:

“The spirits do dispute among themselves because there exist the good and the evil, and the good does not get adapted to the evil. The evil always wants to dominate the good in any way.”

³⁰ I understand that Rodrigues (1948) bases his supposition on the prejudiced view of Mamiani ([1699]1979) who, as a Catholic missionary from the seventeenth century, would not consider that shamans could work with goodness.

I interpreted Pajé Júlio's explanation that "chains of spirits" are associated to the kinship status, which shamanic specialists occupy within a cognatic ritual kinship system. According to Keesing (1991), those kind of classificatory kinship systems form "discrete or relatively discrete corporate groups... and choice, flexibility, and multiple memberships are never as broad as the ideology implies" (Keesing 1991, 92). As already approached in the second section of this chapter, classificatory kinship terminology statuses (such as Mãe, Pai, Avó, Avô) are traced through descent. In this logic, shamans and their descendants may form categories or groups called clans, and if it is a case of a society "conceived as divided into two parts, determined by descent, these are called *moieties* (patri-moieties if one belongs to ones' father's side, matri-moieties if one belongs to ones' mother's side)" (Keesing 1991, 31). Considering this logic of a cognatic kinship system, which I argue exists ritually among the Kariri-Shoco, and considering Pajé Júlio's information on "chains of spirits," in which shamans "are part of only one," it is strongly possible that through those "chains of spirits," associated with ritual kinship status, clans and moieties form as experienced by the Kariri-Shoco within their shamanistic ritual kinship system.

Actually, this is the case of the Fulni-ô, an affiliated indigenous group of the Kariri-Shoco that practices Ouricuri ritual. The Fulni-ô was ethnographically described by Pinto (1956) and Bodin (1949). Pinto (1956) identified five different *sibs* that Boudin (1949) called *clans* within Fulni-ô's social organization. Pinto (1959) observed that those Fulni-ô sibs are associated with animals and plants. This is part of Fulni-ô's secrecy about their Ouricuri ritual practice that Pinto (1956) explored and

exposed. The Fulni-ô strongly reject today Pinto's (1956) book because, according to them, the book contains information about their secrets related to their Ouricuri ritual. My intention here in discussing this subject does not expose the Kariri-Shoco's secrets, but clarifies that their shamanic specialist status within a cognatic ritual kinship system is associated with their ideas of "chains of spirits" on which conceptions of "good" and "evil" are based. Also, this is evidence that they have an indigenous idea of evil, from which the shamanic work of avoiding, not letting the evil dominate the good, is intertwined with their perceptions on diseases-illnesses causations and their medical practice.

In order to understand how embodied health problems as *doenças* (or symptoms related to *doenças*) are experienced among the Kariri-Shoco, I propose to use Foster and Anderson's (1978) classification of medical regimens. Foster and Anderson (1978) make a distinction between illnesses characterized by what they define as the "personalistic system," which are those caused by actions of malevolent or punitive agents, and illnesses characterized by the "naturalistic system," which are those that the causation of the illness is based on the properties of the body itself and aspects of the cosmos, which interferes with the balance of the body (Foster and Anderson 1978, 53-54). It is based on those definitions utilized for understanding how Kariri-Shoco perceive embodied *doenças* (or symptoms related to *doença*), from which I trace them as characterized by 'personalistic' or 'naturalistic' medical regimens.

It is important to note that health problems among the Kariri-Shoco caused by evil, evil eye, witchcraft (and, I would suspect, evil spirits) can be considered as

within an intersection of the personalistic and naturalistic accommodation domains, which, according to Foster (1994), is the case of the notion of evil eye found in several Latin American contexts. Foster's (1994) observations can be confirmed in several ethnographic studies, which have focused on evil eye in Brazil (Araújo 1955; Maués 1990; Galvão 1955; and Taussig 1993). Strathern and Stewart (1999) argue, though, that in Latin America this intersection has occurred, not because of the imposition of the naturalistic medical regimen as a result of the wide spread humoral ideas (of hot/cold scheme) disseminated into the New World (according to Foster's [1994] analysis). Strathern and Stewart (1999) argue that the naturalistic view of humoral ideas was assimilated, meshing easily with indigenous concepts, because such concepts as hot/cold (wet/dry) already existed among indigenous cultures, as exemplified in the case of the Aztec who had already a culture where the hot/cold scheme of the naturalistic medical regimen as utilized before Hispanic colonization. Thus, I plan to describe shamanic specialists' perceptions of disease-illness causations, and continue to discuss and analyze where indigenous concepts and experiences characterize their concepts of *doenças*.

During an interview, when I asked Pajé Júlio about why a *doença* (disease-illness) is caught and how a person can become sick, he explained how it happens among the Kariri-Shoco people:

“Doença is a contamination the person catches. It can be a contamination from a *doença* of the white man or from those [evil] things with the permission of the religion [shamanism]. Because the person has the knowledge of his religion [shamanism], from which everything evil can be avoided, it is difficult to receive something like this [disease-illness], but the person facilitates. Sometimes it happens in a moment that the person is not covered, and then the person receives it there, which can be a *doença*. It can also be

something spiritual, because the spirits can also reach us, and I can take it out directly. And the person be cured.”

Pajé Júlio’s explanation demonstrates a perception which is very common among the Kariri-Shoco as to how health problems in general are treated using the indigenous medical practice. From their shamanism, Kariri-Shoco people conceive that they obtain all the protection they need, including protection from doenças. Thus, if somebody becomes sick, there is always a suspicion that something happened, like Pajé Júlio explained, that the person “facilitated” something. Thus a person may be “contaminated” by a doença or “something spiritual” whenever he or she, “with the permission of the religion,” as a punishment from shamanistic world, reaches someone by a doença or spirit. This perception reflects what Foster and Anderson (1978) have defined as the personalistic domain, when a punitive agent is responsible for illness causation. In Pajé Júlio’s explanation above, there is also a naturalistic perception, when he mentions that “maybe in a moment that the person [was] not covered” or “not protected,” which implies the vision that, from a determined characteristic of the body (related to a naturalistic disposition or property of the body) the person can be contaminated by a doença or spirit.

Chiquinho provided a statement that can be interpreted as containing only the personalistic medical regime perception, when he explained that it is usually easier to cure-heal non-indigenous people than indigenous people. Chiquinho, who nowadays only works with cure-healing practices within the reserve, told me:

“It is easier to cure white people because with the Indians, the Pajé knows that if somebody makes a mistake the person will be punished by the religion itself, and the Pajé knows that we have to work with that Indian to discover if he has been exemplified [punished] by the religion, by a supreme power, so

we have to work to ask for the person's redemption, for the person's forgiveness. Thus, it is different from the white."

In Chiquinho's explanation, he was only telling about the "Indian's disease" domain, when the personalistic perception is clearly defined as being "exemplified by the religion." But different kinds of *doenças* among the Kariri-Shoco are intersected with personalistic and naturalistic causations. Something evil (personalistic as punishment) that enters the person's body is usually associated with symptoms of the body's vulnerability through its 'openness' as a naturalistic causation. For example, "open arcs" is a health problem, which causes pain and provides vulnerability of the body.

From the health problems treated in cure-healing rituals, there are two major kinds of health problems perceived, experienced, and treated by Kariri-Shoco shamanic specialists on their indigenous patients. There are those that enter the body (evil, evil eye, "contamination," evil spirits, etc.), which I discuss first, and there are those which relate to something that is displaced or was displaced within the body, such as "open breast" ("*peito aberto*"), "fallen spine" ("*espinhela caída*"), "leaked gall" ("*fel derramado*"), the "owner/mistress of the body" ("*dona-do corpo*"), and others.

Thus, someone who becomes sick usually utilizes the Kariri-Shoco *reza* ritual, which is very often one of the first steps taken towards cure-healing processes, and, after that, the *mesa* ritual when it relates to dangerous spirit causation. The shamanic specialist investigates the nature of the patient's health problem, then "takes it away" or "attracts" it from the patient, closing the person's body. The *reza* rituals described in the next chapter and Pajé Júlio, Chiquinho, Kenedy, and Dona Maria Velha's

explanations about the purpose of reza rituals reveals that it investigates “what God has to do” (“*o que Deus tem a fazer*”) and “what is behind” (“*o que esta por trás*”) the patient’s embodied health problem.

Kenedy’s patient’s explanation, described next chapter, illustrates a naturalistic perception, when Geny’s “anger” (“*raiva*”), which is considered a negative emotion (naturalistic cause), may have worsened her disease-illness (evil eye). The fact that she drank a cold drink (hot/cold scheme) worsened her evil eye symptom, provoking “fever inside” and “headache.” Thus, the intersection between both medical models was perceived and experienced. The emotion of “anger,” when she was not being “covered,” provided a naturalistic imbalance and provoked openness of her body and vulnerability to “catch” or worsen a health problem, in her case, evil eye.

For the Kariri-Shoco, not to be “covered,” means a vulnerability of the body, when it is open. Thus, the emotion of anger is directly associated with her bodily imbalance (a naturalistic perception), from which she has received or worsened an evil eye (personalistic view), sent probably by her husband’s relatives. The emotion of anger is also the cause of several pregnancy losses, which will be described in Chapter VIII. The emotion of *susto* (sudden frightening) is also directly associated with causes of pregnancy loss that are often perceived as a naturalistic way of miscarriage. Thus, very often both medical models, naturalistic and personalistic, converge as intersecting causations for disease-illness symptoms and health problems.

During an ethnographic interview I asked a verification question to Dulcilene about why the rezador/rezadeira yawns during a reza ritual. She explained how

differently she experiences it, depending if it is a man or a woman that may have caused an evil eye:

“When it is a man who puts evil eye, I feel that will to yawn but it comes back. When it is a woman I feel that will and I can, I open my mouth (yawn) very much, that sometimes tears drop from my eyes. The yawn is because of the evil eye, because it is passing. Why is it evil eye? Because of the bad eye, of admiration, on the person’s work that someone admires, it is because of that eyesight. But the will to yawn depends on the evil eye, if the person doesn’t have evil eye, the rezador/rezadeira does not open the mouth [yawn], but if the person has, the rezador/rezadeira yawns and the person also yawns because feels that evil eye passing, feels that the bad eye is getting out with God’s words.”

Then Dulcilene described how recently her eight year old son “caught” an evil eye. She said she noticed that he was so quiet, without wanting to eat, sleepy, with a “*gastura*” (nausea). Dulcilene told me that she decided to pray on him: “To see if he had something,” when she discovered that he was with “such a strong evil eye,” that she “yawned so much that even tears came out from [her] eyes.” She told me that after she prayed on him, she felt “something bad inside” her, “like without strength, feeling nausea.” She described how the leaves were shrunk and the way she had yawned during the ritual, the person who put an evil eye on her son “could only be from a woman.” Dulcilene’s explanation illustrates how she embodied her son’s evil eye. During reza rituals the shamanic specialist’s body opens and that is why an embodiment of the patient’s health problem may occur in the shaman’s body.

Once, I asked Dona Maria Velha what is the most common health problem that she cures during the reza rituals she performs. She said that it is evil eye, which she considers “the weakest one” (“*o mais fraco*”):

“Evil eye happens because the child is fat and is eating well, is being breastfed with that taste and appetite, and somebody looks and say: ‘Look, what a boy!’ The person doesn’t know how to say ‘God bless!’ And says, ‘Look how he is

eating!’ Can you see? All of this is an eye. And it is not an eye that can only be put on a child. Like on a child, it also can be put on an adult, on an old man, on a young woman, on anybody can be put. But the person doesn’t know that is putting an evil eye, doesn’t know that is with a bad blood on that time, that is doing that evil, without willing to, but is doing.”

After this explanation, Dona Maria Velha mentioned that the person has “a bad blood” when he/she is jealous of someone and puts an evil eye by saying something. She describes, then, evil eye as the “worst *macumba* [witchcraft] that exists”:

“Now, if someone goes to the open market every week, and brings that big bag of groceries, and someone looks and says: “Look, will she have it next week [the big grocery bag]?” Then it is already weakening your body... You don’t know what is bothering you. It is the eye that was put on whatever was on you. Then it goes weakening, weakening your body. You go to the doctor and doctor doesn’t know what it is. Then comes back home. It is! It is the worst *macumba* that exists, it’s the big eye, on what it has, and the worst thing is the evil eye. It is the weakest, but it can kill. If it passes to the intestines of the child, it is the last one [last place]. When it is provoking [vomiting], with belly ache, but when it passes to the intestines of the child is the last one... the child dies.”

Thus, from shamanic specialists perceptions, evil eye is associated to a notion of witchcraft, to evilness, as something intentionally or unintentionally sent upon someone by alive (“alive evil eye”) people or a spirit (“dead evil eye”) which may enter someone’s body causing a health problem that can only be treated through shamanic specialists’ reza rituals.

Dona Maria Velha’s perception confirms that evil eye, evilness, and evil spirit, are health problems understandable by the intersection of the personalistic system and naturalistic perceptions of disease-illness causation. Dona Maria Velha’s explanation also shows that Strathern and Stewart’s (1999) observation on how the person who feels the emotion of envy (naturalistic causation) is the one who endangers someone

by transmitting an evil eye (witchcraft, personalistic). According to my analysis, Kariri-Shoco perceptions of the possibility of this evil transmission (or “contamination”) is possible because both parties have their bodies opened: the one who sends, who transmits evil through an emotion (vision and speech), and the one who receives, who is “not covered.” This situation, according to Strathern and Stewart (1999) in analyzing evil eye, evidences also the intersection of “morality and illness” (Strathern and Stewart 1999, 21), which I argue is based on a naturalistic way of experiencing the body.

It is in this context of intersection between both systems that Kariri-Shoco shamanic specialists are able to treat health problems caused by something evil. In this cultural context something evil may come out from someone through vision or speech (usually from the emotion of envy), or through the evil “airs” or “winds” that may enter in someone’s body (the victim of the evil eye, several ‘diseases of airs’ [*doença dos ares*]).

Thus, evil eye among the Kariri-Shoco happens because it is based on a naturalistic theory of the body (‘openness’ and ‘closedness’), as it also occurs when *doença dos ares* are caught. Considering cure-healing performances, this theory of the body allows a communication between the shamanic specialist and the patient. The shamanic specialists have the power and strength of words and sacred-secret airs (soft blows and suction). From shamanic specialists’ communication with spirits, they are the channels of the goodness of spiritual beings. The effectiveness of cure-healing rituals is realized through this shamanic power and strength from an ‘openness’ and ‘closedness’ of the body during ritual performance.

It is when the person has “bad blood” (“*sangue ruim*”) that he/she may transmit evil. But this transmission as witchcraft, which is strongly based on a personalistic view, is also strongly based on their knowledge of the body. Thus, speech and vision are dangerous bodily channels from which the ‘openness’ of the body, allows the transmission of the evil in a naturalized way, through the body of the one who is with a “bad blood” to the victim who casts the evil (which often happens when the person has the body open, and, in the case of Julie’s baby, which I describe in next chapter, newborns are still open).

Several explanations which I have recorded about how a person can “put” (“*botar*”) an evil eye on another shows that evil eye is transmitted (“put”) when a person says something, sometimes with admiration, or with envy. Thus it is through the act of speaking (when air comes out of a person’s body through the mouth) and also through a person’s eyes during the act of looking (the eyesight that comes out of the person’s body) that an evil eye is sent or put upon someone. Thus, both speech and vision are dangerous channels through which evilness can be transmitted.³¹ Often it is explained that the person does not know that has put an evil eye on someone. After Dona Marieta prayed on Julie’s newborn child, Julie recognized that, through her eyes, looking at her newborn’s eyes with admiration, she had put an evil eye on him when he had his eyes opened, but this was her assumption.

Julie, who brought her newborn child for Dona Marieta’s reza ritual, was willing to let her son receive a “cure” that is not provided through biomedical

³¹ Seeger (1981) in researching the Suyá, an indigenous Macro-Gê group from Central Brazil, observed and registered how vision and speech are dangerous and sacred senses for the Suyá.

assistance, in order to achieve the baby's health recovery and protection. In both cases (Kenedy's patient and Julie's baby), they were with evil eye, from which something evil inside their bodies could only be taken out through a reza cure-healing ritual. The personalistic medical regimen is the cause of the evil eye (Julie suspected that she was the one who sent the evil to her newborn, and Kenedy's patient suspected her husband's relatives), but in both cases diseases-illnesses such as symptoms of diarrhea (Julie's baby) and "sore throat" or "fever inside" (Kenedy's patient) characterized naturalistic perceptions of doença causation, intersected with their health problem.

The same thing happened with Dona Marieta's doença, when she was a victim of an evil spirit from the wind, and assisted by shamanic specialists cure-healing medical practices. She was diagnosed and treated for a health problem that intersects with a personalistic cause (evil spirit) which provided her loss of bodily balance (naturalistic cause) caused by something from the cosmos (wind, airs), but also related to the moment that she was not "covered" (body open). Her daughter, Tarcisia, suspected that it could have happened because of the "hot mango" (hot/cold scheme) that she ate on the morning she had a stroke.

The Kariri-Shoco understand that it is through different "kinds of winds" or "airs" that several diseases-illnesses can be caught.³² Pajé Júlio explained to me that actually it is conceived that "the air of fourteen modes" ("*ar dos catorze modos*") is a spirit that "commands all winds and airs." Pajé Júlio explained: "He [the air of

³² It is important to observe that the Kariri-Shoco consider "air" or "wind" as actually the air that we breath related to a light breeze or to a strong wind, which are perceived as dangerous because they may carry or bring evil spirits.

fourteen modes] is the chief who dominates all airs, which are all bad spirits, only bad spirits, and that is why they are so dangerous.” Those different kinds of airs related to “bad spirits” are mentioned in several reza rituals, when shamanic specialists sense that the patient’s health problem relates to those diseases-illnesses. The “air of congestion” is “the lightest one,” which causes a “startle” of a person who “can be cured quickly with a tea.” The “feared air” (“*ar temeroso*”), which is similar to the “tremble air” (“*ar de pancada*”), is “the one that may catch a person who is walking in a forest or on his[or her] path,” when the person “suddenly feels a different kind of air” and “with the fright or fear the person has to make the Cross sign to be protected.” They are both “dangerous airs.” The “bad airs” also mentioned during a reza ritual refer to “all bad spirits.” The “yellow air” is the one “who provokes typhoid fever,” while the “cold air” provokes “malaria.” The “hot air” provokes “fever or hot flushes on the body,” like the ones that “women during menopause catch,” and the “warm air” also provokes “*caloria*” (“hotness”), but it is lighter” than the “hot air.” The “air of sinusitis” causes “headaches” and it has to be carefully treated because it continues to induce bad symptoms.³³

³³ It had been several years that I had suffered from regular sinusitis crises. When I experienced one during field research, I went to a otorrinolaringologist in Recife who prescribed a strong and expensive antibiotic treatment, which I decided to take. Fifteen days after the antibiotics treatment I still had sinusitis symptoms, and decided to ask for Candara’s indigenous medical help. He made a “bottle remedy” for my health problem, which I took three times a day, and also he gave me three pieces of a certain kind of a beehive (“*cera*”), I was told “to burn one piece each night [on coal fire] during three days” along with the “bottle remedy.” The beehive smoke I had to strongly and deeply inhale through each nostril at a time. Candara explained that, after a time, “something bad” would come out from my nose, but I should not worry because it would be part of the healing process. Candara also told me that during those three days of treatment I should not have sexual intercourse, because I was going to drink Jurema which was mixed with other medicinal plants in his “bottle

The “air of epilepsy,” which provokes “epilepsy,” and “air of *parnar*,” which causes “stroke,” are considered “very dangerous airs.” Pajé Júlio explained that those “airs,” which are similar, are associated with health problems that are related to “the air of seven modes” mentioned in reza rituals.³⁴ He told me that a person who is affected by those kinds of “air has to be treated urgently before seven days with smudges³⁵ and prayers.” According to Pajé Júlio’s description “they are very dangerous and evil airs” which are identified as those that “break glasses and mirrors,” that “break matter.” Those are the ones that sometimes cause irreversible damages on the body.

Taussig (1987) registered and described his Colombian informant curandeiro’s descriptions of different kinds of *mal aires* (evil airs). According to the curandeiro’s explanations mal aires come from the forest, river, dead spirits, and from spirits of dead people who drowned in the river. Taussig (1987) also describes two ways of healing from mal aires, one with the use of words (to scare them away) and another, of a girl cured by a curandeiro’s blows of *yagé* smoke. Taussig (1987) suggests that those perceptions of mal aires causations are associated with the historical process of colonization as something evil brought through colonizers.

remedy.” Another procedure was that after I inhale the bee remedy smoke, as a “*resguardo*” (confinement), I should not talk to anyone, and had to stay in bed to rest and sleep. After Candara’s health treatment I have not experienced any sinusitis crisis yet.

³⁴ According to Ortiz (1978), within Quimbanda Afro-Brazilian religion there is a Caboclo called *Ubirajara*, who is a *Exu* (spirit related to the evil) of seven winds.

³⁵ “Smudges” are treatments made with the use of smoke of plants that is directed to patients who may inhale some of the smoke. It is also used inside houses to purify environments.

Bastien (1987) mentions mal de aires among the Kallawayaya from the Andes (Bolivia), and explains the air is “an invisible fluid substance” perceived by these people as one of the “primary body fluids” (Bastien 1987, 70). This author mentions that “breath is associated with wind [*wayra*], the cause of mal de aire, which includes muscle and nerve disorders from paralysis, such as Bell’s palsy, to muscle cramps” (Bastien 1987, 70) and “rheumatism and arthritis” (Bastien 1987, 46). Bastien (1987) also describes treatments that the Kallawayaya perform by blowing smoke on the paralysed muscle, and inhaling tobacco as a preventive procedure for respiratory diseases. Bastien’s (1987) ethnographic descriptions of the Kallawayaya’s perceptions on mal de aires as an invisible substance, which cause paralysis, rheumatism, and arthritis, is similar to the Kariri-Shoco’s experiences. As described above, the Kariri-Shoco do have a perception of “evil air” or “evil wind” as a channel from which several different kind of diseases-illnesses can be caught. Among the Kariri-Shoco, the treatments for those health problems caused by evil winds are also similar to the ones that the Kallawayaya have. The use of smudges, the smoke of medicinal plants, is part of Kariri-Shoco treatments. Bastien (1987) argues that the health problems’ perception is associated not with an imbalance of the body, but with a non-circulation of body fluids’ perception. I argue that, among the Kariri-Shoco, it relates to their conceptions of different disposition of the body, through its ‘openness’ and ‘closedness.’

It is in the field of health problems exclusively from naturalistic causation perception that the theory of the opened body is more visible. “Leaked gall” and “fallen belly” (“*ventre caido*”) are health problems that usually happen by a

movement on the body, which may happen on a newborn child when the person who holds the baby makes a movement that may cause something inside the baby's belly, for example "leaked gall" (upsurge of bile, or gall) harming unintentionally the baby and causing digestive malfunction, which is very dangerous for newborn children.

Health problems like "open arcs," "open breasts" and "failed spine," which happen more in adults, are caused by the person's own move, from which something is displaced in the thorax, whether on the back ("arcs"), on the breasts, or on the spine. These provide pain, weakness, nausea, and other symptoms associated with the body's 'openness'.

Pajé Júlio explained to me that when the person has "open breasts, they feel that something is not fixed between the breasts" and they "feel weak." In addition, he told me that "open arcs" is the same problem, but it is felt on the person's back "between the shoulders." According to Pajé Júlio, what is dangerous about this health problem is that "the person has the body opened" (on the thorax), and in this way "the person is subject to be contaminated by an evil spirit." In this kind of health problem, it is through the "opened" thorax where "an evil spirit can enter a person's body."

Thus, those health problems, which are intrinsically within the naturalistic domain, cause 'openness' of the body, and, therefore, they have to be treated by a specific reza ritual, which provides the 'closedness' for health recovery, by making something inside "go back" to the right place. This characterizes the perception, not of an imbalance in the body, but of a state of being, that I decided to define as a disposition of the body, related to a property of the body.

It is within those categories of naturalistic causation that I focus now on a displacement of something inside the female body called the “*dona do corpo*” (which can be translated as “the Mistress” or “the female owner” of the body). The *dona do corpo* is an emic female organ that provokes “*dor de mulher*” (“woman’s pain”). I consider the word “*dona*” as having double meaning senses of Mistress as in Portuguese, “*Dona*,” in a sense of a way to treat a woman who is the head of a household (like the way I was treated as “*Dona Sílvia*”), and, also, I consider the meaning of “*dona*” in the sense of the “owner,” as the female one who owns the body. In this phrase the – *dona do corpo* – can have the meaning of the female owner of the body.³⁶ It is in the next chapters where I describe how Kariri-Shoco shamanic specialists conceive and women experience the “*dona do corpo*” inside their belly as part of female ethnophysiological concepts and experiences. Here I only describe information provided by Pajé Júlio, and ethnographic data about a similar emic organ experienced by southern Brazilian woman workers.

After I asked a verification question to Pajé Júlio about health problems caused by the “*dona do corpo*,” he gave me the following explanation:

“The *dona do corpo* is *criada* [grows] inside the woman’s belly. The fetus may catch her [contract the *dona do corpo*] during pregnancy inside the mother’s belly and the [female] baby is already born with her. When this happens, it is more difficult to treat, but when another woman catches it, it is easy to cure. I know seeds that make it to be cured. It is also easy to cure because the woman only needs to put a man’s belt on her belly and ‘she’ goes back to her place.”

³⁶ The word “*dona*” is a female word according to the female gender of the one who owns something. For example, if the owner is a male, the word used is “*dono*.”

It is interesting because from Pajé Júlio's quotation, "dona do corpo" is directly identified as a female *doença*, which can be only congenital or can be contagiously gender-transmitted. I found in reproductive women's discourses their use of the same term, "dona do corpo," associated with symptoms of pain, often referred to as "dor de mulher." Thus, this term "dona do corpo" converges semantic meanings of a gendered health problem, a gendered symptom of pain, and a gendered female emic organ. I understand that Pajé Júlio answered the question by making reference to "her," considering it as a disease-illness because my ethnographic question was directed to verify how it causes health problems. Then, I asked him another verification question about how a pregnant woman transmits the "dona do corpo" to her baby, and as he continued clearly considering it as a *doença*, he explained:

"When the *dona do corpo* is caught by *nascença* [from delivery, congenitally] from the pregnant mother that passes to the daughter, when it is a woman that doesn't take care of herself, the baby [girl] is already born with that *incômodo* [incommodate, health problem], it is like an inflammation, but I have remedy to give, there is also *reza* [ritual] to take out the pain."

The "dona do corpo" as a *doença*, provokes pains and can be gendered congenitally (contracted from the mother) or can be gendered contagious (as it can be transmitted by a woman who has it). It is responsible for provoking pains in different parts of the woman's body. What characterizes this female gendered emic organ is as an "inflammation" (as Pajé Júlio mentioned). It causes pain and blood fluxes (by vomiting, through the intestine) when it is displaced. Thus, "dona do corpo," as a *doença*, can be considered as an intrinsically naturalistic gendered disease-illness.

The medical anthropologist Ceres Victoria (1997) has ethnographically described a similar female emic organ called “*a mãe do corpo*” (“the body’s mother”). She interviewed one hundred women who live in shantytowns in Porto Alegre, and seventeen who were in a public hospital of this same city in southern Brazil. This anthropologist describes how the women researched, who were urban workers, consider the “body’s mother” as “something that ‘looks after the baby before it is born,’ and ‘it looks for the baby after delivery,’ which reflects cultural notions of space occupation and correlated ideas about how people should dwell” (Victoria 1997, 171). She explains that:

For the Brazilian groups who live in a more fluid space organization, the body has a more fluid structure, allowing the possibility of organs that move from place to place or are ‘awakened’ according to the bodily situation, such as the ‘emic’ organ ‘the body’s mother’ (*mãe do corpo*). (Victoria 1997,171)

This anthropologist attributes the existence of “the body’s mother,” experienced by shantytown urban workers, to “their lived experience of space/domestic organization [which] provides the framework required for such understanding” (Victoria 1997, 171). From information about how Kariri-Shoco women experience “*dona do corpo*,” it is not exclusively experienced during labour or post-delivery. It is an intersected gendered female embodied emic organ that provides symptoms of female pains, and is conceived as a female *doença*. Thus, the context in which Kariri-Shoco women experience “space/domestic organization” may contribute to the understanding of the existence of this female emic organ, but their experiences belong to an ethnophysiological reproductive process domain intersected with a naturalistic disease-illness. I will argue that Kariri-Shoco women experience this emic organ as a matrix of a displacement reflected and produced within a

historical process of male oppression. In the following chapter I describe four reza rituals (one was for “arcas abertas” [“open arcs”]) performed on indigenous people and a mesa ritual performed on a non-indigenous woman.

CHAPTER VI

CURE-HEALING RITUAL PERFORMANCES

Shamanic (ritual) cure-healing involves experiences which, more than beliefs, are related to knowledge. Its efficacy has been considered from a perspective that symbols and meanings are expressions of communication. It is through this communication that efficacy takes place as a metaphor that expresses and alters experience and perception (Lévi-Strauss 1963), or as a subjective experience that involves healing form, assumption of the world, and genres or rhetorical devices that provide transformation of context and meaning (Geertz 1973).

Robert Desjarlais (1996, 150) points out that this “symbolist position” could not provide explanations in his research for answering the question “why a Yolmo shaman from Nepal searches for a spirit and actually finds it” (Desjarlais 1996, 150), nor for “how or why Yolmo shamans heal” (Desjarlais 1996, 150). The existential ground of the shamanic experiences Desjarlais (1996) approached through a focus on “the nature of [Yolmo] spiritlessness” is based on the importance of the understanding of “the sensory grounds of a person’s existence” and how the recovery of “lost vitality” works through ritual practices. He identified that the comprehension of Yolmo healings, during or after a “spirit-calling” ritual, reflects on bodily feelings (of being “electrified,” “heartmind renews,” “eyes brightness”). The phenomenological perspective Desjarlais (1996) uses privileges the senses and perceptions, and focuses on how people actually have a being-in-the-world bodily experience. This perspective provided theoretical tools to Desjarlais’ (1996) approach to a model of Yolmo “spirit-calling” ritual healing, in which he focuses on

embodiment related, but not restricted, to representations and symbolic aspects of ritual healing. His analyses reflect a contemporary theoretical concern with the notion of healing as performance.

Several authors have considered performance and practice, experience and embodiment in situated and contextual interactions with healing processes and rituals (Laderman and Roseman 1996). In these studies the power of performance is experienced, connected, and interpreted as embodied communication. Ritual healing is perceived as an enrichment of experience in which the success and effective role of healing is engaged with the senses and the social order (Laderman and Roseman 1996). Sickness and ritual healing are then perceived as cultural performance. This performance is related to individual experiences, as in the Warao healing through songs as described by Briggs (1996), in the Malay shamanistic “words of powers” connected with the senses analyzed by Laderman (1996), or in Roseman’s (1996) descriptions of Temiar’s narrative “songs of healing” performance in which music, dance, and social healing are linked together.

The perspective utilized in my research focuses Kariri-Shoco ritual practices through this phenomenological orientation, describing how words of power and performances relate to senses, perceptions and cultural meanings. It is through embodiment that Kariri-Shoco shamans experience and sense the patient’s health problems. It is through an embodied communication, when the senses work as an embodied shamanistic knowledge, that Kariri-Shoco shamans perform cure-healing rituals exercising the *poder* (power) and *força* to cure-heal.

Therapeutic or curing-healing processes take place within a cultural environment with implicit cultural meanings and definitions for sickness, illness or distress (Csordas and Kleinmen 1990). In the case of Kariri-Shoco shamanism, the shamans are the ones who diagnose and treat, and in few cases they are also seen as the ones who provoke or send a health problem upon someone. In this way, shamans are those who hold the power of their knowledge and practice. In the cultural dimension of medical efficacy contexts there is an apparently implicit paradox as posed by Kleinman and Sung (1979) that “to the extent that indigenous practitioners provide culturally legitimated treatment of illness, they *must* heal” (Kleinman and Sung 1979, 24). This is perhaps not a paradox but the context of the medical practice domain. The path followed for understanding Kariri-Shoco cure-healing rituals links the healer and the patient who experience an embodied communication through the senses. The effectiveness of the cure-healing rituals belongs to a cultural domain of medical practice. I consider that the interaction between the shamanic specialist and the patient through embodiment is a medical practice realized with shamanistic medical knowledge, such as Good (1994) would consider. Thus, the theoretical perspective adopted for description and therapeutic methods utilized for understanding Kariri-Shoco cure-healing practices involve embodiment through which shamanistic rituals are performed as a medical practice where the patient’s body is under control of the shamanic specialist. These cure-healing medical practices are expressed through a language enacted within experiences and meanings intertwined through the senses.

It is important to note that both Mamiani ([1699] 1942, 84), in the late seventeenth century, and Nantes ([1706] 1979) in the early eighteenth century registered,³⁷ when describing Kariri peoples, use of words, chants, and blows, which are indigenous therapeutic medical practices. Nantes ([1706] 1979) observed:

One could believe that some of them had agreement with the Devil, because they did not use, as remedy, for all maladies, other than the tobacco smoke and certain prayers, singing chants savage as themselves, without pronouncing any word.³⁸ (Nantes [1706] 1979, 4).

Those therapeutic methods continue to be utilized as medical practices by contemporary Kariri-Shoco shamanic specialists when performing cure-healing rituals. Mamiani ([1699] 1942) mentions that those earlier Kariri used “to cure the sick with blows, to cure with words, or with songs” (Mamiani [1699] 1942, 84). I consider these indigenous therapeutic methods and the historical continuity of their use evidence of the important status of language, words, and “*ares*” (airs) for indigenous people. The use of words, chants and blows for cure-healing shows the importance and power of what comes out of the shamanic specialists’ mouth through words (prayers, songs) and airs (blows, suction and blows). The three reza rituals described below illustrate those therapeutic methods utilized by Kariri-Shoco shamanic specialists.

³⁷ Mamiani ([1699] 1942) registered the Kipea language of Kariri people located in Northeast Bahia state, while Nantes ([1709] 1979) described Kariri people who used to speak the Dzubukua language, located in a missionary settlement by São Francisco River in the North of Bahia state (Rodrigues 1948).

³⁸ My translation, *Podia-se acreditar que alguns deles tinham entendimento com o Diabo, pois não usavam, como remédio, para todos os males, senão a fumaça do tabaco e certas rezas, cantando toadas tão selvagens quanto eles, sem pronunciar qualquer palavra.* Nantes ([1706] 1979, 4).

Cure-healing rituals performed by Dona Marieta, Candara, Kenedy, Ducilene, and Dona Maria Velha were observed and video-recorded at their homes. The scenes recorded were obtained sporadically and opportunistically when people very often came to request their indigenous medical practice. Thirty-eight cure-healing ritual performances were digital video-recorded during field research. From the beginning, I was amazed by how often those shamanic specialists are busy with those who seek their help, particularly Candara, Dona Marieta and Dona Maria Velha, who were the ones I watched closely performing those rituals. Indigenous and non-indigenous people requested them very often for reza rituals. Non-indigenous people come from the country, from other larger cities (from Sergipe, Bahia, and Alagoas states), or from Porto Real do Colegio town. Most of these non-indigenous people are poor, but many cases of middle-or upper-middle class people were registered, who also use indigenous medical practice. Examples of these last cases were the wife of the Judge from Porto Real do Colegio Ministry of Justice Court and a medical doctor who came for Dona Maria Velha's medical practice. This shows how, in this cultural context, indigenous medical knowledge occupies a status of effective medical practice, particularly for health problems related to evil eyes or evil spirits. Because I focus on indigenous cure-healing ritual performances practiced by shamanic specialists among the Kariri-Shoco themselves, the selection of rituals for description and analysis were those only concerning indigenous people. The exception is the mesa ritual, which is only allowed to be watched by non-indigenous when performed on a non-indigenous individual.

In the beginning I was shy to record film images, but as I continued to watch these events, and with the shamanic specialist's and patient's consent, I started to video-record them. The experience of frequently video recording, each time I watched reza rituals with the same shamanic specialists, provided a naturalization of my use of the camcorder for shamanic specialists whom I selected as case studies. The use of the camcorder actually turned out to be a tool with which those rezador/rezadeira and curandeiro shamans became very familiar and comfortable.

The purpose of these three different rituals which I have observed, such as “reza,” “reza para arcas abertas” (“reza for open arcs”) ³⁹ and mesa, is to cure-heal the patient by closing the person's body. The idea that the body can be “opened body” (“*corpo aberto*”) or “closed body” (“*corpo fechado*”) is central to cure-healing practices since it expresses implicit dispositions of the body. When I describe how these rituals are performed, I illustrate which sicknesses are treated through them. In the next section, I focus and analyze diseases-illnesses as they are experienced. It is in the next chapter, about female embodiment, where I discuss the shamans' explanations of how embodied gendered aspects of the shamans' experiences relate to this knowledge of the body, where the ‘closedness’ or ‘openness’ of their bodies is fundamental for their ability to perform rituals of cure-healings.

It is important to note that although those ritual performances are part of contemporary Kariri-Shoco cure-healing medical practices, they also appear throughout Brazil, where rezadores/rezadeiras or curandeiros perform those kinds of rituals (reza and reza para arcas abertas and mesa rituals). Those practices have been

³⁹ Reza ritual for “open arcs” is usually associated to other health problems such as “failed spine” (“*espinhela caída*”) or “open breast” (“*peito aberto*”).

registered since the seventeenth century, and authors associate them with magical practices (Priori 1994) or of popular medicine (Souza 2002), which are widespread throughout Brazil.

For example, Souza (1986) mentions that in the eighteenth century a rezador named José Januário da Silva, used to start the reza for evil eye saying the person's name and "...with two was given, with three it is taken, in the name of God and of Virgin Mary"⁴⁰ (Souza 1986, 179). This is a beginning similar to that of the reza ritual performed by Kariri-Shoco shamanic specialists, when a similar sentence is used for starting the ritual, such as "with two was put in you, with three I take from you" referring to evil eye. Thus, the notions and rituals of evil eye (and other health problems) remain present for at least three centuries in the Northeast Brazil cultural context. The contents of Kariri-Shoco rezas are different, particularly concerning spiritual beings mentioned in prayers, who often belong to the cosmos. Even when Catholic saints are mentioned, they are considered indigenous. Also, while non-indigenous Catholics consider and experience those reza rituals as a blessing, Kariri-Shoco patients experience those rituals within their particular way of embodiment, which is associated with their theory of the body.

Freyre (1986), based on wide ethnographic information about the formation of the family under the patriarchal economy in Brazil describes as indigenous cultural influence several procedures to protect children from "evil spirits... evil eye and other malign influences" (Freyre 1986, 143). As I will discuss in the next section, there is

⁴⁰ My translation, ...*com dois to deram, com três to tirem. Em nome de Deus e da Virgem Maria.* Souza (1987, 179).

strong evidence to consider that indigenous Kariri peoples had already the notion and experiences with evil eye before the colonization process.

My objective here is to describe how Kariri-Shoco ritual cure-healing performances are medical practices when the use of traditional therapeutic methods of words, blows and chants, which Mamiani ([1699] 1942) and Nantes ([1706] 1979) described, are still part of indigenous medical practices in rituals. This is illustrated with “reza,” “reza para arcas abertas” and “mesa” ritual descriptions. My focus is on embodiment and also on how cure-healing rituals are experienced through indigenous therapeutic methods, which are still being used as indigenous medical practice by the Kariri-Shoco.

6.1. Reza Ritual Performances

The most common ritual that I observed is the one referred to as *reza* or *cura* (cure), which is performed by the *rezadeira/rezador* and *curandeiro* shamans when they pray on the whole patient’s body in order to discover if the cause of the suffering relates to something evil. This evil often relates to a diagnosis of evil eye that was put on the patient’s body. Depending on what the shaman finds in the patient’s body about “what is behind” (“*o que esta por trás*”) the patient’s *doença* (“disease”), the patient can be cure-healed. During the *reza* ritual the shamanic specialist uses three or five leaves, mostly of a plant called “*pinhão-roxo*.”

Plants used during a *reza* ritual give spiritual protection by absorbing something evil from the patient’s body. Medicinal plants like *vassorinha*, *mastruz* and others may be used. The shamanic specialist may use leaves of different plants jointly to perform the *reza* ritual. This may vary according to the shamanic specialist’s

preference. The rezadeira or rezador shaman collects the plant leaves directly from a shrub in their back or front yard before the ritual. It is also through the leaves that the shaman confirms if the patient has an evil eye (when the leaves shrink) and discovers if the evil eye was put in the patient by a male or female person (depending on the leaves disposition after the reza ritual is performed). This provides also a visual sensory confirmation of diagnosis and cure, when both shaman and patient visualize the effectiveness of the treatment through the ritual performance.

Dona Marieta, Candara, Kenedy and Ducilene utilized the method of trembling the hand that holds the leaves (usually pinhão-roxo), making a shaking movement to four different directions (up, down, left, right) and also circular hand movements with the leaves in the direction of the patient's head or breast. I concluded that they have the same style of performing reza rituals because they conduct them in a similar way. Dona Maria Velha has a different method. She usually stands in front of the patient (while the others sit in front of the patient) and she uses plants, such as vassourinha or mastruz, making circular movements with the leaves. She passes the leaves on the head, arms, and legs of the patient's body as she is expelling or attracting something out of patient's body.

Usually during this ritual the patient sits in front of the rezador/rezadeira shaman in an open space outside the shaman's house. When this ritual is performed inside a house, the patient sits close to an open front or back door of the house. It is considered dangerous for somebody to stand in the doorway when a patient is under a reza because something evil that leaves the patient's body can "catch" (*"pegar"*)

somebody on the way, where a “*corrente de ar*” (“air chain”)⁴¹ forms a breeze through the door. This relates to the fact that “contamination” (“*contaminação*”) can happen through the wind, which is a common way a person can “catch a disease” (“*pegar uma doença*”).

One of the first steps that the rezador/rezadeira shaman takes is to ask the patient’s name, which will be mentioned several times throughout the reza ritual. The shamanic specialist also asks about the symptoms that the patient is feeling, or what caused the patient to seek the shaman’s assistance. Depending on the symptoms that the patient describes, the shamanic specialist will “make a cure” (“*fazer uma cura*”) according to those symptoms, as well as from what the rezador/rezadeira shaman senses during the ritual. Thus, the reza ritual can vary in content. The shamanic specialist “makes a cure,” performing the ritual on the whole patient’s body where something “evil” may be located and that “walks” inside the patient’s body, which is often called “evil eyes.”⁴²

When the shamanic specialist mentions spiritual beings, they are ones whom he or she contacts or worships. As I have not researched the religious aspects of the reza ritual, I do not consider the saints, divine and spiritual beings contained in the ritual. I understand that Kariri-Shoco rezador/rezadeira shamans deal with different spiritual beings when they mention entities from Catholicism (the Holy Trinity, saints) or from the cosmological domain during reza rituals. Those approaches are part of the way the

⁴¹ The word *corrente* (chain) is also used to refer to spiritual beings who are associated through chains.

⁴² There are among the Kariri-Shoco many cover terms which refer to the evil domain, as I describe them during rituals.

Kariri-Shoco deal with the spiritual world and spiritual beings evoked during the ritual, who provide the poder and força to cure-heal.

The reza ritual is performed through several different spoken prayers jointly, which are each repeated several times. Different parts of the body from the head to the feet are mentioned during the reza, including abstract body parts like “memory.” As a way to “attract” the evil from the patient’s body, the shaman refers to health problems that the evil may cause, which are mentioned when the shaman asks spiritual beings to protect the patient (saying the patient’s name). Those rituals are very rich evidence of Kariri-Shoco concepts of health problems, and what provokes them.

It is during reza ritual performance for evil eye that shamanic specialists mention the patient’s body (searching for and taking out the patient’s sickness), they sense what is causing the patient’s suffering within their own body, and obtain confirmation of whether the patient has been a victim of an evil eye or of an evil spirit, causing the health problem. From my observations, the reza ritual is a way that the patient receives from spiritual beings cure-healing. It is through the rezador or rezadeira shaman that powerful words of the prayers and airs (soft blows) are a channel for cure-healing. They conduct a cure-healing ritual making a journey through the patient’s body, “attracting” and extracting “evilness” (“*maldade*”). It is through shamanic specialists’ own bodies that they sense “evilness.” Through their interaction with spiritual beings they experience a light trance and receive the power to cure-heal.

During an interview with Dona Maria Velha, when I asked a descriptive question about the communication with spiritual beings during the reza ritual, she explained:

“Behind the cure [reza ritual] the person who is curing has a body guard, who comes already from our grandparents, from our parents. As you know we are Indians, we live with our worship, we have to have our protector behind.”

Dona Maria Velha explained how she feels during the ritual, when she describes how the words of the prayers work against the evil. If it is the case of an evil spirit, she embodies it, feeling it on her own body. She told me how the rezador/rezadeira experiences being under the vision (“eye”) of the evil spirit who is “feeling” (“*sentindo*”) the effect of those words in the patient’s health problem. I transcribe this ethnographic interview where she describes her experiences:

“[I asked:] D. Maria Velha, when you ‘pray’ [during a ritual], what do you feel?”

“[D. Ma. Velha:] Look, when I pray, if that person is sick by a spirit, do you know? Then, when it [the spirit] sees that the [words of] prayers are strong! That spirit can be in trouble. He is feeling.”

“[I:] Do you feel it?”

“[D. Ma. Velha:] I feel.”

“[I:] What do you feel?”

“[D. Ma. Velha:] On my left side.”

“[I:] On your breast?”

“[D. Ma. Velha:] On my arm. Then I feel that chill, you know? Feel that person like it is there.”

“[I:] Is it like it is coming to you?”

“[D. Ma. Velha:] It is!”

“[I:] Can this happen when you pray on a child, on an adult?”

“[D. Ma. Velha:] Yes, it can, because I am making a cure on that person who comes.

Then through that disease there is something behind, do you understand? Then, who is behind it, it is nothing good. Then he [the spirit] is thinking that those God’s words are bad on that creature [the patient] because [the words] are taking him [the spirit] out. Then he is with the eye on the one who is curing. When it goes, I feel

strong chill. I feel chills from what is bad, not from what is good. What is good does not give chill to anyone. Then, if it is something that is not, if it is something that was given by God, that crises [health problem] we're going to make the cure.”

Dona Maria Velha continues, explaining that there are different kinds of “cures” (“*curas*”) that she makes for different parts of the body for different health problems. She explains that the “cure” for the evil eye is the one that is done on the patient’s “whole” body. She also explains that sometimes one “reza [ritual] enters” on another one, because of different health problems she finds on the patient. The contents of the reza rituals follow the symptoms described by the patient and also what the shamanic specialist finds out. Thus, she explained:

“When a person becomes sick, if it is something that is not from spirit, it is only sickness. If it is evil wind, from a road, then we ‘pull the cure’ [*puxamos a cura*’ performing the ritual] in a way. If it is rheumatic pain, it is another [‘cure’]; ‘*entruzidada*’⁴³ caused, it is another.”

Health problems such as rheumatic pain, chronic rheumatism (*entruzidada* caused) and those diseases-illnesses provoked by “evil winds,” are also treated through reza rituals. During this ethnographic interview, Dona Maria Velha also mentioned that when the patient has symptoms such as “headache and pointed pain,” she prays on the patient’s head. If the symptom is “open arc or fallen spine,” she prays on the patient’s thorax. Those are health problems and symptoms that she treats through different reza rituals, when “each cure is one cure, and sometimes one [reza] gets inside another one.” Then she explained that the reza for evil eye, “it is on the *ramo* [bunch of leaves], on the whole body.”

⁴³ “*Entruzidada* caused” is considered chronic rheumatism, and it is usually considered a “family” health problem, when other members of the same family also have it.

As an illustration of the reza for evil eye, I selected the one Kenedy performed on a young Kariri-Shoco woman, who complained about “pains,” “fever inside [herself]” and “sore throat.” Kenedy asked for her name and said that he would use it during the ritual. He started silently, bending his head down, and with his eyes closed for about twenty seconds before he began trembling his hand (holding three pinhão-roxo leaves) towards the patient. They sat outside in front of the house, and Kenedy’s daughter was sitting on his lap during the whole ritual. The ritual lasted approximately twenty minutes.

When Kenedy started talking, he evoked “strengths” (“*forças*”), “graces” (“*graças*”), and “powers” (“*poderes*”) from the “Holy Trinity” (“Father,” “Son,” “Spirit Saint”) and from saints (which are considered indigenous by the Kariri-Shoco) that he worships. Kenedy continued trembling the leaves towards the patient. After he prayed spiritual beings for the patient’s “cure” (“*cura*”) “protection” (“*proteção*”) and “resistance” (“*resistência*”) in order “to cure” (“*curar*”) the patient, he mentioned different causes of evil eyes associated with “alive evil eyes” (“*olhos maus vivos*”)⁴⁴ and “dead evil eyes” (“*olhos maus mortos*”)⁴⁵ when he mentions:

“...To cure Geny,
From evil eye,⁴⁶
From *quebranto*,⁴⁷
From thick eyes,⁴⁸
From jealousy and from usury,

⁴⁴ “Alive evil eyes” is evil eye caused by alive people.

⁴⁵ “Dead evil eyes” is evil eye caused by spirits of dead people, for Kariri-Shoco, only spirits from dead indigenous people may harm them.

⁴⁶ “Evil eye” is something evil that is sent towards somebody through the eyesight and through speech. It is usually conceived that it is unintentional.

⁴⁷ “*Quebranto*” is a symptom of evil eye that makes the person become without strength, and *quebranto* is also a cover term for evil eye.

⁴⁸ “Thick eyes” are those from someone who envies another.

From bad friends,
 From left services⁴⁹,
 From *magic, simpatia*,⁵⁰

The following part varies according to what symptoms the patient describes to the shamanic specialist and to what the shaman discovers in the patient. Kenedy mentions different kind of pains and health problems, which can be located in different organs or parts of the body:

“...From headache, sharp pain, rheumatic pain, pain in the flesh, pain in the bones, pain in the nerves,⁵¹ pain in the *tutano*, [marrow]⁵²
 ...I beseech Thee to cure the liver, kidney, worms, indigestion, constipation, open breast, *barso*, stomach, heart, aorta vein and the lungs.
 All pains which are caused from *sereno* [dusk], cold, *restia* [shade], and
 Pains that walk⁵³,
 Pains that persecute,⁵⁴
 Infernal pains,⁵⁵
 Pains from swelling,⁵⁶ sharp pains,⁵⁷”

The following part is spoken in all reza rituals, including the ones Silva (2002) described, when the “sea” or “sacred sea” is the place where the rezador/rezadeira

⁴⁹ “Left services” means everything which is related to the “demon” and evil through witchcraft actions of someone.

⁵⁰ “*Simpatia*” means a practice or the result of a light, not strong, witchcraft or magic practice.

⁵¹ “Pain in the nerves” refers to how a person becomes nervous, worried, not able to rest.

⁵² “Pain in the *tutano*” refers to a “dangerous disease that affect the bones, when the fat (“*tutato*”) which is inside the bone dries and the person may become paraplegic.”

⁵³ “Pains that walk” are those pains which “run a person’s body through the blood” and cause pain. It is usually understood that they are caused by infection that the blood carries all over the body and causes pains in different parts inside the body.

⁵⁴ “Pains that persecute” are all those pains caused by “contamination from all [those] evil airs,” “all air which is dominated by the fourteen modes of airs,” “with spirits from any kind of disease caused by the airs that provoke disease.”

⁵⁵ “Infernal pain” is a very strong and dangerous pain so that, if it is not cured, the person may die.

⁵⁶ “Pain from swelling” is when somebody hits or is hit by accident and a specific part of the body is swollen.

⁵⁷ “Sharp pain” is a pain described as “thin,” “pointed,” that “comes eventually strong and sharp and goes away.”

shaman sends all evil or evilness, which are associated with health problems. Pajé Júlio explained that “nothing contaminates the sea,” and at the same time “the sea can hold everything,” including evil. When Kenedy starts speaking the following prayer, he makes different movements with his hand holding the leaves. He directs the leaves towards the patient with movements from the patient’s left and right shoulder to her breast and then he makes a circular movement when he mentions, “Lock us up” (“Nos trancai”).

This expression, “lock us up,” according to domain analysis, relates to the purpose of the ritual which is to close the patient’s body. It also reveals, since he is saying, “us,” that both patient and shaman experience an ‘openness’ and ‘closedness’ of the body during the ritual. Thus, during the reza ritual the shamanic specialist experiences an ‘openness’ of his/her own body during the cure-healing when words come out from his/her mouth and enters into the patient’s body for cure-healing purposes. This is the difference in how reza rituals are experienced by the Kariri-Shoco and non-indigenous Catholics, when the experience of these latter ones relate to the “blessing” they receive from prayers that the rezador/rezadeira shaman uses during the ritual.⁵⁸

In the following part Kenedy speaks prayers also used in all reza rituals, when it refers to Virgin Mary’s experiences (of conceiving Jesus and suffering with his

⁵⁸ It was on Dona Maria Velha’s explanation that I base this observation, when she spontaneously told me in an ethnographic interview: “You know how those Catholic white people think that the reza [ritual] is a blessing for them!” I realized that this notion of “blessing” was also my own perception in the beginning of the field research. Thus, it was from Dona Maria Velha’s commentary that I began to be more reflexive with my preobjective way of perceiving words of prayers and reza rituals. I started to observe and to understand how this ritual is experienced by the Kariri-Shoco within their own experiences and concepts of the body.

death) used as metaphor through the following expressions: “three trembles” (“*três abalos*”) and “three tightens” (“*três arroxos*”). Those words “trembles” and “tightens” are associated with the impact of the words towards the patient (which are “trembles”) that provide ‘closedness’ as “tightens.” Pajé Júlio, during an ethnographic interview, when I asked him verification questions about the reza rituals, he explained that those words refer to what the person has received during the reza, according to “everything that has been re-jointed [closed], which was not controlled, and [that] through the reza [ritual] the person becomes recovered and protected [closed] from anything evil.”

Kenedy proceeds to focusing on the evil eye as a possible cause for the patient’s health problem. He mentions again different parts of the body where an evil eye may have been put on the patient from hair to legs, and also mentions the possibility of evil eye on her relationships with relatives and neighbors, and on the patient’s belongings. From this moment of the reza ritual, Kenedy started to pray Catholic prayers, like the Our Father and Hail Mary, and he prayed the Act of Faith twice. The reza ritual continued with Kenedy asking to ward off evilness. This part is particularly interesting because he repeated passages where the patient’s “head,” “body,” and “blood” were mentioned. He also asked again for “grace,” “strength,” and “power.”

In the following part of the reza ritual, Kenedy mentioned several different kinds of “airs,” which cause diseases or health problems and that are very dangerous, asking spiritual beings to cure the patient from those symptoms and diseases-illnesses:

... all bad airs that exist, and all evil,
 I come to beseech Thee to cure from stroke,⁵⁹ the cold air,⁶⁰ the warm air,⁶¹
 from the *gota serena*,⁶² from the air of tremble,⁶³ from the yellow air,⁶⁴ from
 air of sinusitis,⁶⁵ from air of epilepsy,⁶⁶ and the air of fourteen modes.⁶⁷

It was at this moment that both Kenedy and his patient opened their mouths and yawned. It diagnoses an evil eye when both patient and rezador/rezadeira eventually yawn. The yawning also relates to “airs” that come out of the body, when something evil from the patient’s body comes out. Thus, both Kenedy and his patient experience embodiment through the bond between him and his patient during the ritual. He absorbs the patient’s evil eye, and expels it through his own yawning.

After he speaks to the patient about “divine forces,” which are from the cosmos and spiritual beings, Kenedy again makes similar movements to those he had done before, when he was holding the leaves towards the patient making an “X” from each shoulder down to the patient’s breast. This “X” sign, like also the cross sign, express the closedness that is being performed on the patient’s body during the ritual. Then he passes the leaves from up to down on each arm and, after this, he gives a strong shake down holding the leaves away from the patient (as he is putting something out of the leaves after he passes them on the patient’s arms). Then, he

⁵⁹ “Stroke” is considered one of the diseases that are caught through the air.

⁶⁰ “Cold air” is the air which provokes malaria.

⁶¹ “Warm air” is lighter than the “hot air,” which provokes hot flushes inside the body.

⁶² “*Gota serena*” is considered something evil.

⁶³ “Air of the tremble” is the same as “frighten airs,” which is a different wind that the person can receive while walking and that causes a disease-illness.

⁶⁴ “Yellow air” is the air that provokes yellow fever.

⁶⁵ “Air of sinusitis” provokes sinusitis.

⁶⁶ “Air of epilepsy” provokes convulsions and epilepsy.

⁶⁷ “Air of fourteen modes” is explained as the spirit who “dominates” all evil airs, which are the ones that provoke different kinds of diseases.

makes the cross sign on the patient's forehead as he finishes the reza ritual after making references to several spiritual beings.

After the ritual, I asked a descriptive question about the reza ritual and Kenedy explained:

“The reza is always the same. In one part we don't reveal it totally. It depends on the problem, but it also depends on the strength of the cure that I pray, because when I pray I have to have that part more in silence, which is the part that strengthens the reza more, which is the part of the secret [he was explaining smiling] and without considering also the mind, what, what...”

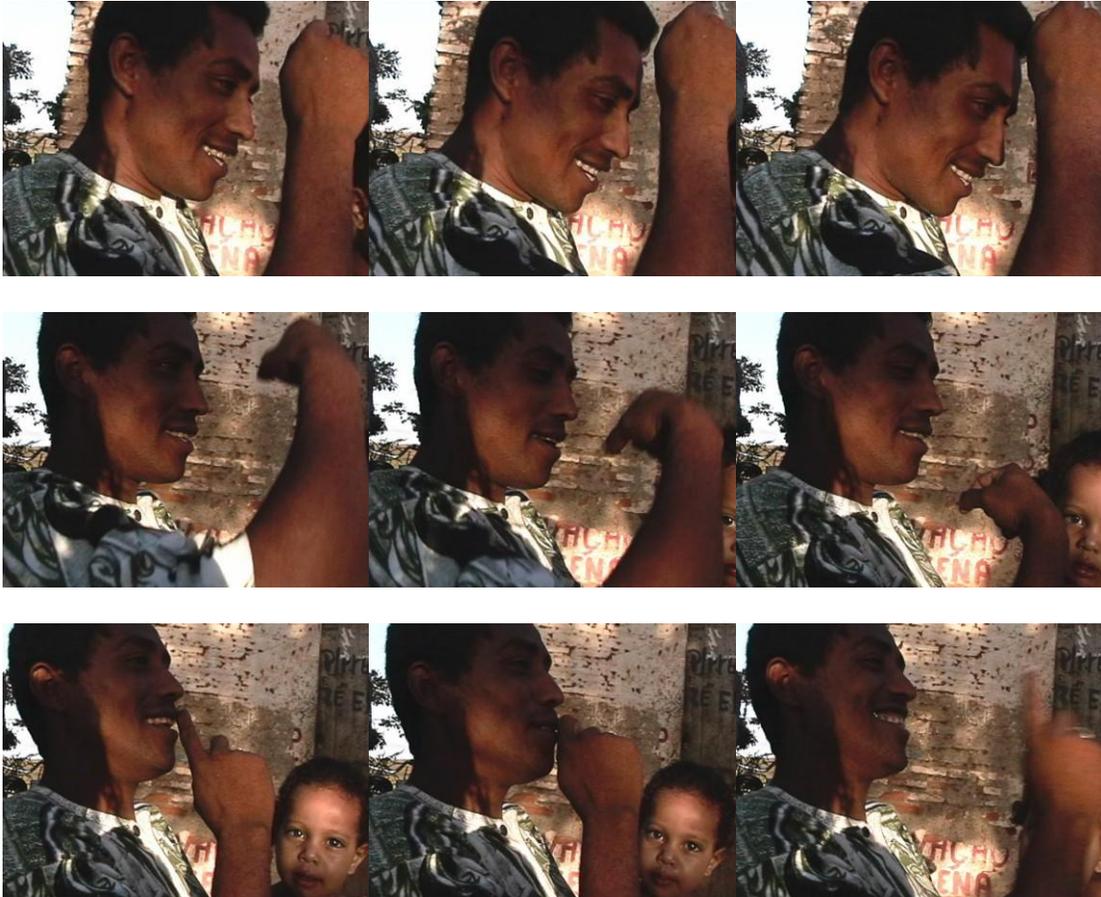
At this moment, Kenedy made a gesture with his hand over his bent head, as if showing that something which comes from above to inside his head, and continued explaining:

“What is written from the heart to the mind, and that doesn't come out of the mouth [because it is 'part of the secret', which is silently]

While he was giving me this explanation, Kenedy pointed with his finger from his heart to his head and directed it pointing out of his mouth, with a big and beautiful smile on his face, and said, “It is like this.” I selected digital stills from this part of the video footage to show how Kenedy's gesture entails a visual explanation. I consider that the 'ethnographicness' of Kenedy's visual explanation through his gestures illustrates how during cure-healing rituals Kariri-Shoco shamanistic knowledge is experienced entailing embodiment. Kenedy tried to explain his experience of the moment of silence. The moment of silence is experienced with airs that do not come out of the mouth through spoken words that can be listened. I understand that the silence relates to his communication and interaction with spirits for cure-healing

purposes, which is intrinsically characterized as indigenous therapeutics of cure-healing, involving soft blows silently whispered.

Digital Stills 1: Kennedy Explaining about the Moment of Silence



These digital stills (ethnographic photos) above contain the images from his gesture showing that something from above comes inside him. He moves his right hand (the one where he holds the leaves during the reza) over his head, he points down to his heart and directs it to his head and out from his mouth. I understand that his explanation through his gestures was an amazing way that he described and expressed his shamanic experience of cure-healing. I use those digital stills from this scene to show ‘ethnographicness’ illustrated through gestures. He expresses the

embodied experience of indigenous cure-healing therapeutic medical practice, when air comes out from his mouth silently as he softly blows.

From Kenedy's explanation, and from several other video footages recorded of reza ritual performances, I observed how the reza ritual involves communication between the shamanic specialist and spiritual beings. This communication is characteristic of the way Kariri-Shoco shamans interact with spiritual beings. It demonstrates how Kariri-Shoco rezador/rezadeira shamans experience embodiment through a light trance in communication with spiritual beings. Kenedy's shamanic experience, which involves "concentration" during the ritual, and particularly in the moment of silence, is realized from something that comes from above his head. Pajé Júlio confirmed this information about the moment of silence, which I mention after describing a reza ritual performed by Dona Marieta. Before I describe Dona Marieta's ritual performance, I add more information video recorded during an ethnographic interview with Kenedy's patient after he performed the reza ritual described above.

I asked Kenedy's patient why she came for a reza. She answered that she was having family problems, she was sick and, through Kenedy's help, she "has felt a lot better." I asked if she had taken any remedy and she answered, "Yes." Kenedy's patient told me that she had taken a "[bush] remedy" that Kennedy gave her. She explained that for what she was feeling, "No 'remedy of pharmacy' [medical prescription] was providing any effect." Then, I asked if she went to the medical doctor from the Sementeira health clinic. She told me that she went there, but the exam she had taken for the stomach was lost, and she never received the result. Then

she described how she felt “a strong anger” and that an “iced” drink she drank had worsened her health problem.

I had already heard that for a dangerous health problem, it is good that the patient goes under three different reza rituals. I found this moment a good opportunity to ask a verification question to Kenedy about this, and he explained:

“Three different rezador/rezadeira [shamans] is good, without any one of them knowing that another had already prayed [performed the ritual]. Because I think that [three reza rituals] attract the disease in a way that the person who is affected won’t be reached anymore.”

Kenedy’s explanation proves how the reza ritual performance is a moment when the shamanic specialist “attracts” the patient’s disease-illness away from the patient. Kenedy explained how during this ritual, the shamanic specialist embodies the patient’s health problem by “attracting” it. Dona Maria Velha explained once that she is very sensitive and feels “tired” (“*cansada*”) or “weaker” (“*mais fraca*”) after reza rituals. Dona Marieta, as I will describe ahead, usually after she performed this ritual would rest on her bed, although she mentioned that she always became “stronger” (“*mais forte*”) after reza rituals.

I recorded several video footages when Dona Marieta conducted reza rituals on infants. I selected one of those video footages which show how a newborn child’s mother recognized that she was the one who put an evil eye on her nine day-old baby. She was one of my case studies whom I code-named Julie. She brought her newborn child, very concerned about her son’s health. She explained that he had “diarrhea” and his feces were “starting to become green.” Evil eye is considered dangerous for newborns particularly because it “can pass to the intestines,” when it becomes life threatening (it is said that “there is no cure”). Shamanic specialists explain that the

reza ritual is performed on the “whole body” because “something evil walks inside the body” of the person affected. When Julie arrived, she explained to Dona Marieta about her newborn child’s diarrhea.

Julie laid her baby on her lap after she sat down in front of Dona Marieta. During most of the ritual performance the newborn child remained asleep. Dona Marieta held three pinhão-roxo leaves, and started the reza ritual. The way Dona Marieta performs the reza ritual demonstrates how powerful a shamanic specialist she is because she does not use expressions that Kenedy did such as “beseech Thee” to spiritual beings. She begins the ritual saying that with “the grace” and “the power” of spiritual beings, she “asks” for the patient’s “good cure,” “good memory,” and “health” for “Manoel.”

Dona Marieta laughed because she named the little patient “Manoel” and Julie also smiled. Then Dona Marieta continued the reza ritual mentioning several parts of the patient’s body and also possible relatives who could have “put” an evil eye on him. There was a moment when Dona Marieta saw the shadow of somebody by the door and said: “Get out of the door!” She was concerned that something evil coming out from her little patient could catch a person by the door. It was at this moment that Julie yawned and put her hand over her mouth. Dona Marieta proceeded with the reza ritual making a circular movement with her hand that held the leaves and threw the hand away from the newborn after she mentioned the word “*quebranto*.” Dona Marieta continued the ritual using Catholic prayers, like “Our Father” and “Hail Mary.” Julie continues to yawn eventually, which is a sign, as Dona Marieta told me

after the ritual, that an evil eye had been put on the patient.⁶⁸ She proceeded and repeated three times the following prayer's verse, where three different health problems related to the digestive system ("fallen belly,"⁶⁹ "leaked gall,"⁷⁰ and "turned intestine"⁷¹) were mentioned, and she "scared [them] away" through "forces" from three different kinds of liquids like "water" (from a "saint" river), and female bodily liquids such as "milk" and "blood" from spiritual beings.⁷² This verse was then repeated twice, with a slight change: instead of "scare away," Dona Marieta told the three digestive health problems to "search" their place. This is particularly related to how those health problems are considered a displacement of something inside the patient's body. In this next part Dona Marieta asked a spiritual being to "show" "health" and "memory" for her, the patient's "belly." The newborn yawned when she mentioned the word "defense."

The following part of the reza is very similar to the one from the beginning of the ritual, where possible places of the patient's body could have been affected by the evil eye, and also possible relatives who could have put it on the patient are mentioned. In the end of this part of the ritual, Dona Marieta spoke silently, just

⁶⁸ This is particularly interesting because it reveals how the embodied bond between mother and infant is experienced, when through the mother's yawning the evil eye comes out of the newborn.

⁶⁹ 'Fallen belly' [*ventre caído*] is a health problem that usually happens to a baby. It is caused when somebody who holds the baby suddenly changes the baby's position. This move may cause something in the baby's belly, which harms the baby and causes digestive malfunction.

⁷⁰ Leaked gall [*fel derramado*] is considered to occur when gall is leaked inside the body," which causes pain and vomiting. It is mentioned that it usually happens with a baby.

⁷¹ 'Turned intestine' [*intestino virado*] is when the person has constipation and may vomit, feel nausea, and have indigestion.

⁷² Male shamanic specialists do not mention when they perform reza rituals those female bodily fluids (blood, milk).

moving her mouth. Then different parts of the body, qualities of the newborn (“beauty,” “expertise,” “knowledge”), and the emotion of “well loving,” that an evil eye may have affected in the newborn are mentioned:

“...If evil eye was put on your hair, on your head, on your forehead, on your eyebrow, on your eyes, on your nose, on your mouth, on your face, on your neck, on your breast, on your belly, on your arms, on your legs, on your feet, on your size, on your beauty, on your expertise, on your knowledge, on your well loving, on your food...”

Dona Marieta made the same circular movement with her hand while she held leaves and threw her hand away from the newborn child after she mentioned “*quebranto*.” Right after this gesture she said, “Saint hours,” and she whispered for about nine seconds towards her little patient. I could not understand or hear what she was saying. It was a silent moment. Then after she mentioned “Spirit Saint,” Dona Marieta spoke silently, only moving her mouth for five seconds, as she was blowing softly. Once more, Dona Marieta prayed Our Father and three times Hail Mary. Then Dona Marieta evoked several spiritual beings, who are mostly related to the cosmos as holy entities in the sky, in order to “announce” the patient’s “health,” “memory,” and “defense.”

After this previous sentence, Dona Marieta spoke in very low voice for three seconds and then she prayed Hail Mary again three times.⁷³ When she began this Catholic prayer for the second time, she yawned. At the end of the third Hail Mary, the newborn coughed and was startled. Then, Dona Marieta again spoke silently, but this time it lasted for nineteen seconds. She continued whispering by only moving her

⁷³ It is interesting because the way Dona Marieta prays Hail Mary is different from the way it is prayed by Catholics. One example that called my attention is that instead of praying “Hail Mary full of grace, the Lord is among us” like Catholics pray, she says “Hail Mary full of grace, the Lord is the comfort.”

mouth toward the patient, moving the leaves over the patient's body in four different directions. She also made movements, bending her head as she silently whispered words towards the newborn.

After the ritual, Dona Marieta made a very spontaneous comment at the end of this conversation about the "last words" that she "had put in" the newborn. I immediately asked what words she said, and both Dona Marieta and Julie did not give me any answer, as I describe part of our conversation below:

Dona Marieta asks to Julie: "Is he a '*caboclo*' [Indian]?"

Julie: [She told her name and explained who her grandmother is]

Dona Marieta: "Ahh! The last words I had, and that I put in him, were very well used! [She was with a smile of satisfaction, bending herself looking and speaking only towards Julie and her newborn.]"

Julie: [She agreed shaking her head affirmatively and smiling looking at Dona Marieta and said:] "It was!"

I asked: "What words?"

At this moment, they remained in silence and both were smiling. Julie looked at her baby and put her hand over his head. I understood that "the words" which Dona Marieta referred demonstrated how Kariri-Shoco rezador/rezadeira shamans use, silently whispering, words and airs of powers, when they "put" them in the patient (experiencing light trances during this ritual). I talked to Pajé Júlio about this moment of silence during reza rituals, when the shaman bends his/her head, which I had observed. Pajé Júlio agreed that it involves a light trance when, according to him, "the rezador/rezadeira [shaman] feels something different." He also explained that it is the moment that shamanic specialists have to "concentrate to receive what he/[she] is asking [for spiritual beings] to make the cure [extracting the evil]." Paje Julio also told me that they ask for spiritual beings by a "communication through the heart."

This is exactly the same explanation given by Kenedy, which I have described showing the ‘ethnographicness’ of his gestures.

It is through the following ethnography about Dona Marieta’s sickness that I describe how her sons, Candara and Mr. Zeca, conducted a reza ritual on her. My description starts on the morning she had a stroke. I also describe how biomedical practices managed Dona Marieta’s health condition. Dona Marieta’s convalescence illustrates how her health problem related to both biomedical and indigenous knowledge, when both biomedical and indigenous knowledge intersected in medical practices and understandings of her symptoms of suffering in terms of her disease.

It was in the morning of October 19 that Dona Marieta went with her twelve-year-old great-grandson to the open market in Porto Real do Colegio town. After she ate a mango fruit there, she felt nausea and laid down by a sidewalk already unconscious. It was noon when Tanira (Dona Marieta’s granddaughter) came to my home and told me that Dona Marieta was in Porto Real do Colegio health clinic very sick. I immediately went to see her, and found her with her right side paralyzed and unconscious.

Porto Real do Colegio municipal health clinic has regular office hours for appointments with doctors and also has rooms for emergency cases, where Dona Marieta was. The medical doctor came and told Tarcisia and Tanira, who were beside Dona Marieta, that she would be transferred to the hospital in Penedo, where adequate assistance would be provided. He also told them that according to her symptoms she had “a brain vascular accident” (in Portuguese it is called *Acidente Vascular Cerebral-AVC*) and that she was already “under medication.” The medical

doctor also said that they were waiting for the ambulance to arrive to take her to the hospital in Penedo.

In that afternoon, Tanira went to the hospital with Dona Marieta in the ambulance, while I brought Tarcisia back home where we found members of her family, including her brother, Mr. Zeca, waiting to hear about Dona Marieta. They were all very concerned with the health problem that affected Dona Marieta. Tarcisia mentioned that the mango fruit that Dona Marieta had eaten in the morning at the market was “probably hot” (“*quente*” from the sun) and could have provoked that problem. Mr. Zeca replied that the “air” was the principal cause for problems like Dona Marieta had. I observed that several neurological and other kinds of diseases-illnesses were associated and caused by the “air,” such as “stroke,” “epilepsy,” “sinusitis,” “paralysis,” and others.⁷⁴

According to Pajé Júlio, the health problem that caused Dona Marieta to become severely ill was caused by an “evil spirit” related to the “air of *parnar*,” which was sent by “the air of fourteen modes.” Dona Marieta’s “air of *parnar*” disease-illness, which the Kariri-Shoco also call “stroke,” is one of “the air of seven modes” that has to be “urgently” treated “with smudges and prayers” before “seven days.” The health problem that Dona Marieta experienced is conceived as an “evil

⁷⁴ Health problems caused by “disease of airs” are described and discussed in the next section. I registered once when Hilda, a woman case study, brought her sister-in-law who had been affected by a facial paralysis to Candara’s health assistance. He performed a reza ritual and made a “bottle remedy” for three days treatment for his patient. This woman completely recovered from her facial paralysis fifteen days after her treatment.

spirit related cause.” Pajé Júlio confirmed that it is an “Indian’s disease.”⁷⁵ When I asked him a verification question about what the word “*parnar*” means, he told me that he could not explain because it is a word from the indigenous “*idioma*” (idiom), which means part of their secret language. Thus, “air of *parnar*” is a disease-illness conceived as caused by a dangerous evil of wind that the Kariri-Shoco have medical knowledge to treat.

Mr. Zeca was concerned that Dona Marieta could die at the hospital. He told Tarcisia that he would await Candara’s return from his trip to talk to him about the possibility of bringing Dona Marieta back home. It was a Friday, when Dona Marieta was sent to the hospital, and Candara was coming back on Sunday. I offered Mr. Zeca to take them to the hospital whenever they wanted to visit Dona Marieta. He arranged that we could go on Monday, after he talked to Candara. Thus, on the afternoon of Monday 22 (October), we travelled to Penedo, and met Dona Marieta’s granddaughters, Tanira and Tanilde, there. Both Dona Marieta’s granddaughters stayed together, accompanying their beloved grandmother at the hospital.

The encounter of Dona Marieta’s sons with her at the hospital was very touching. Candara prayed without any leaves in his hand, while tears dropped from his eyes. During the reza ritual she started to open her eyes a little bit and also moved her left arm. While Candara was praying, Mr. Zeca talked to her saying, “Mother, we are here! It’s your son Zeca! And Candara! We are here!” Mr. Zeca, during Candara’s reza ritual, also performed cure-healing practices. Dona Marieta moved herself especially during the ritual, which I describe below.

⁷⁵ I explain and discuss in the next section Kariri-Shoco notions of “Indian’s disease” and “white man’s disease.”

Both Tanira and Tanilde were taking care of their grandmother very kindly. Tanilde had brought “bush remedies,” which she put under Dona Marieta’s pillow, and placed close to Dona Marieta’s nose, allowing her to smell the scent. Tanilde explained to her uncles that Dona Marieta had opened her eyes on the day before and that she was not moving her right side. This was understood as a good sign, since it is considered that it is on the left side where evil harms a person dangerously. Tanilde also told them that, in the morning, after Dona Marieta had pulled the sheet and moved, they felt a strong scent of *batata-de-cheiro* plant and that it happened twice. I asked if the smell was exhaling from Dona Marieta, Tanilde explained, “Yes, it was all over the room!” I understood that *batata-de-cheiro* was a very special plant for them.

Candara performed the reza ritual speaking very low, almost whispering. I describe here some parts that I heard when he said, “I ask for our Lord to cure Maria de Lourdes [Dona Marieta’s real name] from evil eye, from usury, from quebranto... all persecutions go to where no rooster crows”... Then he mentioned health problems and body organs, “fallen spine, high blood pressure, low blood pressure, sciatic pain, constipation, open breast, stomach, heart, and aorta...” He bent his head and with his hand he made circular movements as if he were collecting and expelling something from Dona Marieta’s body. While Candara was praying, Mr. Zeca was touching her body, her arms, and her legs. He put his mouth on Dona Marieta’s left ear, as if he were sucking something out, which he expelled, blowing out strongly. This same procedure he made with her right ear. I had never seen this cure-healing therapeutic method performed by Kariri-Shoco shamanic specialists before. Mr. Zeca talked to

Dona Marieta, asking if she was with “*quentura*” (hot flush), and told her again that they were there. Candara also prayed Our Father and Hail Mary, while he was with both hands together and looking towards the ceiling.

After the ritual performance, Candara walked towards the door wiping tears from his eyes. Mr. Zeca sat Dona Marieta on the bed and talked to her. Tanilde also helped him, while Tanira turned the hospital bed up to make Dona Marieta more comfortable. The medical doctor came and talked to Candara and Mr. Zeca. He explained about her health condition, that he was keeping her blood pressure under control, and that she was “*medicalizada*” (“medicalized,” meaning under medical prescription). Candara and Mr. Zeca explained to the doctor their intention to bring Dona Marieta back home. The doctor told them that she could die at any moment. Candara then explained to the doctor about his knowledge, and his experience as a man who understands about remedies. After the medical doctor had examined Dona Marieta’s belly, he mentioned: “You have to be prepared for this, she can die suddenly. She is under medication and the blood pressure has dropped.” Candara explained to him:

“All remedies are medicinal. I was traveling when my mother became in this situation. I was traveling helping persons. Because I know remedies, doctor, that are in a way that when the person has to die, I pass the remedy, then [the person] ends up dying there. When [the person] is to become well, it is only a matter of keeping the ‘resguardo’ [health care].⁷⁶ They are remedies from my head, given by God. I work very hard not only with this sickness, but also with several sicknesses. Now you know that there are many sicknesses that need surgery. Now there are many sicknesses that you sirs make surgery, and I with

⁷⁶ Resguardo is a term also related to what I have translated as confinement, which is the period post-delivery women go under certain health care practices, which I describe in the next chapter. Candara uses this word referring to the period of necessary care (food, activities, etc.) for the success of treatment.

my plants' treatment, it is not necessary surgery, I treat. You forgive me, but that is what I explain to you, sir.”

It is interesting that Candara tried to explain to the medical doctor the different nature of indigenous remedies, from which the effect of the remedy is determined by the remedy itself. When Candara gives the explanation above to the doctor, he is telling the medical doctor that after he gives the remedy to the patient the remedy will provoke the patient's death if it is meant to happen. On the other hand, if it is meant for the patient to recover, the remedy will provide to the patient a healthy recovery. This perception that Kariri-Shoco shamanic specialists have with “bush remedies” effect relates to the effect that each remedy has accordingly to the owner of the plant's (spiritual being) will.

The doctor's position was very emphatic on Dona Marieta's severe sickness and the limitation of biomedical assistance to treat her case, considering her advanced age. That is the principal reason that he agreed and respected Dona Marieta's sons' will to bring her back home. After the medical doctor left, they arranged that Dona Marieta would stay at Tarcisia's house, where both Tanira and Tanilde could give assistance to Dona Marieta, helping Tarcisia to take care of her. Dona Marieta was sent home the next day.

When Dona Marieta arrived at home, Candara performed a reza ritual and he prescribed “bush remedies” for her treatment. Tarcisia prepared a remedy mixing *mastruz* and *pau-ferro* plants with milk, and told me that it was for Dona Marieta to become stronger and also for pain. Dona Marieta was brought to the reserve only with the intravenous “*soro*” medication and the medical prescription from the hospital doctor (where five different drugs were prescribed). One of the nurse assistants,

Elizabeth (the non-indigenous nurse assistant) came to take Dona Marieta's blood pressure and to provide drug for high blood pressure, which she had available in the health clinic pharmacy. The hospital medical doctor's prescription was handed to one of health agents, who billed medical prescriptions, although he still had to wait for the Sementeira medical doctor's arrival, because she was the only one who could request them from the pharmacy in Porto Real do Colégio.

At night Vana (Dona Marieta's granddaughter) came to help Tarcisia and also prayed and sang Catholic prayers and chants in Dona Marieta's bedroom. Tarcisia told me early that they needed alligator's skin to make the remedy. I went to Propria's open market where I bought it, and gave it to Tarcisia for Dona Marieta's remedy. This remedy was prepared on a clay plate, with different mixed medicinal plants and alligator's skin. A big flame was made in the bedroom when Vana burned the remedy on the clay plate. The smoke covered Dona Marieta's bedroom. Kenedy, who came to see his grandmother, explained to me that if Dona Marieta did not die in the next few days, she would "survive longer from her disease." Several relatives and friends came that night to see Dona Marieta, and several grandchildren gathered and stayed up until late at night outside, where they made a fire and stayed chatting. Erismo and Vana stayed overnight at Tarcisia's house.

Next day, Candara arrived in late afternoon to perform a reza ritual on Dona Marieta. He told me that he thought that if Dona Marieta "had stayed at the hospital, she would have already been dead." Then he explained about his responsibility as the oldest son:

"She would feel so much [if left in the hospital]. It would be risky for me, because I am her oldest son. She would come to complain [after dead] to me."

Tarcisia talked to Candara about the possibility of bringing Dona Marieta to the Ouricuri ritual, which would start on Saturday. They were sure that Dona Marieta would want to attend, since she never missed them. Their concern was how to bring her without a car. They planned to ask the medical doctor for authorization to use the ambulance for that purpose. I asked Candara if it would not be risky to Dona Marieta be taken to the Ouricuri, considering her health condition. Candara answered: “No, she is more protected there, two or three times more protected than here.” Candara also explained how the smudge treatment of medicinal plants and alligator’s skin, which he told to Tarcisia how to use, would determine if Dona Marieta would survive from this “crisis.” He explained that “if she doesn’t die during these three and four more days after the treatment,” then they would be sure that “she will live longer.” He mentioned that “rattlesnake’s skin” was “also a good remedy,” but he did not have it available there, only far in the *Sertão* (Northeast drought region) could it be found. He said, “Thank God my mother is still alive!”

About a month after her stroke, Dona Marieta was only taking one pharmaceutical drug, which was prescribed to control her blood pressure. Tarcisia continued to regularly give her medicinal plants mixed with milk, or different kinds of teas, which should make Dona Marieta “stronger.” Also, regularly Dona Marieta was bathed with medicinal plants. She was also given different teas made of medicinal plants.

Dona Marieta was brought to several other Ouricuri rituals, where she died on January 16, 2002 during the biggest Ouricuri ritual celebration. Kariri-Shoco people consider that to be born or to die in the Ouricuri village during rituals is a blessing for

the person. Whenever a Kariri-Shoco person dies, the next Ouricuri ritual can only happen at least one month later. Only when someone dies in Ouricuri rituals, they continue the ritual while family members bring the deceased body to be buried in Porto Real do Colegio cemetery.

During Dona Marieta's convalescence she was not speaking, seeing, or moving her right side of the body. Baioca told me, "She is going away." Dona Maria Velha commented, "The stroke affected her right side and her arm that she used to pray!" For Dona Maria Velha this was a sign of how a rezadeira/rezador shaman can eventually receive something evil as a consequence of the hard work of cure-healing others. Tacinha (Dona Marieta's granddaughter) told me how before Dona Marieta's disease happened, she was "like '*se despedindo*' [saying goodbye] to everybody," when in the previous Ouricuri ritual she danced *Toré*⁷⁷ and was "happy, talking to everybody." Tarcisia suffered very much with Dona Marieta's health problem. She was devastated and concerned with Dona Marieta's possible death, when all her family would "lose a powerful family guardian."

Dona Marieta's children and grandchildren took very good care of her during her convalescence, giving nutritious liquid-creamy food in her mouth and keeping her clean. Each time I went to see Dona Marieta, I noticed that several indigenous and non-indigenous people were coming to visit her, when very often I heard people say to Tarcisia: "May God give Dona Marieta health!" I continued to visit her regularly. I understood why her family wanted her close to them. It was fundamental the

⁷⁷ Toré is an indigenous ritualistic dance very common among northeastern indigenous people, when they sing and celebrate festivities.

protection and cure-healing practices that Dona Marieta received through indigenous shamanistic treatments.

During Kariri-Shoco cure-healing rituals several diseases-illnesses and their causes are mentioned. The indication of health problems and their causes during the reza ritual depends on the patient's symptom descriptions and on the shamanic specialist's focus. Several kinds of "airs," like in the reza ritual performed by Kenedy and in the one performed by Candara on his mother, were mentioned. This reveals their perception of the air or wind as a channel for "contaminations," which is one of the most common and dangerous ways the Kariri-Shoco conceive that diseases-illnesses can be transmitted and "caught" (through different kinds of "airs" or "winds"). Dona Marieta's sickness is an expressive case where biomedical and indigenous systems intersected. It is an example, from an indigenous knowledge perspective, of how she caught a health problem through the "air of *parnar*." It illustrates how this contamination damages "the matter" (substance), breaking the body, which may be paralyzed and absent. That is how the Kariri-Shoco conceive the effect of "the air of *parnar*" on a person's body.

Lévi-Strauss (1963) mentions that one of the therapeutic methods of shamanistic cure, which he observes is frequently efficient, is when "[t]he sick organ or member may be physically involved, through a manipulation or suction, which aims at extracting the cause of the illness" (Lévi-Strauss (1963, 191), which is a method often found in tropical America, Australia, and Alaska. He also gives the example of the Navaho, where shamans "may recite incantations and prescribe actions" (Lévi-Strauss 1963, 191). Lévi-Strauss (1963) explains that the efficiency of

this therapeutic method is difficult to interpret, but he attributes the “psychological mediation,” particularly when the ritual is very abstract and the body is neither touched nor a remedy is prescribed, from which the song (like in the Navaho case) “constitutes a *psychological manipulation* of the sick organ,” and that “it is precisely from this manipulation that a cure is expected” (Lévi-Strauss 1963, 192).

Lévi-Strauss (1963) uses for his analysis of shamanistic cure-healing (through therapeutic methods of physical or abstract manipulation of the sick person’s organs or members) a dualistic theoretical perspective of the mind-body where a metaphor, exemplified by the Navaho case of the use of song, expresses and alters psychologically (mind) the patient’s experience and perception with the body. As my theoretical perspective utilizes the notion of embodiment within a phenomenological framework, representations and symbolic aspects of ritual healing are situated in contextual interactions from which an embodied communication is engaged with the senses (Laderman and Roseman 1996). Therefore, the manipulation of the sick patient’s body during cure-healing performance belongs to embodiment, where the senses work within communication that is provided, established, and experienced during the ritual performance.

In Dona Marieta’s case, this embodied communication was based on how indigenous people experience health problems. This communication was experienced and established with her sons, since she moved herself, she reacted to words of powers (Candara’s ritual performance) and touches and suction (Mr. Zeca’s ritual performance). It is in the next section where I explore how diseases-illnesses are experienced and relate to Kariri-Shoco concepts of the body.

Thus, the disease-illness which Dona Marieta experienced belongs to the “Indian’s disease” domain. The fact that it is recognized by the biomedical domain of knowledge and practice, as stroke, provided the legitimization for the biomedical management of her health problem, although the Kariri-Shoco have medical knowledge and practice to deal with her disease-illness. It is part of their indigenous medical knowledge. Actually, the fact that she was diagnosed as a terminal patient, when the medical doctor emphasized several times her imminent death, and that she lived more than three months, demonstrates the effectiveness of Kariri-Shoco medical knowledge and practice. In the following part, I describe a reza ritual performed by Dona Maria Velha for “open arcs.”

6. 2. Reza Ritual For “Open Arcs”

Before describing the “open arcs” cure-healing ritual that Dona Maria Velha performed on a man, I describe an ethnographic interview when I asked her verification questions about which was the most difficult case she found on the previous day, when she had traveled to the country (of Porto Real do Colegio County) to perform reza rituals. She gave me details about what she felt after spending a whole day “making cures” (performing reza rituals) in the country for non-indigenous people, and what she receives as payment and why she charges when she performs a “cure” for “open arcs”.⁷⁸

⁷⁸ “Open arcs” is a health problem related to the thorax where the patient feels pain and is associated with others such as “open breast” and or “fallen spine.” I give details about those health problems below.

“[I asked:] Dona Maria Velha, which was the most difficult case that you found yesterday?”

“[D. Ma. Velha:] The most difficult case that I felt was the one in the last house I prayed. I found a lady, who is a woman older than me, and she told me: ‘Oh, it was good that you appeared. I live so sick!’ She suffers this business of high blood pressure and also from nerves. The nerves attack her and even throw her down. She sometimes stays like losing her speech. Then I said: ‘I’m here, Dona Nazaré! I arrived!’ She told me that she wanted me to pray on her. Before, I had already prayed on a woman who had a swollen knee, rheumatism, where I also had measured her husband here [she shows and points to both shoulders], because all cures that I make, in the name of our Lord Jesus Christ and [she said spiritual name that I did not understand and continues:] ... on my ritual, I don’t charge anything, I receive those gifts from whoever wants to give me. But only this here [pointing to her shoulders] on the ‘arcs,’ from ‘fallen spine’ and ‘open arcs’ when the breast is open, only for this one I charge! Because when I am closing those open breasts with the reza, mine are opening! Now for this, anything has to be given to me. The best is ‘alive eyes!’”

“[I:] How, ‘alive eyes’?”

“[D. Ma. Velha:] An ‘alive eyes’ is a little chick, it is a chicken... But if it’s not, because not everybody has [‘alive eyes’] to give, then some give me two *reais* [Brazilian money], another gives me rice, one kilo of beans, like this, do you know?”

“[I:] Yes, I understand.”

“[D. Ma. Velha:] It is not a great quantity of money, like those smart ones receive! I don’t want to be smart! There’s nobody smart! God is the only wise one! What we know is to make a little defense on the Eternal Father’s name!”

Dona Maria Velha starts the reza ritual for “open arcs,” in two phases, by checking if the diagnosis is correct. First, she uses a white cloth to measure and compare different distances of the patient’s body parts. She measures the size of the patient’s forearm to his hand (when the patient bends his arm, showing his forearm and straight hand to her) with the white cloth.

Digital Stills 2: Dona Maria Velha Measuring a Patient's Shoulder



After, she takes the cloth on which she marked the previous measurement, and she puts the cloth on the patient's chest from left to right shoulder to see if the previous measure matches the distance between the patient's shoulders. She found out that the measurement from the forearm to hand was "four fingers" longer than the measure between the patient's shoulders. This shows that the patient is with "open arcs."

Digital Stills 3: Dona Maria Velha Measuring Patient's Breast



Then, she starts to take other measurements with the cloth, for comparison, in the same way. This time she compares the distance between the patient's elbows (while the patient has both arms straight open), with the measurement obtained from the patient's breast size (by putting the cloth around the patient's breast). She found

that the cloth measure obtained from elbow-to-elbow is smaller than the patient's breast size.

The measurements that do not match give evidence that the patient is suffering from a dangerous health problem, since his "breast is open." That is why the patient complains about breast pain, and that he is not feeling well. Because it is a sign that the body is open through the "open arcs" or breast, the patient is vulnerable to catch diseases-illnesses, and is more vulnerable to evil spirits which can enter inside his body that is opened through his breast.

Dona Maria Velha shows me the different sizes she measured, and starts the reza by putting the cloth around the patient's breasts. She strongly twists the cloth and holds it. She tightens the cloth by holding it, placed around the patient's breast.

Digital Stills 4: Beginning of the Reza Ritual for "Open Arcs"



Then she starts the ritual by making the Catholic cross sign and silently bends her head with her hand open, which reminded me of the same move Kenedy had done when he explained about the moment of silence.

Digital Stills 5: Cross Sign and Bending Head



During the whole reza ritual for “open arcs,” the rezador/rezadeira shaman focuses on the patient’s thorax. I selected a few examples to show how Dona Maria Velha experiences embodiment related to this cure-healing ritual performance, one of which is when her “arcs” also open during the reza. She begins with “concentration.”

Digital Stills 6: Cross-X Signs During the Ritual



Then she prays, making a cross sign on the patient’s breast, asking for spiritual beings:

“To be raised up [She twists the cloth tighter and pulls it up]
 Taken out,
 And suspend it up
 Open Arcs,’ fallen spine, leaked gall,
 ...Raised up! [she makes a movement as she twists even more tightly the cloth
 on the patient’s breast]
 Raise up arc!
 Close up spine! [She twists tidily the cloth]
 In the name of God Father, God Son and God Spirit Saint”

During the ritual she makes the cross sign several times and also X signs with her thumb on the patient's breast (and later on his back) over and under the cloth. Sometimes she makes this X sign on his right and left arms close to his shoulder. It is in the following part of the ritual, when she mentions again health problems related to "open arcs," and different kinds of pain, and other problems, that she demands the patient's "arcs" and "spine" to "raise up" and to "close up."

Digital Stills 7: "Raise up Arcs!"



This is the moment when she uses her strength during the ritual, when she twists and holds tightly the cloth. She prays:

"In the name of God Father, God Son, and God Spirit Saint!
 ...Open Arcs,' fallen spine, leaked gall, rheumatic pain, sciatic pain,⁷⁹ pain on the column, *entruzidada* caused,⁸⁰ blood
 And your Sun Divine Sun will raise up, [She twists more tightly the cloth]
 With the three trembles,
 With the three tights..."

Then she stops the reza when she goes to pray on the patient's back. She unties the cloth and places it around the patient by holding it at his back. She follows the same procedure as she did before; she pulls the cloth in opposite directions, making twisting movements on the cloth to tighten it, while she keeps holding it to continue the ritual. She makes cross signs on the patient's back. She looks at me and says: "Look, do you want to see? One word I am going to ask him: '[While she pulls

⁷⁹ "Sciatic pain" is a pain that the person feels suddenly, without any reason.

⁸⁰ See footnote n. 55 for "*Entruzidada* caused."

the cloth in opposite directions she asks him:] ‘Adelson, does it go good?’” He answers: “It goes!” And she tells me: ““Do you see?” I said, “Yes,” as I understood that she showed me that he was already feeling better, that it did not hurt like when she began the ritual. Then she laughs and continues the reza using basically the same verses but with some changes. This part was longer than the previous one.

It is in the beginning, when she starts saying the prayers on the patient’s back that Dona Maria Velha coughs and speaks with difficulty. It is at this moment that I think her “arcs” are opening; since the way she tries to speak is similar to the way she had described one day about when a person has “open breasts.” She also has an expression on her face that indicates that she is feeling something different, as she continues the ritual.

Digital Stills 8: Dona Maria Velha Embodies Symptom of “Open Arc”



In the following part of this reza ritual, Dona Maria Velha spoke very quickly, and so it was not possible to understand the words she said about spiritual beings related to the Ouricuri:

“With saint trembles of my ... of the my *novelo* white⁸¹
With the wood from my Ouricuri,⁸²

⁸¹ “*Novelo* white” is considered the thread that is used (through the white cloth) to tight the patient’s breast.

⁸² By mentioning “wood from my Ouricuri” she refers to a sacred tree located at the Ouricuri village.

The three hit of the *maraca*,⁸³
 ... Stand up!
 Open arc, fallen spine, leaked gall, go to the waves from the sea!”

After Dona Maria Velha twists tightly and pulls the white cloth, which she holds on the patient’s breast, she finishes this part of the reza and she unties the cloth and pulls different ends in opposite directions and twists it again very tight to pull it up. She repeats the health problems related to the patient’s symptoms and demands again at the end of the ritual that the patient’s breast to “raise up,” “close up,” and “lock up”:

“...Open Arcs,’ fallen spine, leaked gall
 The Divine Sun went; [She pulls very tightly the cloth in different directions]
 And raised up [She holds the cloth and pulls it up]
 Close up, arc!
 Lock up spine!”

Then Dona Maria Velha unties the cloth and continues standing by the patient’s back. She puts her hand on his breast, where she makes cross signs on his chest, and prays Our Father, Hail Mary, and then she prays Hail Queen, mentioning his name on the end of the Catholic prayers, and she asks to see Adelson’s “health,” when she finishes the ritual.

After the ritual I asked Mr. Adelson if he was feeling better. He smiled and said, “Yes.” Then I told him: “It is very good when a person is feeling something and finds somebody who can help!” He agreed and left smiling.

I started to talk to Dona Maria Velha, who I noticed was tired as she said: “My work is this” and we started the following conversation:

“[I said:] It is a lot, your work!”

⁸³ By mentioning “the three hit of the maraca,” she is fortifying the patient’s heart.

“[D. Ma. Velha:] It is, with open arc the service is big.”

“[I:] It is good because it really closes.”

“[D. Ma. Velha:] It does, but while I am closing his arcs, mine are opening.”

“[I:] Do you feel?”

“[D. Ma. Velha:] Yes, I feel. Because I make a nod and have to suspend! When it is too fallen I tell to sit on a chair. With one like his I still pray with him standing. But if it is very fallen, when the body is more fallen, I pray on a chair [the patient sits on a chair]. Because he won’t stand the tight that hurts, then I will fall on him [she laughs]!”

“[I:] When is it too fallen?”

“[D. Ma. Velha:] When it is too open. We can see from the measurements. Then I put that strength [to tie up and suspend it] I go to take it snoring [because the person with a too fallen spine make a sound like he/she is snoring]! Because the wind passes here! [She points and shows between her breasts]. What puts on the reza is this: the flesh!”

From those explanations, I understood how this kind of reza ritual involves embodiment, which, as Dona Maria Velha explained, while she is closing the patient’s breast, she is opening her breast. She evokes spiritual beings during the ritual, and although there is a moment of silence at the beginning, I did not notice any other moment that could suggest a trance. From my observation, and based on her explanation above, this ritual, which is performed for a specific health problem related to the thorax’s dislocation, has the purpose of making the patient’s body, which is with “open breast,” close. The is why the shamanic specialist demands to “raise up” and “suspend” “arcs,” and, to “close up spine,” in order for “flesh” to be “put” on the patient’s thorax through the reza ritual. Thus, the patient’s breast becomes closed and completed with “flesh.” Several indigenous sacred and secret elements are used in this cure-healing ritual (as tree, maraca, and so on) for the purpose of closing of the patient’s body.

Once I asked to Dona Maria Velha if the way to take measurements for women who are with “open arcs” is the same. She told me that it is the same, but if the woman is breastfeeding her breasts are bigger than usual, thus the measurement is

taken under her breasts. Then I asked, “how are the breasts open?” She told me that it could happen at any time when the person moves, for example, laying down in bed sleeping at night, “stretching the body in a certain way that makes the breasts open.” Then I asked about the symptoms. She said that usually “the person feels a ‘pulsing pain on the breasts’ or on the back,” “weakness on the legs,” and also when the person “wants to talk, opens the mouth but stops [she showed a gesture] because of difficulties for speaking.” She also explained that the reza is done “on both sides [of the body: front and back]” to “cover’ (*tampar*”), to “complete” the thorax.

6.3. Mesa Rituals:

It was with Candara that I had the opportunity to observe a more complex cure-healing ritual called “*mesa*” (“table”), which is performed on a patient with the participation and actions of other Kariri-Shoco individuals. The curandeiro shaman, called *mestre* (“master”), is the one who opens the event and “maintains control” over the situation. I observed three of these kinds of rituals performed on non-indigenous patients. I would not be allowed to observe when these rituals were performed on indigenous patients because it involves their secret shamanic practices. During this kind of cure-healing ritual, I could only audio record. I was only allowed to record video images of the setting where it was performed, before and after the ritual performance.

As I have already mentioned, it is through the reza ritual that the rezador/rezadeira shaman finds out that the patient has a more serious problem, such as spirit related cause, and a mesa ritual can be arranged for the patient. All mesa cure-healing rituals that I watched were opened by Kenedy, while his father Candara

assisted from outside the mesa mat. Kenedy was directly in communication with the patient and spirits that enter, or are inside, the patient's body. Four other persons, two men and two women called "*mesários/mesárias*" ("table sitters") or "*padrinhos/madrinhas*" ("godfathers/godmothers") also work beside the patient. The "table sitters" actively participate, singing and working with the patient's body.

Although I had not seen Kenedy drinking the Jurema remedy, he told me that he had drunk it when I asked him before the ritual. The patient also drinks the Jurema remedy, which is the remedy that, in the case of spirit-caused disease-illness, brings out the spirit who is afflicting the patient, makes the spirit identify itself, and reveals who sent it to the patient. I observed that it was considered that not exactly the patient spoke with the shaman whenever an evil spirit was brought out, but the spirit itself through the patient.

Dona Maria Velha described an experience she had when participating in one of these mesa rituals as a *madrinha* (godmother). She told me that all who take part in this ritual must have a "cleansed body," which means that "all of them have to be with the body closed," principally "without having had sexual intercourse for at least three days before this ritual." All other shamanic specialists who perform these rituals, and whom I have interviewed, also gave this same explanation. Dona Maria Velha said that she told her brother-in-law, who also participated as one of the "godfathers," that "no spirit would come even close" to her, that "it would pass by his side." Thus, during the ritual, her brother-in-law "felt the spirit first in his arm, after in his leg, and then it went inside the patient's body."

During the mesa ritual sacred songs are sung, evoking the healing through the “Masters” (“*Mestres*”), who are mentioned through the songs. Similar to the reza cure-healing ritual, the purpose is to discover who or what is causing the suffering, in order to cure-heal the patient by closing the person’s body. Candara explained that it is in the mesa, not in the reza ritual, that the person’s body is effectively “closed,” since it is through this ritual that an evil spirit can be exorcised from the patient’s body. Thus, the mesa is considered a stronger therapeutic cure-healing ritual. The ritual has the objective to close the person’s body, and it can eventually lead to an exorcism when it is a case of spirit possession. I will describe Monica’s case in detail, as an example of the mesa cure-healing ritual performance.

On the Friday of Monica’s mesa ritual, I met Dona Marieta walking by the road in the direction to Porto Real do Colégio town. As I was on my way to Candara’s house, I asked her if she wanted to come with me to watch Monica’s mesa ritual. She was happy that I invited her, and we arrived together at Candara’s house before Monica arrived. I was glad to bring Dona Marieta because I knew that she would enjoy being present at Monica’s mesa ritual, since Dona Marieta had prayed on Monica two days before and discovered that she suffered from an evil spirit health problem. It was also an opportunity to observe Dona Marieta’s reaction during this kind of ritual. Dona Marieta was the one who sent Monica to Candara, when then he performed a reza ritual and prescribed the mesa because of the nature of Monica’s health problem.

The mesa ritual took place inside the living room of Candara’s unfinished house. The last scene that I video-recorded shows Monica sitting on a mat with

remedies, candles, plants, and sacred objects to be used during the ritual. When we were all there, Candara asked everybody to “hold on God,” asking for goodness in order to help Monica’s healing. Kenedy explained that he does not “focus on the body.” He says, “I aim the closedness of the matter [*matéria*].” The word “matter” is often used among the Kariri-Shoco to refer to the concrete material substance of living things that have spiritual life, such as human beings, plants, animals, and the cosmos. By closing Monica’s “matter,” I understand that means providing a necessary state of recovery and protection for the substance of her body.

The ethnographic description of Monica’s mesa ritual will be incomplete because Candara and Kenedy asked me to keep the recordings of the ritual to myself. They gave me consent, though, to describe the ritual. Thus, it involves elements of their shamanistic secrets that they do not wish to divulge. I would not be allowed (as a non-indigenous individual) to watch a mesa ritual when an indigenous person is treated. Thus, I have decided to describe only information about procedures and actions performed during the ritual.

After all four “table sitters” took their places (two on each side) on the mat and each couple was sitting on different sides, facing each other, Kenedy started the ritual by bending his head with his eyes closed, as he was having a moment of silence. The “table sitters” were Candara’s sons, daughter, and a daughter-in-law. They start to sing a beautiful song, which evokes and calls spiritual beings. Another song mentions the sun and tells that a spiritual being is arriving. The following song evokes a female spiritual being. Several times they sang, using expressions such as “hey-eh-ah-hey-ha-hey-ah-hey-ah,” which gives a beautiful rhythm and musicality.

Those chants remind me of some Pankararu's songs, which I heard several years ago. Most of the songs are sung three times during the ritual.

Inside the room, where the ritual was performed, about twenty people were watching, sitting on chairs around the "table" mat (where Monica, the table sitters, and Kenedy were placed. Several children (Candara's grandsons, granddaughters), and even non-indigenous people who live close to the reserve were present. I observed that most of the children sang the songs and were enjoying watching the ritual. I sat close to Dona Marieta, and could observe that she made the cross-sign as the ritual began. She sang all of the songs during the ritual and kept trembling her hand, as though she was holding and shaking a maraca with her right hand.

All "table sitters" held a thin branch of leaves, while they were singing during the ritual. Each "table sitter" held a white candle, which was lit and re-lit three times over parts of Monica's body during part of the ritual when they close her body. Candara was the shamanic specialist who was outside the "table" mat and coordinated the ritual, moving close to Monica whenever his assistance was necessary.

After those songs were sung, Kenedy gave Monica a glass of Jurema remedy that he took from a container, and told Monica to hold the glass with her right hand and drink it. Monica drank it and complained about its bitter strong taste. Then a song was sung again, evoking a spiritual being when they asked permission to "play" with a specific plant that is mentioned in the song. Then another song was sung asking a question and an answer was given speaking about the "sea."

The songs, in general, are sung three times. Some songs were sung with just "hey-eh-ah-hey-ha-hey-ah-hey-ah" sounds, when places are mentioned at the end. I

understood that some songs are not sung in words because this ritual was for a non-indigenous person. One of the songs says, “You drank *mesinha*,⁸⁴ you have become drunk” and mentions the “mesa” and that “it is time to work” finishing with “hey-eh-ah-hey-ha-hey-ah-hey-ah.”

Then, Kenedy starts to ask Monica questions. The remedy is once more given to Monica drink. She already has a serious expression on her face, and after she drinks, she vomits.⁸⁵ Kenedy asks her to speak. Then, Monica starts to laugh loudly and to move her legs and arms as though she was avoiding everything. This scene was very similar to the one that I had watched when Monica embodied a spirit for the first time. At this moment Kenedy, Candara, and both male “table sitters” held Monica, and Kenedy told her to speak about “who” was “there.” This scene lasted for more than twenty minutes. After several attempts, she finally spoke about someone from the past, from southern Brazil, where Monica travels to see her biological mother. It is discovered that it was a person from southern Brazil who sent the spirit to possess Monica’s body. After Kenedy exorcises the spirit, Monica remains quiet.

Kenedy gives the last glass of the Jurema remedy to Monica. After a little while, he finds out that there is another spirit that embodies Monica. It is something that he senses as he starts asking her questions and making her speak. Monica apparently is not possessed and she speaks normally. Kenedy discovers that a “left service” from somebody from Propriá city, who is occasionally in contact with

⁸⁴ Literally translated in Portuguese, *mesinha* means little table, but in the sense of this colloquial use it means remedy, which they use to refer to the Jurema remedy that Monica had drank.

⁸⁵ Candara says that it is good that it happened because it is cleaning her body, and also that a diahera may happen

Monica, sent an evil spirit to her. He tells Monica to search her bedroom for something that was given to her. Monica mentions a red rose, which she kept dry in her bedroom. Kenedy tells her to get rid of it, and to throw it away from her home.

Then, Kenedy asks three questions to Monica, telling her to answer “No” when it relates to evilness, and telling her to answer “Yes” when it relates to goodness. He repeats the questions, and Monica answers them, three times. While the “table sitters” light their candles and place each one on different parts of Monica’s body, they simultaneously blow them out. This procedure is followed from her head, to her shoulders, elbows, wrists, knees, and ankles. Before they light and blow the candles, they sing a song which tells that they are going “to close” her body with “the four lights of the sky” to avoid male and female “enemies,” and also “evil winds.”

I understood that it is at this moment of the ritual that the body is literally closed, through the use of fire from the candle’s flame, which is mentioned in the song as “four lights from the sky.” Airs, which the “table sitters” make by blowing out the candles, are also used as a tool to close the body. The parts of the body that are focused on are mostly joints, where possible movements and flexibility of the body are located. They are places where the body is vulnerable to airs passing through and spirits get through.

When they finished, Monica seemed happy. Kenedy talked privately with Monica and her boyfriend. It was very interesting because, after the ritual, all of those who came with Monica asked shamanic specialists for a reza ritual. So, together in the same room, Dona Marieta and Candara each performed a ritual on different people. Dona Marieta performed a reza on Monica’s aunt, and then on Monica’s

mother, while Candara performed a reza first on Monica's cousin and then on Monica's boyfriend.

I had the opportunity to watch two more mesa rituals. Neither, however, involved spirit possession as with Monica's case. One was performed on a young man who lives close to Propriá city. I interviewed him after the ritual and he explained that he came to the mesa because he had been "weak," "without strength." He said that after Candara "prayed" on him and prescribed "bottled" remedy, Candara had suggested that a mesa ritual was appropriate for him. He mentioned that he had recovered considerably after he had met Candara and followed his advice.

The other case of a mesa ritual that I watched involved a teenage girl who was very angry and seemed "out of control." It did not relate, however, to spirit possession. Kenedy told me that her problem was caused by cannabis use, but he did not mention this to her mother. They performed this ritual when the teenager's mother and uncle brought her. The girl cried during the ritual and talked about her problems. After the ritual, she seemed already recovered from her emotional distress.

In the mesa ritual is the use of the Jurema remedy, which is considered among the Kariri-Shoco as the "remedy of the Indian." Both the mestre shamanic specialist and the patient drink Jurema. Nascimento (1994) describes a few historical references which evidence that since the eighteenth century Jurema plant has been used as an indigenous beverage in Northeast Brazil in rituals. Hohenthal (1960a, 1954) mentions that "Jurema Cult apparently was extremely common" (Hohenthal 1960b, 76) among all groups that he had visited in this region, such as Fulni-ô, Tushá, Pankararu, Shucuru, and many others. He describes it as "a narcotic drink to induce

visions” (Hohenthal (1960b, 76). Hohenthal (1954) also mentions that two different kinds of Jurema were used: “the ‘white’ (*Acacia jurema* Mart.) and the ‘black’ (*Mimosa nigra* Hub.), depending on tribal preferences” (Hohenthal (1960b, 148). Hohenthal (1954, 148) describes that the Fulni-ô “prefer the ‘black’” while the Shucuru use both (black or white ones). Mota (1987) mentions three different kind of Jurema (*Vitex agnus-castus* Linn., *Mimosa verrucosa* Benth., *Mimosa hostilis* Benth.) that the Kariri-Shoco use, which have a central role in “sacred life,” as having “both traits of gentleness and strength... [and] being classified as both female and male [spirit plant]” (Mota 1987, 159-160). Pajé Júlio considers Jurema as a female plant. During field research I had opportunity to observe that shamanic specialists distinguish three different kinds, as “white,” “black,” and “red” Jurema plants. Among the Kariri-Shoco, the use of Jurema varies according to the shamanic specialist preference. Candara prefers to use the “red” (“Jurema *vermelha*”) either in mesa rituals, preparing “the remedy” with the plant’s root, or for making any kind of “bottle” remedies, according to the patient’s health problem, mixing the barks of the “Jurema *vermelha*” with other different kinds of medicinal plants. Jurema is a psychotropic plant and its hallucinogenic properties and effects depends on how it is prepared, which is not the case for the “bottle” remedies that Candara prepares and prescribes for his patients.

The use of what Langdon (1994a, 17) calls “psychedelics” is very widespread in South and Central American shamanisms as a technique of ecstasy. Luna (1994), who describes Peruvian *mestizo* shamans’ use of *ayahuasca* (*Banisteriopsis caapi* plus *Psychotria viridis*), mentions the ingestion of *peyotl* (*Lophophora williamsii*)

among the Huichol, the use of mushroom (*Psilocybe*) among the Mazatec, and many other psychotropic plants as examples on how different peoples use those kinds of plants. Luna (1994) also discusses anthropological studies describing ethnographic data about the association of songs with psychotropic plants indigenous' use. As an example of a relation between shamans and plants, Luna (1994) describes how Don Emilio (shaman) considers “*Ojé* [tree] a powerful plant teacher” (Luna 1994, 237) when its “spirit” is who “instructs [him] in the cure of certain illnesses” (Luna 1994, 237). Thus, the use of Jurema by the Kariri-Shoco as a psychedelic and medicinal plant characterizes a widespread indigenous practice in Central and South American shamanisms.

In those rituals described, shamanic specialists utilize indigenous therapeutics of medical practices for cure-healing purposes. All of them involve the use of words of powers from which shamanic specialists experience a moment of silence, but in a case of evil spirit, blows, Jurema psychotropic plant, and songs (Monica's case) or suction and words of powers (Dona Marieta's reza ritual performed by Mr. Zeca and Candara) are utilized as therapeutics which characterize indigenous medical practices.

Indigenous therapeutics of cure-healing rituals are within a context where the force and power of the cure is in the words that are spoken by the shamanic specialist, but also the breath that comes out from the shaman's mouth. Dein (2002) argues that “healing by the recitation of religious text can only be understood through an examination of how participants understand the nature of language and its relation to the world, a ‘cultural ontology of language’ (Dein 2002, 45). In the case of reza rituals for evil eyes and “open arcs” the performance involves powerful words which

are directed to the body and health problems, from which a communication is established with the patient's body. It is through embodied knowledge that shamanic specialists, during reza rituals, sense, feel, and "attract" what is causing the patient's health problem. As I have described, those two reza rituals illustrate how shamanistic embodied knowledge serves as a medical practice.

The power of the words of prayers during reza rituals belongs to the domain of how language is experienced by the Kariri-Shoco. The evil can be removed from the patient's body through words from the sacred and secret domain of shamanistic power. Because those words have this power and strength through the shamanic specialist's body, it is removed from the patient's body when he searches (in different parts of the body) and when he also mentions and finds (different health problems, symptoms, and causes) speaking, asking, and obtaining from spiritual beings the power to cure. Taking Dein's (2002) suggestion, in this cultural context the words are effectively able to extract the evil from the patient's body. In the case of evil eye, the words that comes out from the mouth of the shamanic specialist have "grace," "strength," and "power" of spiritual beings. It is through air from the yawning that the evil comes out of the patient's body, but it is also through softly blowing (almost whispering) or strong suction or blows (in the patient's ears, on the head) that the evil may be extracted. It is in the following chapter that ethnographic data will be presented and analyzed about Kariri-Shoco ethnophysiological concepts, physiological reproductive processes, and gender and female embodiment.

CHAPTER VII

GENDER ASPECTS: KARIRI-SHOCO FEMALE EMBODIMENT

I am not able to stand back from the body and its experiences to reflect on them; this withdrawal is unable to grasp my body-as-it-is-lived-by-me. I have access to knowledge of my body only by living it. (Grosz 1994, 86).

This chapter discusses Kariri-Shoco female and gendered embodiment through which the female body is characterized by culturally coded sexual differences. Female embodiment here is approached considering how the female body, which is a materiality open to cultural inscriptions, has irreducible specificities through experiences and bodily processes (Grosz 1994). The notion of gendered embodiment is utilized from the articulation of biological sex and gender within discursive domains, where a discursive dichotomy (between feminine and masculine) coheres within representations (Butler 1990). Thus, the notion of gender utilized when researching Kariri-Shoco shamanic specialists' and women's perceptions and experiences focuses on what underlies logical assumptions through discourses about the gendered body.

Grosz (1994), who suggests that lived experiences and perceptions can provide a basis for approaching and articulating the mind-body and subject-object problematic, argues that embodied subjectivity can be approached by the subject-perceiver intertwined with the subject's corporeality. The focus on the perceiving subject as a corporeal subject provides the possibility to approach embodied

subjectivity through an existential ground (Grosz 1994). Butler (1990, 1993) focuses on how gender, sexual practice, and desire become arranged, and argues that it is through the “heterosexual matrix” framework that gender intelligibility naturalizes bodies, genders, and desires. Thus, the concept of gendered embodiment demarcates a discursive domain, while the female embodiment addresses to existential domain of lived experiences in which my research focuses on Kariri-Shoco female embodied subjectivity.

In order to describe cultural knowledge and cultural symbols about Kariri-Shoco female embodiment, ethnographic interviews and domain analyses are described focusing upon ethnophysiology and reproductive processes as cultural domains.⁸⁶ Ethnophysiology and reproductive processes are arbitrarily considered cultural domains. Spradley’s (1979) ethnographic interview method was used, searching directly for cultural knowledge associated with these domains, to explore female embodiment as a cultural theme.⁸⁷ This procedure helped to guide the research to in-depth data collection about symbolic categories within those domains. In order to control the consequences of my arbitrary identification of ethnophysiology and reproductive processes as cultural domains, I made an effort to be reflexive and interpret data from my subjective understandings and analysis.

⁸⁶ Spradley (1979) considers “domains” “any symbolic category that includes other categories.” The discovery of domains is done by identifying the existence of “similarities among folk terms” (Spradley 1979, 100), which should be investigated and associated with symbolic categories.

⁸⁷ Spradley (1979) defines cultural theme as “any *cognitive principle, tacit or explicit, recurrent in a number of domains and serving as a relationship among subsystems of cultural meaning*” (Spradley 1979, 186).

I first describe how Kariri-Shoco shamanic specialists perceive and experience female embodiment. In the following chapter, the focus is on how it is experienced as lived experiences by Kariri-Shoco reproductive women. I discuss here how Kariri-Shoco shamans' knowledge of the body relates to perceptions of sexual difference, and detailed descriptions of Kariri-Shoco shamans' concepts of gendered embodiment related to their own cure-healing practices and knowledge of the body are provided.

7.1. Kariri-Shoco Shamanic Specialists Knowledge of the Body: Experiences and Perceptions of Gendered Embodiment

Here, I draw attention to Kariri-Shoco concepts of the body and point out how these are intertwined with cure-healing shamanic practices and sexual differences. Then, I explain how female corporeality and bodily fluids, particularly from menstrual blood, are intertwined with these concepts of the body and physiological reproductive processes, including concepts of how women conceive.

I consider that physiological reproductive processes, particularly birth control, use of *aborto* (abortion or miscarriage), and sexual practices and desire, are sensitive and difficult areas to research because they imply legal, moral, and ethical issues. The descriptions are mainly based on two shamanic specialists, Dona Maria Velha and Frederico, with whom ethnographic interviews were conducted about ethnophysiology and reproductive processes.

I wanted to discover if there was any difference in the power in cure-healing practices between a male and a female shaman. As Dona Marieta was considered a powerful *rezadeira* and her son Candara, also, a powerful *rezador* and *curandeiro* shaman among the Kariri-Shoco, I asked them about who was the strongest one

between them. Dona Marieta explained that her son is “stronger” (“*mais forte*”) than her “because he is a man.” She considered, like several Kariri-Shoco shamans that I have interviewed, that the man has a stronger body and Kariri-Shoco male shamans always have a body strong enough to perform cure-healing practices. On the other hand, Candara told me that his mother was a stronger rezadeira shaman than himself. Candara explained that the reason why Dona Marieta was “stronger” was that she had been a widow for over fifty years and since then she had no man. He also added: “She has not menstruated anymore for a long time.” He continued telling me with a smile on his face, that although he was already seventy-two years old, he was still “strong enough to perform [his] duties as a man” (“*forte o suficiente para cumprir [suas] obrigações de homem*”) that he and his wife still have sexual intercourse, and “of course this interferes” with his ability to cure-heal.

Although I was aware that ethnographic interviews are guided by the use of both questions and answers discovered from informants,⁸⁸ I realized that questions I made when conducting first ethnographic interviews with shamanic specialists to discover whom they considered stronger between male or female shamans reflected my interest in gender asymmetry or inequality. I realize, as I describe in this section, that Kariri-Shoco perceptions on gender issues often regard how male and female bodies have “*força*” (strength) according to certain properties of the body. For example, the conception that menstrual blood makes the female body weaker for female shamanic practices reflects a characteristic of the female body’s ‘openness’ that female shamanic specialists experience while menstruating. Thus, I discovered

⁸⁸ See Appendix C for detailed explanation on how ethnographic interviews were formulated by descriptive, structural, verification, etc. questions.

that although both Kariri-Shoco men and women consider men stronger than women, this perception is linked to their conception of bodily processes in which male and female bodies differ. This perception is reflected in how female shamans might become *rezadeiras*, while male shamans might become *curandeiros*, who are those able to deal with more dangerous health problems.

From Candara's point of view, his mother was "*mais forte*" ("stronger") than him, considering the long time that she had been without having sexual intercourse and without menstruating. I confirmed, then, why Dona Marieta had the opinion that male shamans are stronger than female. Among the Kariri-Shoco, sexual differences between the male and female body are demarcated through bodily processes, from which female bodily fluids related to the menstrual cycle and post-delivery bodily processes, interfere with shamanic specialists' ability for cure-healing.

Kariri-Shoco concepts and knowledge of the body imply understandings that the body can be "*aberto*" ("opened") or "*fechado*" ("closed"). When women are in menses (also after delivery), and for both men and women after sexual intercourse, or after drinking alcoholic beverages, the body becomes "*aberto*." The "*corpo aberto*" ("opened body") is more susceptible to catch diseases-illnesses, vulnerable, "not strong enough" for cure-healing and Ouricuri ritual practices. That is the reason why sexual intercourse practices and alcoholic beverages are forbidden for three days before Ouricuri rituals. It is necessary to wait at least three days after those practices, including after menstruation, for the body to become "closed" again.

The number three represents a perfect timing for 'closedness' of the body, when the body closes three days after sexual intercourse, menstruation, and alcoholic

beverage drinking. Several medicinal plant treatments are also completed during three days. Quite a few reproductive women interviewed experienced, when they menstruated for the first time, a treatment done with the ingestion of three seeds, in order to have menstruation for three days, which is considered the perfect duration. Several of them told me that it worked, as they explained they had their period during only three days every month.

Since menstruation is considered something natural, a menstruating woman can go to Ouricuri rituals, although female shamanic specialists do not participate in shamanic practices while menstruating. On the other hand, sexual intercourse is considered a practice realized by people's will, and thus, it could be avoided. The ones who do not respect those rules, avoiding drinking alcoholic beverages and sexual intercourse for at least three days before Ouricuri rituals, are susceptible to a great danger when a "punishment" from the shamanistic realm may reach the person or the ones close to the person (like family members). One shamanic specialist selected as a case study described his experience when he had sexual intercourse less than three days before an Ouricuri ritual. He told me that he was very sick for more than six months and almost died. He explained that he was "*exemplado*" ("exemplified") and "*punido*" ("punished") by his religion.

During an interview with Dona Chiquinha and her rezadeira shaman granddaughter, Dulcilene, I asked them a descriptive question about whether women could perform cure-healing practices like men. Both affirmed that "women can," but Dona Chiquinha explained:

"It depends on a woman's age. Because a woman arrives at that age that stops menstruating... then there is no more impediment [*imparo*], she is sure, she is

always sure for a reza [ritual], for a cure. But in the case when she is young, when she is *regrando* [ruling, which she means monthly menstruating], not all the time she is secure for reza [ritual performance].”

The word rule, which in Portuguese is *regra*, is a cover term for menstruation. The way Dona Chiquinha uses this term as a verb demonstrates a semantic relationship between menstruation and associated ideas that menstruation is a rule since it happens monthly. This idea of menstruation as a rule also reflects a perception that menstruation is part of woman’s fate, exemplified in Baioca’s discourse when she speaks about menstruation during an ethnographic interview that I describe below.

Thus, post-menopausal female shamanic specialists are considered more powerful than younger female ones, since they have, according to Dona Chiquinha, “no more impediment” for cure-healing shamanic ritual practices. Dulcilene told me that when a woman is menstruating it is “dangerous” for her. The “cure can only be done when the person’s body is *fiche* [strong].” Dulcilene also explained:

“Menstruation is something allowed by God, it is something natural, but we cannot make a cure [reza ritual] because we have to face it having strength [*força*]; because several things in that reza [ritual] can come out. Because in that reza, in everything that is being prayed, a spirit can arrive and come down [*baixar*], then I have to face [*enfrentar*] it.”

Shamanic specialists often use the word *força* as reference to the power they have during cure-healing rituals. It is with their strength that they face evil during cure-healing rituals. This word – *força* - is also used when shamanic specialists refer to how remedies are prescribed to those who have sexual problems, in order for them to have more strength in producing male or female sexual body fluids.

According to Dulcilene, cure-healing practices are particularly dangerous for a menstruating shamanic specialist because the body is not strong enough to “face” evil spirits, who may be causing the patient’s health problem. The menstrual blood provides vulnerability to the female shamanic specialist’s body for cure-healing practices.

Like Dona Marieta, Dona Zezinha is another example of a Kariri-Shoco female shaman who decided not to establish a conjugal relationship and became single as a shamanic specialist. After she separated from her second husband, when she was forty-three years old, Dona Zezinha explained that she had several men who were interested in her, but her Ouricuri was enough for her “fulfillment.” I asked Dona Zezinha if she thought that male shamans were stronger than female among the Kariri-Shoco, she answered:

“Women here are as strong as men. Women sometimes have more strength than many men because men drink, sometimes because they have two women and they have to satisfy one and the other, a man like that is not prepared all the time.”

Dona Zezinha also explained how all Kariri-Shoco elderly women who are “Avós” have been “*fortes*” (“strong”), and also that they are those who “provide a lot of protection” (“*dão muita proteção*”) to Kariri-Shoco people through their “obligations” related to the Ouricuri ritual. In this explanation, Dona Zezinha touched on two issues that I had already observed among the Kariri-Shoco. Men usually drink alcoholic beverages (there are several cases of alcoholism among them), and practice infidelity. Consequently men have their bodies opened alcohol and from sexual intercourse practices.

I asked Baioca about who are stronger male or female shamans and she commented on her role as a powerful Kariri-Shoco shamanic specialist:

“In my case, I am strong and prepared for everything. I confront evil things; I have how to care to defend myself... there are persons strong and others weak. Because I have this gift given by God, I was born for that, therefore I have to search to see what is happening, to see, and to defend, through the body, soul and spirit.”

Baioca’s explanation is an example of how menstrual blood is perceived as something that cleans the female body, which shows how it is related to women’s health. She also speaks about sexual intercourse practices:

“Menstruation is from nature, cleans our body. Because it is from nature, we were already born with this *sina* [fate]. We have our way. What is important for God is the heart. In the case of us Indians, we have our ritual, which is a manner to adore God and God’s persons [spiritual beings]. Then if we are not menstruating, and not kissing the husband [having sexual intercourse], our body is stronger, it is clean and we are not afraid of any vision. And we being menstruated or kissing the husband, we love God in the same way although being weaker. In my case, I consider myself the Mãe of this people; I can only put my hand on fire [conduct shamanic practices] if I am not menstruating and if I have not been with my husband. The body is pure and clean, it is stronger, and I don’t fear any vision. I am more prepared.”

The concept of the ‘openness’ and ‘closedness’ of the body is also intertwined with how menstruation and conception are perceived and associated as being part of same domain of cultural knowledge. This was discovered through several Kariri-Shoco reproductive women’s discourses, after asking them verification questions about when during the month that they could easily become pregnant. As a shamanic specialist, Dona Maria Velha explained:

“She [menstruation] goes away [finishes] but the womb’s mouth stays opened. The blood stays going away, then three days and a night after this, the man goes [has sexual intercourse], then it [male bodily fluids] goes rightly because she [the woman] is opened, and her liquid [female sexual bodily fluids] also helps.”

The Kariri-Shoco idea that menstruating women have their body “opened” is empirically related to their perceptions that when there is menstrual blood fluxes the “womb’s mouth” is opened and continues open for at least three days after menstruation is over. Several interviews revealed this perception as I provide examples below.

Frederico explained that after menopause the woman becomes “colder, but there are those who become more *fogosa* [excited]” for sexual practices. Frederico told me those changes occur, “because her ovary closes, because before [menopause] she was *despachando* [delivering menstrual blood] every month.”⁸⁹ Then, Frederico mentioned that “after menopause the woman becomes dry” (“*depois da menopausa a mulher fica seca*”) because she is “closed.” Thus, female menstrual bodily fluids and processes are intimately intertwined with the female body’s ‘openness’ and sexual desire.

It is widely perceived that women may avoid having the “sensation” (“sensation,” meaning orgasm or sexual pleasure) before man during sexual intercourse, in order to prevent pregnancy.⁹⁰ Frederico explained:

“Although there are women who search to have more sensation for her hormones stay younger, many women are more resistant to have the sensation,

⁸⁹ Frederico uses the word *despachando* (the verb is *despachar*) in a peculiar way. I have translated *despachando* as delivering, which he uses to refer to menstrual cycle blood fluxes. This verb is often used to refer to the act of delivering, which for Kariri-Shoco women happens when the placenta comes out after they deliver the baby. I discuss this perception of delivery when I describe reproductive women experiences. The context in which Frederico uses the verb *despachar* illustrates it as cover term associated with menstrual cycle blood fluxes and also with delivery, as something that comes out of women’s bodies (whether menstrual blood, fetus, or placenta) related to reproductive processes.

⁹⁰ Kariri-Shoco reproductive women in this study often explained that three or four days after menstruation women are more susceptible to conceive, and that female sexual pleasure, related to sexual intercourse, also contributes to women’s conception.

and therefore they don't get pregnant because the semen cannot be sustained [inside her body].”

According to Federico, Dona Maria Velha, and other shamanic specialists, both female and male bodily fluids during sexual intercourse provide the possibility for female conception. I understood that it is female openness associated with wetness (from male and female bodily fluids during sexual intercourse) that makes the woman become pregnant. That is why after female and male menopause (as I explain below), when both men and women become dry by not having sexual bodily fluids, which for women also include lack of menstrual cycle, that both male and female bodies are disabled for fertility and also disabled for sexual practices.

When I asked a structural verification question to a female shamanic specialist about whether it was more difficult for men or women to have sexual pleasure, she told me that “the woman is receiving that liquid going up [male bodily fluids] and coming down [female bodily fluids], she is the one who has to feel more pleasure than he; it is more difficult for men than for women.” She continued: “Because she is receiving it [male bodily fluids], the woman has the possibility to *gozar* [to have orgasm] faster than him.”⁹¹ Then, after I asked her if it was her own experience, she answered affirmatively, “For sure” (“*Com certeza*”). This same shamanic specialist explained with more details how men and women experience sexual intercourse and its risk for conception:

“There are men that *coisa* [thing, ejaculates] first and quickly [she referred to premature ejaculation]. When he is there agitating himself to enjoy, she has also to agitate herself to accompany him. Several women don't *se agita*

⁹¹ This female shamanic specialist's perception illustrates how female and male sexual bodily fluids are associated with sexual pleasure. Other shamanic specialists, like Federico as I describe below.

[agitate herself] together with him because, when this happens, the child stays at that right time [of the orgasm]. The [male bodily] liquids go up through her vagina and then it goes to her belly and the child is generated. And if he is the first and she is the last [to have orgasm], there is no problem, they can do what they want and the child won't stay. For her to get a pregnancy it is necessary that she feel pleasure, so the son [child] comes."

Frederico also shared this view that it is easier for women than for men to have sexual pleasure, although when I asked him if more men or women were his patients, he said that mostly women searched for his help. Frederico explained that most of women's problems relate to the relationships they have with boyfriends, husbands or partners. Regarding sexual problems, he said that both women and men had problems because "they can get dry" ("*eles podem secar*"). He said that he knows "remedies that can generate more [female or male bodily fluids]" and that "man's força comes from the mind, while woman's goes up to the head" ("*a força do homem vem da mente, enquanto que a da mulher vai para a cabeça*"). Frederico's explanation relates to his perception that it is more difficult for men to perform sexual practices because "the man has to prepare himself [to have erection], while the woman is always already prepared" ("*o homem tem de se preparar, enquanto que a mulher já está sempre preparada*").

In this ethnographic interview, Frederico uses the word "força" as an included term from the ethnophysiological domain to explain the capability or strength of male and female bodies for sexual intercourse and pleasure. I understand that Frederico states that "woman's força goes up to the head," because a woman is able to control her sexual pleasure and she may use this ability during sexual intercourse in order to avoid pregnancy.

Then, Frederico spoke about how he treats men and women who have sexual problems, and explained that men's problems are associated with "the nerves" ("os nervos") and women's to "hormones" ("hormônios").

"The man who has finished [bodily fluids] is a depleted man [*homem acabado*]. Those older than seventy years search me and I apply a remedy for him to return [male bodily fluids] and to get more strength [*força*] and strengthen [*fortalecer*] the nerves. For the woman, it is to strengthen the hormones."

The concept that Frederico uses of "nerves" is an included term associated to his concept of another included term, "mind," which is responsible for men's *força* in the ethnophysiological domain. I consider "nerves" as an included term for "mind" or "head" based on domain analysis, according to which other Kariri-Shoco shamanic specialists also use those words. I consider his use of the term "hormones" as an included term associated with women's *força* in the ethnophysiological domain, which stands for female's bodily fluid production. Dona Maria Velha refers to "woman's liquids" ("*líquido da mulher*") during an ethnographic interview described in this chapter. I understood that Frederico's concept of "hormones" relates to his perception that "hormones" are associated with women's bodily fluid production, which includes sexual bodily fluids and menstrual blood. His perception of the "nerves" that relates to men's bodily fluid production is linked to the idea of "to be prepared," which is necessary for male sexual practices. Those perceptions are associated to sexual differences that are implicit in how male and female bodies differ, which are also implicit in Kariri-Shoco ideas of how male and female bodies are formed.

What I often found in discourses related to bodily sexual differences was the use of the word “força” (“strength”), rather than comparisons or statements on which is the strongest between male and female bodies. I recorded data among shamanic specialists, a midwife, and several reproductive women who experienced pregnancy loss about how it is possible to distinguish if an embryo is male or female after an *aborto*/miscarriage. Shamanic specialists, the midwife, and reproductive women explain that, when a woman has an *aborto*/miscarriage, if it happens close or after the third month when the fetus is already formed, one can see the sexual difference. When it happens before that, it is also easy to distinguish because the female embryo is a “ball of blood” (“*bola de sangue*”), “like an egg of blood” (“*como um ovo de sangue*”), while, when it is a male embryo, it is “like a snake” (“*como uma cobra*”), “a thing of flesh” (“*uma coisa de carne*”), “like a tiny lizard” (“*como uma víbora pequena*”). I recorded several explanations that reveal this conception about the embryo’s sexual difference. This perception is based on reproductive women’s empirical observations of embryos, whenever they experience a pregnancy loss and discover if it is male or female.⁹² According to descriptions, the female embryo is formed by blood, and has a liquid consistency, while the male is formed by flesh. Thus, making domain analysis about ethnophysiological included terms, I associate those explanations on differences of female and male embryos with Frederico’s perceptions on “nerves” (male/flesh) and “hormones” (female/liquids), which he

⁹² I recorded data from descriptive questions during ethnographic interviews about interviewees’ experiences with *aborto*/miscarriage by asking them about the embryo or fetus gender and how it could be identified.

mentions as responsible for body fluid production and which characterize sexual difference.

I was surprised with the perception on how women are “already prepared” for sexual practices. I understand this relates to the fact that men have to have erections (to “be prepared,” to “get ready”) in order to perform sexual practices, while women “are always already ready.” In my point of view, this relates to what I had often heard from reproductive women: they have to “serve” their husbands whenever they want to have sexual intercourse, even if the women lack desire. It also relates to the way female corporeality is perceived, in which it is not necessary for a body change (like the male’s erection) to perform sexual practices.

Dona Maria Velha gave details about male sexual problems:

“It happens because man has problems when he becomes weaker and cannot raise it up [to have erection] and he is not anymore the man he used to be. I know how to make remedies for young ones who have this problem, but for old ones I don’t have remedy. To old ones it is more difficult because he is already on weakness.⁹³ Is he going to raise it up [to have erection] to go where? He has to be quiet. But the younger one has to take remedy to become stronger and to become again the man he used to be, to be man.”

Frederico was the only shamanic specialist who spoke about “male menopause,” which he defined as “the problem that it is more difficult for a young man to have and it happens usually to a man at the age of seventy years, when he gets dry.” Thus, it is clear that male and female bodily fluids (including menstrual blood fluxes) are fundamentally perceived as linked to conception and sexual practices and

⁹³ The context in which D. Maria Velha uses the word weakness (*fraqueza*) shows how the male aged body is perceived as weak. I believe that in the Kariri-Shoco cultural context, while women become stronger with the age, particularly after menopause, men become weaker as they become old. I do not have sufficient data to confirm this observation.

desires of males and females. It is very interesting how female sexual pleasure (related to orgasm) is considered directly accountable for conception, particularly if it happens before the male's orgasm. I consider this perception of female sexual pleasure associated with conception evidence of how gendered embodiment among the Kariri-Shoco, which is constructed within a "heterosexual matrix" (Butler 1990, 151), follows biological sex. This perception is also expressed in other discourses.

A female shaman said that she made the "experience" (*“experiência”*) of avoiding sexual pleasure before her husband. She mentioned that it "worked" (*“funcionou”*), although when she first got married she did not have any experience of it and she had several children. Then she explained:

“Nobody used to explain [about sexuality]. Then I started to learn how to live. I still delivered a lot [several children]; during my whole life I was afraid to take pills, because I would have to go on surgery to take out [from the belly] a bag full of them. I used to say: ‘Oh my God, am I the excited one?’ I talked to my relatives, and they told me: ‘Don’t have pleasure!’ Then I decided, I am not going to sleep before him [as she explained that she would not have orgasm before him]!”

This female shaman is a middle-aged woman. Her opinion on biomedical contraception relates to how women from her generation perceive birth control pills as something that accumulates inside a woman's belly and that are dangerous for women's health. As I approached contraceptive methods that Kariri-Shoco reproductive women use, I found out that this perception has changed, since there are several younger women who were using (or had used) birth control pills.

An elderly shamanic specialist also told me, based on her own experience, that whenever she had pleasure during sexual intercourse she became pregnant. She explained that she had twelve children (she got married when she was fourteen years

old) and that she had never been “a woman with too much pleasure” during sexual intercourse, but every time she had pleasure she “caught a pregnancy” (became pregnant).

About conception, which relates to the post-menstruation body and female sexual pleasure, Frederico explained:

“About pregnancy, sometimes the woman gets pregnant and doesn’t know [that she conceived]. When they [man and woman] are having sexual intercourse, she is getting pleasure and then she finds the man who finds her ovary open. When the woman menstruates, she is opened and on the day that she has sexual relation [after menstruation is over] then the liquid from the man gets sustained and strength [inside her body]. Then there is the risk to get pregnancy. It is very difficult to have sexual intercourse when the woman is menstruating.”

It is widely conceived among the Kariri-Shoco that sexual intercourse must be avoided when a woman is menstruating. Candara explained about several diseases-illnesses that a man could catch if he has sexual intercourse during the time a woman is menstruating. After delivery, one of the most important health care issues related to *resguardo* is that sexual intercourse has to be avoided for at least thirty days.⁹⁴

I interviewed a Kariri-Shoco shamanic specialist who told me that she had sexual intercourse when she was menstruating. She said that her menstrual blood kept “coming down” (“*descendo*”) and “coming up” (“*subindo*”), alternatively, during sixteen days after she had sexual intercourse when she was menstruating. She explained that she drank a remedy, made with a mushroom called “wood’s ear” (“*orelha de pau*”), which is used to interrupt menstruation by “making the blood come up.” She told me that this remedy “worked” (“*funcionou*”) and that she

⁹⁴ It is very widespread among different indigenous peoples in Brazil that sexual intercourse is prohibited after delivery (Fausto 2001; McCallum 2001; Seeger 1981; Viveiros de Castro 1986).

discovered, not long after her “blood came up” (“*o sangue subiu,*” stopped menstruation), that she was pregnant. She explained her experience to tell me how during menstruation the female body is opened, when it is possible to “catch a pregnancy.” Thus, Kariri-Shoco women associate and experience the female body’s openness with the risk of conception.⁹⁵

Once, I was at Dona Maria Velha’s home when her relative (a thirty-six year old single woman) came to ask for her help. Dona Maria Velha’s relative explained that her menstruation was not “going away” (“*indo embora*”), that she had had a menstrual hemorrhage for more than ten days. Dona Maria Velha told her relative to find “wood ear,” which grows on wooden fences, and suggested that she make a strong tea for drinking as a remedy. After several days, I visited Dona Maria Velha’s relative to find out if she was well and if the remedy had been effective. This woman told me that she only drank the “tea” remedy twice for stopping menstruating, and that she was relieved and well.

Talking to Dona Maria Velha about this remedy, with which I was impressed for having this effect of stopping menstrual blood fluxes (including hemorrhage), she

⁹⁵ Leal (1995, 1997) conducted an important study on working class women in southern Brazil where they conceive that fertility either overlaps or coincides with the menstrual period. It is through understanding the “logic behind the social representation of the body, of bodily fluids and of conception” (Leal 1997, 157) that Leal (1997) articulates their choices and use of contraceptive methods. Leal (1997) argues that instead of ignorance of reproductive and contraceptive practices, in the context of “massively broadcast” information about contraception, these women subordinate the medical advice on reproduction to “an essentially feminine domain” (Leal 1997, 158), in which a “cultural model of the body specific to the working class” is produced (Leal 1997, 158). This situation where menstrual blood symbolizes fertility for women has also been ethnographically registered in other studies in southern Brazil (see Victoria 1995, 1997), including among another indigenous group, the Pataxó HãHãHãe, in Northeast Brazil (Souza 2002).

explained that sometimes women who are menstruating also take it before going to Ouricuri rituals. Dona Maria Velha explained that since in the Ouricuri village everybody stays together, when relatives gather in small houses, a menstruating woman does not feel comfort when she has to be concerned with her menstrual blood. Thus, this is the reason why some women prefer to take this remedy before they go to Ouricuri rituals.

I describe data in the next chapter that show how reproductive women use indigenous contraceptives to regulate their menstrual cycle when they take “bush remedies” to induce menstruation. I have no doubt about the effectiveness of those Kariri-Shoco remedies for menstrual bodily fluxes, when women have the control for making menstruation stop (by “making the blood come up”) or inducing menstruation (by “making the blood come down”). This data reflects how Kariri-Shoco women have the ability, through indigenous medical knowledge, to control their menstrual bodily fluxes and their fertility. This control demonstrates how they exercise power over their own bodily processes, which also include decisions they take regarding female orgasm and/or sexual pleasure during sexual intercourse. This is the reason why I interpreted Frederico’s statement, which I have already discussed, that woman’s strength “goes up to the head” to be associated with the power that woman have over their own bodily processes, sexual pleasure and desire, and fertility.

I asked Dona Maria Velha descriptive questions about female ethnophysiology. She helped me to understand data that I was finding while researching Kariri-Shoco reproductive women. She explained how the female body differs from the male, when she described different parts of the female body:

“We call *orvalho* [ovary] which is close to the appendix. The *ultra* [womb] and two *langas* [glands, I understood she mentioned the fallopian tubes] and the owner of the body, who receives all man’s *ceboseira* [filthiness; she referred to male body fluids] and that [the owner of the body] makes the menstruation.”⁹⁶

Then, Dona Maria Velha explained about this emic organ called “the owner of the body,” which is part of the female reproductive body. It is responsible for the menstrual cycle and also generates the fetus and feeds it by “making blood.”

“She [dona do corpo] is who makes the child to be generated when they couple [*pareia*; she refers to male bodily fluids’ encounter with the dona do corpo], it is for sure her [the dona do corpo]. The child is generated with her [the dona do corpo]. The dona do corpo stays making blood to feed the child. When the child is born she stays searching, moving, in the same way like the child. She forms like a child’s head inside the woman’s belly.”

A female shamanic specialist told me about her own experience, when a medical doctor thought that she had another child inside her belly after she delivered a baby in the hospital. This female shamanic specialist explained to me:

“Doctor Mucio asked me if I had relatives who had twins. It was not another child; it was she [the dona do corpo] forming that cake [*bolo*] of blood. And he [the medical doctor] tried, tried [as he was making a curettage], and he only found those cakes of blood [*bolos de sangue*]. While he didn’t take out those cakes of blood, the pain didn’t go away.”⁹⁷

⁹⁶ The words *orvalho* (ovary), *ultra* (womb) and *langas* are colloquial included terms that Dona Maria Velha uses to speak about parts of the female reproductive body domain. Thus, I did not translate literally and considered the colloquial use of those words for translation.

⁹⁷ This shamanic specialist told me that she suffered considerably because the doctor’s hand was too big, and he searched to find out if she had another fetus inside her belly. I understood from her description, and from the obstetric suspicions of another fetus, that he made curettage on her.

When I asked a verification question to this shamanic specialist, if this situation was dangerous, since the medical doctor could make the “dona do corpo” come out of her body, she explained:

“She doesn’t come out, if she does she dies! She is blood, Silvia; the woman dies [if she comes out]. She makes a sound *bauummm*, a snoring on the hips; it is her that is alive. Sometimes, when she snores like that, you go and defecate as the person is with diarrhea;⁹⁸ or when she is in the stomach you can vomit blood. She is like a snake that has a tail and walks [inside the body]. She walks, she goes to the rectum, she goes to the hips, she goes to the belly bottom, and she goes to the stomach.”⁹⁹

Dona Maria Velha told me about how she performs reza rituals using the *ramo* (bunch of leaves), but she also described another kind of reza ritual when she puts her right toe on the woman where the woman feels the pain caused by the “dona do corpo.” Dona Maria Velha and I had the following conversation when she described the reza ritual and more details about the “dona do corpo.”

“[D. Ma. Velha:] When [the woman] goes to the rezador [or rezadeira shaman], the rezador [or rezadeira shaman] prays on the dona do corpo.”

“[I asked:] Do you know how to pray on her?”

“[D. Ma. Velha:] I know. Sometimes I pray using the *ramo* [bunch of leaves], but sometimes I make another reza [ritual]: I put this toe on the woman’s belly with the right foot, where the woman feels the pain. Then I make the Cross-sign with the foot to make the pain go away, I put the foot and with the words I say:

...If it is my filthy *comade* [term used between godmother and godchild’s mother, as a fictive kin],

I cut your head and I cut your tail!

Search for your place!”

“[I said:] It is like a threat you make for her to back off.”

“[D. Ma. Velha:] Yes, it is like this, for her to back off. Then I continue.

... if it is my filthy *comade*,

Make an arc [to move as an arrow] pain and search for your place!

...Make arc blood, and run inside the body,

⁹⁸ I describe, in the next chapter, a case study (Ann), who experienced diarrhea, when she felt the “dona do corpo.”

⁹⁹ This female shamanic specialist told me about a woman she knew who died vomiting blood caused by the “dona do corpo.”

...Make arc pain of blood, climb up and search for your veins!
 ...Because if it is from blood, if it is my filthy comade “

Dona Maria Velha told me that the pain is the “dona do corpo,” then she continued to tell me the reza ritual:

“I cut your head and cut your tail!
 I lock you up with the words and chains with blessed... strings!
 I tie you up, and lock you
 ...I tie you up with the saint water and words and saint blessed strings!
 I tie you up!”

Dona Maria Velha explains that she uses a string to tie around the woman’s waist. I found that this reza ritual has analogous procedures to the one for “open arcs,” described in the previous chapter, when a knot is made with the use of a white string (not a white cloth, like in the one for open arcs) on the person’s body to make the “dona do corpo” go back to her place (while for open arcs, the objective is also to make the breast get back to its place). Dona Maria Velha explains how she finishes this reza ritual for the “dona do corpo” when she makes a knot in a string that she uses during the ritual:

“[D. Ma. Velha:] Then I go with the string, tying it up until it gets on the woman’s waist.”
 “[I asked:] Do you tie the string around the person?”
 “[D. Ma. Velha:] I tie it up [the string] through words and I use the string on the person to make a knot. I make that knot on the woman’s waist and when I make that knot, she [dona do corpo] runs away.”

Dona Maria Velha’s explanation reveals how words during the reza ritual have the power to direct manipulation of the body. The words used in this reza ritual literally tie the “dona do corpo” making her goes back to her place. Then, as we continued our conversation, Dona Maria Velha told how the use of a man’s pants or belt can also make the “dona do corpo” go back to her place. Dona Maria Velha

explained, “She is like a woman” (“*Ela é como uma mulher*”) and “made of blood” (“*feita de sangue*”):

“[D. Ma. Velha:] And if she is threatening in the rectum, the woman can take and fold a man’s pants to sit on it, because the *dona do corpo* doesn’t like man. A woman can also put a man’s belt around her belly when she feels belly pain caused by the *dona do corpo* and it works too.”

“[I asked:] Why doesn’t she like man, Dona Maria?”

“[D. Ma. Velha:] It is because the pants and belt belong to a man. And she is like a woman. The use of pants and belt are to make her [the *dona do corpo*] go to her place.”

“[I said:] I didn’t understand, she is like a woman?”

“[D. Ma. Velha:] I’m making a comparison, she is like a woman, like a species of person. For example, if I am suffering and it is she, if it is the pain of blood that the newborn came out, she keeps moving inside, because she is alive. Then the cure [reza ritual] has to be done. It has to be given a remedy that she doesn’t like for her to go away from there [because she is displaced].”

From Dona Maria Velha’s explanation the “*dona do corpo*” can be considered with the meaning sense as the “*Dona do corpo*” as the “Mistress of the body” or like Dona Maria Velha literally has explained, “she is like a woman [*ela é como uma mulher*], like a species of person [*uma espécie de pessoa*]).”

Then I decided to make a structural verification question using the information that Dona Maria Velha had given me when she mentioned, the “*Dona do corpo* ... doesn’t like man... she is like a woman.” Thus, I asked her:

“[I said:] But I still don’t understand why she doesn’t like man. Don’t women like man?”

“[D. Ma. Velha:] Yes, they do. I say like that because she [the *Dona do corpo*] is made of blood. The man doesn’t have blood to provoke pain on his belly! And the woman is the one who receives it [blood], I mean the woman’s womb is opened to receive the man to *transar* [have sexual intercourse] and the womb has to open to make the newborn be delivered, the newborn is generated by the blood, by the veins, the blood is what is going to feed and generate the child, and it is generated with her [the *Dona do corpo*], do you understand? That is like this.”

I understand from Dona Maria Velha's explanation that since blood (which includes the Dona do corpo as a female organ) characterizes the female's body, the use of male's objects like pants and belt (which men use on the abdomen) work as a tool to make the Dona do corpo go back to her place and stop the pain that she provokes. Frederico mentions the use of a man's belt to control "dor de mulher" ("woman's pain"), which I describe below.

During an ethnographic interview, I asked a descriptive question to Frederico about the Dona do corpo and dor de mulher. He gave me the following explanation:

"The Dona do corpo is part of the ovary. When the woman has the bladder lower, she [the Dona do corpo] can come out. I met an old woman here who needed to go to the doctor to suspend the bladder. I know how to pray on the Dona do corpo. I take two small white rocks and pray Hail Queen. It is necessary a reza [ritual] because it makes the spiritual and material cure. Dor de mulher is generated during pregnancy, when the pain is too strong she [the woman] can take a man's belt and put it on her waist, then it will hold the pain. The Dona do corpo provokes pains and makes a cake like a worm [inside the woman's belly]. She [the Dona do corpo] stays after delivery hunting [searching] for the child that she [the Dona do corpo] generates. But dor de mulher comes from the family [congenital] to have it or not.¹⁰⁰ There are women that do not take care of themselves then the dor de mulher is created [*criada*].¹⁰¹"

Frederico's explanation is similar to Pajé Júlio's perspective, which I have mentioned in the previous chapter. Thus, Dona do corpo as a health problem is a congenital and contagious kind of gendered pain, dor de mulher.

¹⁰⁰ I describe ethnographic data that confirms this notion that "woman's pain" is congenital. In the section where I describe reproductive women's case studies, I mention what Ema explains to me why she does not have "woman's pain" related to the "Dona do corpo." She told me that never caught it from another woman who has "dor de mulher." Thus, dor de mulher is considered contagious and also congenital.

¹⁰¹ Kariri-Shoco reproductive women regularly make use of gynecological preventive treatments using "bush" remedies, which they often explain they are using to keep healthy. From Frederico's explanation, those preventive treatments are associated with health care connected to dor de mulher and/or to the Dona do corpo.

I base my analysis here on Frederico and Dona Maria Velha's discourses. I understood from Dona Maria Velha's explanation that the Dona do corpo is conceived "like a woman... a species of person" because she is something "alive" inside the female body and "she is made of blood." Male's body is not characterized by blood, as Frederico uses the word "hormones" as responsible for female bodily fluids production.¹⁰² The "nerves" and "flesh" characterize male's embryos. This perception of sexual difference between male and female embryos, from which the male's body is widely conceived as stronger than the female, is reflected in embodied ethnophysiological concepts and logic. The use of a man's belt to make a Dona do corpo go back to her place (as Dona Maria Velha explained) or to make dor de mulher stop (mentioned by Frederico) shows how a male object can serve as a powerful tool on a female ethnophysiological organ (Dona do corpo) and symptoms (dor de mulher).

The Dona do corpo characterizes sexual difference during sexual intercourse, when she receives male sexual bodily fluids, and consequently she has fundamental roles: for conception (when she "generates" the child), pregnancy (when she "feeds" the fetus), menstrual cycle (when she is responsible for menstruation), delivery (when she "provokes pain") and post-delivery symptoms (when she "searches" for the fetus and "walks" inside the woman's belly provoking pain). Those are situations

¹⁰² During another ethnographic interview (which I describe in subsection 6.3.1), Dona Maria Velha clearly stated that a man does not have menopause because "he doesn't have blood in his belly to provoke pain!" It was from analysis of included terms, such as "blood," mentioned by Dona Maria Velha, and "hormones," mentioned by Frederico, that I discovered that blood and female bodily liquids ("hormones"), have a semantic relationship through analogy. Still, my analysis is based on my interpretation because I have not realized an extensive taxonomic and componential analysis following Spradley's (1979) method.

(menstruation, sexual intercourse and [post-]delivery), when there is a transgression of the female body's 'openness'. Since the Dona do corpo has the role of receiving male sexual bodily fluids and generates the child, she is the one responsible for conception from a male's intrusiveness into a female's body during sexual intercourse. That is the reason why the Dona do corpo does not like man. This is my interpretation of why the Dona do corpo is "like a woman" and why "she doesn't like man," based on Dona Maria Velha's perception and explanation, using also Frederico's perceptions of the female body.

Among the Kariri-Shoco, ethnographic data show how differences between the female and male body are based on their perceptions in domains related to corporeality and bodily processes, which include physiological reproductive processes. From my observations and from ethnographic data collected, I understand that although there is a wide perception among the Kariri-Shoco that the male body is stronger than the female, women have demonstrated a great power over their own bodies. Although the cultural context is male dominant, when patriarchal conjugal relationships are established among men and women, I found evidence, like the decisions Dona Marieta and Dona Zezinha have taken for being without a man, that show how women take decisions and have control over their own bodies. This control relates also to the female reproductive body, which I will discuss in the following chapter, when women have a knowledge from which they control their fertility (through the menstrual blood control) and their sexual pleasure. Kariri-Shoco female power is evident through female shamanic specialists' discourses, like those of Dona

Zezinha, Dona Chiquinha, Dulcilene, Baioca, and even Candara's, when he explains how his mother is stronger than him.

I learned with the Kariri-Shoco that menstrual blood is considered a substance conceived as part of women's bodily nature and related to bodily "força." Thus, menstrual bodily fluids (blood from menstruation and after delivery), and also bodily fluids from sexual intercourse for both men and women, are directly associated with Kariri-Shoco concepts and perceptions of the body's permeability over sexual differences. Female menstrual bodily fluids do not determine that Kariri-Shoco women cannot become shamans, but they do demarcate the fact that women do not become *curandeiras* (female curandeira shamans), or mestres, who open mesa rituals. It does not determine that only men among the Kariri-Shoco may become shamans, as Mota (1987) has pointed out. Male and female bodily fluids provide a different sense of the body, and indicate that shamanic activities become dangerous and must not be practiced. Thus, shamanic practices depend on the 'closedness' of the body. Bodily fluids that open the body are an impediment for shamanic ritual practices.

The Dona do corpo provokes dor de mulher whenever "she" is displaced or induces menstruation. Kariri-Shoco reproductive women very often mentioned dor de mulher. Although many women do not feel Dona do corpo, usually they heard about "her" and/or they associate "her" with dor de mulher, as I describe in the following chapter. Those concepts (Dona do corpo and dor de mulher) related to the Kariri-Shoco female ethnophysiological domain attest to Kariri-Shoco gendered and female embodiment. I consider that those ethnophysiological concepts demarcate a specificity that characterizes the female body, which is marked with blood (female

embryo, menstrual cycle, post-delivery) and pain (through dor de mulher). Those ethnophysiological concepts demonstrate female embodied subjectivity through female corporeality and sexual difference. It is in the following chapter that I continue to explore gender and female embodiment among Kariri-Shoco women as they describe their experiences related to physiological reproductive processes.

CHAPTER VIII

KARIRI-SHOCO REPRODUCTIVE WOMEN AND EMBODIMENT

The women used to dominate their husbands, the children do not respect father and mother and were never punished. (Nantes [1709] 1979, 4).¹⁰³

This research conducted among Kariri-Shoco women had the objective to discover how they have experiences with reproductive processes and female embodiment. In order to investigate those research topics, I conducted two small surveys, interviewing a total of fifty Kariri-Shoco adult women. It was based on these semi-structured interviews (Appendix A and B) that I selected twelve Kariri-Shoco women who live inside and outside the reserve in Porto Real do Colégio as case studies.

In the first section of this chapter, these surveys are discussed through data that were organized in tables according to the use of the first (Appendix A) and second (Appendix B) interview schedules, from which information registered about reproductive processes, such as pregnancy, menarche, pregnancy loss (abortion or miscarriage), and the use of methods to avoid pregnancy are described. Then, in the second section, I also describe in-depth data based on the second survey when

¹⁰³ My translation, “*As mulheres costumavam dominar seus maridos, os filhos não respeitam pai e mãe e nunca eram castigados*” (Nantes [1709] 1979, 4).

interview schedule B was utilized. Thus, information about Kariri-Shoco women's knowledge and experiences with *Dona do corpo*, *dor-de-mulher*, and menopause (using the expression "*amarrar-o-facão*" ["to tie up the big knife"]) are described and discussed. In the third section, Kariri-Shoco women case studies are described, mainly focusing on their experiences with conjugal relationship (marriage), pregnancy, pregnancy loss, and delivery. It is describing women case studies where the particularity of their experiences with conjugal relationship, reproductive processes and female embodiment are approached. It is in the last section where data on Kariri-Shoco women's use of biomedical and indigenous medical practices are illustrated, focusing on how medicalization of reproductive processes and authoritative knowledge are displayed within the Kariri-Shoco cultural context.

8.1. Conducting Interviews with Kariri-Shoco Women

The women are now submitted to their husbands and the children to their fathers, who punish them with *chibatas* [whip], which did not happen before (Nantes [1706] 1979, 17).¹⁰⁴

The semi-structured interviews conducted with Kariri-Shoco women provided the chance to meet them and to collect and gather quantitative data about their reproductive experiences. As semi-structured interviews were open-ended, after each interview was conducted, I had the opportunity to ask and record more detailed information. It was based on my experience conducting interview schedule A that I

¹⁰⁴ My translation, "*As mulheres estão agora submissas aos maridos e as crianças aos pais, que os castigam com chibatas, o que antes não acontecia*" (Nantes [1709] 1979, 17).

decided to elaborate and use in-depth interview schedule B with twenty-one other women, which I explain after I present the results of the first survey conducted among twenty-nine women (Appendix A).¹⁰⁵

Because in Portuguese there is only one word *aborto*, that can mean both miscarriage and abortion in English, I have decided to use the words *aborto/miscarriage* (or the expression pregnancy loss) in tables and within the text, while I consider both possibilities of abortion and miscarriage that Kariri-Shoco women have experienced. I will deal with this issue later. For now, I decided to leave them as open data, which includes both possibilities of miscarriage and abortion.

The first survey was conducted using interview schedule A (Appendix A) among twenty-nine adult women selected opportunistically, where questions were directed to find out how many pregnancies each interviewee had experienced, if any *aborto/miscarriage* happened, if methods to avoid pregnancy were used, and also to gather information about infant mortality. My concern with infant mortality was based on high rates of infant deaths that had occurred in Northeast Brazil (Scheper-Hughes 1985; 1988; 1992).

¹⁰⁵ In this interview schedule A, I included a question where I asked the interviewee if she used methods to avoid pregnancy (question 7). I discovered later that by using the verb to avoid (*evitar*), the interviewees often understood that I was asking if they used birth control pills. I discovered that the expression “to avoid pregnancy” is implicitly related to the use of biomedical contraceptives. In interview schedule B, I used a question directed to contraceptive use (question 6) and explained to each interviewee that I was asking if she used something in order “not to become pregnant.” This provided a better question about their indigenous contraceptives use.

Table 4. Pregnancy, Aborto/Miscarriage, Contraception, Tubal Ligation and Infant Mortality (Survey 1)

	Age		41-60+	
	<u>N</u>	(%)	<u>N</u>	(%)
Are You Pregnant? (Yes)	2	7	0	
Have You Ever Had an Aborto/Miscarriage? (Yes)	11	65	7	58
Do You Use Methods to Avoid Pregnancy? (Yes)	6	35	1	8
*Women Registered Who Had Tubal Ligation	6	35	1	8
Women Who Have Experienced Infant Death	1	8	8	67
Total	17		12	

*During Survey 1, information about women who had tubal ligation was registered from question 7 (Appendix A), when they explained that did not use methods to avoid pregnancy because they had tubal ligation.

This first structured interview schedule (A), which is a simpler one, revealed that all women interviewed had experienced pregnancy and had children. This survey shows that older women have experienced more pregnancies and have had more children, and younger women have experienced fewer pregnancies. For example, the

number of children of women over age 51 shows that most of them had more than ten pregnancies (only one had eight children), while twelve fertile women between ages 21 and 40 showed different profiles: five (most of them are more than age 30) had two children, four women had three or four children, while two had five and six children, and only one, at the age of 31, had ten children. This data suggests that younger women have had more control over fertility, particularly considering that several women between age 31 and 40 have had only two children.¹⁰⁶

Table 4 also shows that seven percent of reproductive women (between ages 21 to 40) were pregnant at the time of interview.¹⁰⁷ Table 4 indicates a high proportion of women (sixty-five percent) have had aborto/miscarriages among reproductive women, which has more or less equally happened among all ages of fertile women, including those who are postmenopausal and above age 41 (fifty-eight percent). About the use of contraceptive methods, this table shows that thirty-five percent of reproductive women (particularly those between ages 21 and 30) were using methods

¹⁰⁶ Citele, Souza and Portella (1998) discuss the fact that the Brazilian birthrate has dropped considerably in the last few decades, where women “dealt with reproduction in a context of limited male participation, through irregular use of oral contraceptives [few available through the public system], without adequate assistance, and through high demand for sterilization and clandestine abortion” (Citele, Souza and Portella 1998, 60). Citele, Souza and Portella (1998) mention that several studies since the end of 1970s have tried to understand this demographic change focusing on multiple factors, but in none of these studies is the drop of the birthrate associated with implementation of Brazilian policy on control over women’s fertility; on the contrary, those studies have shown the lack of governmental “regulation of fecundity,” where the Brazilian government had not provided necessary assistance (Citele, Souza and Portella 1998, 60).

¹⁰⁷ Actually according to their age ranges, no fertile woman above between age 31 and 40 was pregnant in this first survey.

to avoid pregnancy when I conducted the interview, while an additional thirty-five percent of reproductive women had had tubal ligation.¹⁰⁸

Although, among the younger women only one 26 year old woman had a child who died, eight women older than age 41 had experienced infant mortality (Table 4). This data on infant mortality shows that two-thirds of the women above age 41 had experienced infant death, which suggests that infant mortality has sharply decreased, particularly for recent newborns. Although the Kariri-Shoco live in a context of poverty, infant mortality has decreased. During the nine months of fieldwork only one case of infant death happened, and it was a newborn child with health problems.

Table 5. Menarche, Aborto/Miscarriage, Contraception, Tubal Ligation (Survey 2):

Age	21-40		41-60+	
	<u>N</u>	(%)	<u>N</u>	(%)
Women Who Knew What Was Her First Period	8	67	4	44
Have You Ever Had an Aborto/Miscarriage? (Yes)	10	83	7	78
Do You Use Contraceptive Methods? (Yes)	9	75	8	87
Have You Had Tubal Ligation? (Yes)	6	50	3	33
Total	12		9	

According to Table 5 from interview schedule B, sixty-seven percent of reproductive women interviewed did know about menstruation before they experienced their first period. Although forty-four percent of women above age 41

¹⁰⁸ The semi-structured interview schedule B has questions where I distinguish contraceptive methods' use and tubal ligation. During interview schedule A, I have registered whenever the interviewee had tubal ligation and that is why I present these data separately.

did know about menarche before they had experienced it, all women above age 51 reported that they only learned about menstruation when they started to menstruate. Thus, this data suggest that menarche has only recently been discussed with teenagers when they approach puberty.

My intention in including this question about menarche in the interview schedule B, was to confirm information that I discovered about seeds that Kariri-Shoco women use, following their mother's or grandmothers' advice, in order to have menstruation last only three days. I registered among reproductive women that four had used seeds to have three days of menstruation, among whom one told me that the treatment did not work for her, since she has menstruation for five days. In addition, four women older than age 41 reported that they have used seeds when they first experienced menstruation and that the seeds had worked.

About data on pregnancy loss, Table 5 shows that ten reproductive women (eighty-three percent) had experienced at least one aborto/miscarriage, while seven women above age 41 (seventy-eight percent) had also experienced pregnancy losses. The percentage of contraceptive methods (indigenous or biomedical) used show rates close to both groups of women. Fifty percent of women in reproductive ages had tubal ligation, while thirty-three percent above age 41 had also had tubal ligation. Data registered in this second survey suggests that while reproductive women opt for tubal ligation as a birth control method, according to their family plan to have two or three children, women above age 41 usually have had tubal ligation when diagnosed as having a high-risk pregnancy.

Among the total of seventeen women (reproductive and above age 41) who had used contraceptives, eleven had used indigenous contraceptives through “bush remedies” made of medicinal plants, and one of these women explained about oil extracted from an animal that was effective as a contraceptive. Most of these women explained that drank a “tea” before or after having sexual intercourse, others that they drank a “tea” or a “bottled” remedy “to make the blood come down.” Six reproductive women explained that they had used birth control pills, and one told me that her partner was using condoms. Two reproductive women who had had tubal ligation reported that they had never used birth control pills before they opted for tubal ligation, and an elderly woman interviewed said that she had never used any contraceptive method.

In this second interview schedule (B), I asked more details about their experiences with aborto/miscarriages. As I have already mentioned, because it is a sensitive issue, I will leave it as open data rather than analyze specific data on how Kariri-Shoco women reported their experiences with pregnancy loss. Thus, I present general data and provide my understandings on this issue. Usually after they explained what caused an aborto/miscarriage, I understood whether they intentionally interrupted a pregnancy or if they had had a pregnancy loss related to miscarriage.

The causes of aborto/miscarriage were usually described as related to *susto* (startle), not realizing a *desejo* (desire) to eat something, *raiva* (anger), or an accident (like the case of a seven month pregnant woman who fell off a bicycle and had a pregnancy loss). The cases of startle were reported in situations where women suddenly experienced a frightening moment. One woman told that she had an

aborto/miscarriage after she witnessed her father-in-law argue and hit her husband. Another situation described was related to a dog that barked and threatened to bite a two-month pregnant woman, who experienced a susto and had an aborto/miscarriage. Thus, most aborto/miscarriages caused by susto involve an unexpected frightening situation that may cause a pregnancy loss. Two women reported that they had an aborto/miscarriage after they felt “anger” during disputes with their husbands. Very often, experience of pregnancy loss is related to a “desire” that was not satisfied; particularly when a pregnant woman feels a “desire to eat” (“*desejo de comer*”) something. One woman told me that she saw pieces of a cooked fish in garbage by the sidewalk of the street where she lives, and wished to eat it, but because it was in the garbage she did not take it. She explained that she “felt that desire” for a few days, and then had an aborto/miscarriage because it was not realized. Although most of those cases happened in the first months of pregnancy, I observed that they usually explain a pregnancy loss (miscarriage or abortion) when I asked if they had an aborto, particularly when it happened at the third month of pregnancy or later.

Kariri-Shoco women also reported experiences of pregnancy loss when they used strong bitter remedies made from medicinal plants with the intention to interrupt a pregnancy. Although I registered three cases where women used a drug called “Cytotec” (which is a pharmaceutical drug for ulcers that has an abortive effect) to induce abortion,¹⁰⁹ I have noticed that when a remedy made from medicinal plants is used, their perception relates more to the experience of miscarriage, rather than

¹⁰⁹ Leal (1997) conducted research among working class women in southern Brazil and reported that the drug Cytotec has been “massively diffused” (Leal 1997, 166) among those women.

induced abortion. I observed that they consider it an abortion when they have a pregnancy loss as a consequence of the use of a biomedical drug, or when they need to be hospitalized because of hemorrhagic problems (which may happen when women are close to the third month or more at a advanced stage of pregnancy). Those experiences suggest that their understanding is more related to the legal aspects of abortion.

During conversations, after questions from semi-structured interview schedules were completed, particularly interview schedule A, I discovered that Kariri-Shoco women often use the expression “to make the blood come down” (*“fazer o sangue descer”*), which means to induce menstruation through the use of medicinal plants, which they conceive as regulating their menstrual cycle. Because this information relates to both interview schedules, I discuss it after presenting the following table.

Table 6. Frequency of Aborto/Miscarriage, Use of Methods to Avoid Pregnancy/Contraceptives, and Tubal Ligation Among Fifty Kariri-Shoco Women. Survey 1 (N = 29) and Survey 2 (N = 21):

	Age		Survey 1		Survey 2					
			21-40		41-60+		21-40		40-60+	
			N	(%)	N	(%)	N	(%)	N	(%)
Have You Ever Had an Aborto/Miscarriage? (Yes)	11	65	7	58	10	83	7	77		
Have You Had a Tubal Ligation? (Yes)	6	35	1	8	6	50	3	33		
*Have You Used Methods to Avoid Pregnancy/Contraceptives? (Yes)	6	35	1	8	9	75	8	88		
Total	17		12		12		9			

*Although both interview schedules (A and B) have a question about methods to prevent pregnancy, in the first survey I used a question (number 7) about methods of avoiding pregnancy, while in the second survey, I asked a direct question (number 6) about contraceptive use.

In Table 6, I describe data from both interview schedules (A and B), where information about aborto/miscarriage, tubal ligation and contraception, show rates from a total of fifty Kariri-Shoco women interviewed. Although this corresponds to ten percent of Kariri-Shoco women older than age 21, it can only be considered an opportunistic sample composed mostly of reproductive women between ages 21 and 40.

The estimated experience of aborto/miscarriage among women became even higher in Survey 2. This happened because, although it was given to a smaller group of women, during interviews I asked about their use of remedies “to make the blood come down” when they suspected being pregnant. The use of contraceptive methods is significant in both surveys, especially among reproductive women, although eighty-eight percent of women older than age 41 in the second survey described their experiences using mostly indigenous methods of avoiding pregnancy. Although both surveys demonstrate that mostly reproductive women have opted for tubal ligation, in the second survey a higher rate of those over age 41 was registered at thirty-three percent. Among reproductive women (when interviewed in Survey 1), I have registered, but they do not appear on tables, that three more were willing to have tubal ligation, of whom one did not have it because her husband opposed it.

Based on my experience in conducting both interview schedules and data registered, I perceived that Kariri-Shoco women’s notions on aborto/miscarriage relate more to miscarriage experiences, when they also experience a pregnancy loss

related to the decision to induce menstruation (“to make the blood come down”). Several cases that I registered as an aborto/miscarriage are based on information obtained, particularly during the second survey, after I asked if they had taken any remedy “to make the blood come down,” which they often answered affirmatively. Thus, in several cases I understood that they considered their experiences of “making the blood come down” as their regulation of the menstrual cycle, which I had registered as experiences of aborto/miscarriage.

One woman older than 41 told me she never took a remedy to make “the blood come down” after three months of pregnancy. In this case, she consciously interrupted different pregnancies before the third month using medicinal plants that she knew could interrupt a pregnancy. These experiences she reported were ambiguous, and it seemed that she had experienced miscarriages, which I understood as induced abortions. In several cases of women who “made the blood come down,” they took a remedy very early, sometimes a few days after they had sexual intercourse, when they suspected that they could have become pregnant. I also registered more than one case of women who decided to interrupt a pregnancy and experienced aborto/miscarriage at four months, another one at five months. I registered one case of a woman, who has always lived outside the reserve, who took a “bottle” remedy to induce abortion when she was already eight months pregnant and she delivered a dead fetus. Although those are exceptional cases, still they suggest that the decision to induce menstruation and, therefore, to induce a miscarriage, can occur at any stage of pregnancy. I registered other cases where, although women were in advanced pregnancy, they tried to induce menstruation using “bottle” remedies,

and were satisfied when their attempt did not work. Usually it is understood that the fetus has “a goodness” (“*uma bondade*”) that does not allow it to come out from their mother’s belly before the right time. Diana, who is one of case studies that describe below, is an example of these women.

I once used medicinal plants for gynecological healthcare, when I decided to have the experience with this kind of treatment that several reproductive women mentioned. I asked two different shamanic specialists which remedy I should use for gynecological healthcare and they suggested the combination of three different medicinal plants. Dona Maria Velha gave me a fourth plant and told me that I should add it to the other ones for the treatment, and I did not hesitate to accept her advice. I was surprised when I had my menstruation on the fifth day after drinking and bathing myself daily during three days with this remedy. When I talked to those shamanic specialists about this, they explained that it was normal and good that I had my period, since it was a natural cleansing of everything inside. About the treatment, they had told me before that one of the plants had a powerful effect of “making the blood come down,” that I should know if I was not pregnant. Since I knew that I was not pregnant, I decided to have the experience of this gynecological Kariri-Shoco female healthcare remedy, which is considered as a healthy preventive female indigenous medical treatment. Although I had been told about the effect of the remedy, I was surprised when my blood came down.

Based on my own experience, Kariri-Shoco knowledge of medicinal plants to “make the blood come down” is effective, since I only used one of those plants that induce menstruation and experienced menstruation. There are several different kinds

of plants to induce menstruation, which have abortive effects. The way “bush” remedies are prepared, by combination of plants, influences how strong and effective those remedies can be, which may induce abortion. I recognize that Kariri-Shoco women, from what I heard about their experiences in using these remedies, mostly do not relate to a decision to induce an abortion per se.

From their experiences with medicinal plants, the Kariri-Shoco people hold the notion that each plant has an owner (“*dono*”) as a spiritual being. I understand that the abortive effect of the remedy depends on the decision of the “owner of the plant” (“*dono da planta*”) used. This is my interpretation of the way I perceived Kariri-Shoco women’s experiences when they use one medicinal plant (or a combination of several plants) to induce menstruation. Each plant has an owner, who is a spiritual being who decides about the effect of the remedy. Thus, their notion proceeds when they use a remedy to “make the blood come down,” which they take to menstruate. If the “blood comes down,” they may have a miscarriage if they were pregnant.

In most cases that I registered, Kariri-Shoco women explained that the use of “bush remedies” was related to their suspicions about missing their period. The remedy is taken to guarantee their menstruation and, therefore, to avoid pregnancy. Thus, several examples registered show that their notion of regulating their menstrual cycle, by making the “blood come down” through the use of a “bush remedy,” was very often not considered as an interruption of a pregnancy per se, but as their will to regulate their menstrual cycle, through the decision of “the owner of the plant.”

It was interesting to conduct two different interview schedules for researching the use of contraceptive methods. In the first schedule (Appendix A), Kariri-Shoco

reproductive women usually understood that I was asking about biomedical contraceptive methods, particularly the use of birth control pills. That is the reason why most of the women reported that they were not using methods to avoid pregnancy in the interview schedule A (Table 4), when only thirty-five percent of reproductive women told me about their contraceptive use, contrasting to a higher rate (seventy-five percent) of reproductive women interviewed in schedule B (Table 5). It was after I found out about the use of medicinal plants “to make the blood come down” that I decided to ask if they had ever used methods to menstruate, whether indigenous or biomedical, when I asked them about contraceptive methods’ use.

Regarding contraceptive use in Brazil, the medical doctor, Olinda Luiz, and medical sociologist, Maria Citeli (2000), demonstrate that current rates of contraceptive use in Brazil are very close to the rates of use in First World countries. What differs in the Brazilian case is that the uses of birth control pills and sterilization (tubal ligation) have been the most frequently chosen options of Brazilian women.¹¹⁰ According to the authors, the recognition of “the complexity that involves social facts related to sterilization” has led to changes in “legal” procedures. They mention that the Ministry of Health regulated norms for public health assistance based on a “Law

¹¹⁰ Based on qualitative research conducted in Pernambuco (Northeast), Rio de Janeiro and São Paulo (Southeast) among poor urban and rural women workers, Citele, Souza and Portella (1998) analysed a “denaturalization of processes which involve reproduction” (Citele, Souza and Portella 1998, 74) that the women researched went through, controlling and deciding their reproductive processes. They show that sterilization combines “women’s desire to not have more children and contributes to their better health” (Citele, Souza and Portella 1998, 74). This study illustrated the suffering that women encounter with experiences with reproduction and control of their fertility. The authors point out that, while the oral contraceptive method has side effects that have caused Brazilian women to suffer with health problems, “reproduction has been widely experienced as a health problem” (Citele, Souza and Portella 1998, 74).

of Family Planning” of 1996, “Bills 144/97 and 48/99” (Luiz and Citele 2000) that regulate access to sterilization of any individual by the public health system. I consider that the Brazilian government’s delay in providing birth control policies through public biomedical assistance demonstrates that the state has exercised power over women’s fertility, where the naturalization of the female body as the locus for prolific function prevails. Thus, it is a matter of inadequate state power contrasted with women’s demands for contraception. From qualitative data collected during field research, Kariri-Shoco women frequently chose indigenous contraceptives use (by “making the blood come down”), which may imply pregnancy loss. Tubal ligation and the use of birth control pills have also been, to a lesser extent, options that they have taken.

According to Sheper-Hughes (1992) Alto women’s views on abortion, as in moral religious perspectives of Bom Jesus (Catholic, Protestant and Afro-Brazilian religions), condemned medically induced abortion. Scheper-Hughes (1992) mentions that sterilization in Bom Jesus had become “the preferred form of birth control among women of all social classes” (Scheper-Hughes 1992, 336), although it is considered, like abortion, “as a serious mortal sin by the Catholic church” (Scheper-Hughes 1992, 336). She observed that sterilization was, after delivery, the most widely used “medical practice” in the “local hospital”. Scheper-Hughes (1992) described cases of poor Catholic women, who after several pregnancies, would “decide to put an end to reproductive years” (Scheper-Hughes 1992, 336) through sterilization, and that the only problem was their difficulties in paying the costs of surgery, which could be financed by politicians during municipal election times. It is interesting that Scheper-

Hughes (1992) observes that the doctors “expressed no qualms about sterilization” (Scheper-Hughes 1992, 336) once the woman “had demonstrated her ‘good gender citizenship’ by producing an ‘adequate’ number of children” (Scheper-Hughes 1992, 336-337)

Reflecting on several examples of personal experiences about Catholic women in Brazil, and several cases that I have observed among the Kariri-Shoco and other indigenous areas (among Catholics), I do not perceive that religion has actually exercised power over the control of contraceptive use in Brazil. Although the Catholic Church still condemns the use of technological contraceptive methods (including condoms), it has insufficient power to control decisions regarding sterilization or the use of other contraceptive methods, such as birth control pills (which is the most frequently used contraceptive method followed by sterilization). I believe that the Catholic Church has had somewhat more influence in the case of abortion decisions, which remains an illegal option in Brazil. Even considering that the Catholic Church and the Brazilian government condemn the practice of abortion, it has still been a widespread birth control option and is the third largest cause of maternal obstetric death.¹¹¹

¹¹¹ Abortion has been the third direct obstetric cause of maternal deaths. Since 1940 Brazilian legislation established that induced abortion is a crime and it is only allowed in circumstances in which a woman’s life is at risk with the pregnancy, or if the pregnancy is a consequence of sexual violence, such as rape. According to data on a report about abortion in Brazil, it is estimated that 1.4 million abortions occur annually in Brazil under clandestine circumstances (Henshaw, Singh and Hass 1999). The Ministry of Health notes that more than 250,000 women are hospitalized with health problems from clandestine abortions annually (Sanematsu 1998). Thus, in Brazil abortion is a serious contemporary public health problem. This information shows that induced abortion, which is widely practiced, is, particularly for poor

Contrasting with medical doctors' discourse from "Bom Jesus" that Scheper-Hughes described (1992), Luiz and Citeli (2000) revealed data on the difficulties that women who opt for sterilization face in order to obtain this assistance through the public health system. The authors mention that in order to analyse the impact of the "sterilization law" through regulated norms, research was conducted in 1999 by "*Comissão de Cidadania e Reprodução*" (a governmental bureau), on 23 sterilization services from 37 hospitals that provide the service in the municipal region of São Paulo. The authors recognized high technological quality of the health services, but there were "obstacles in applying the law," where there is "culture of resistance to sterilization among medical doctors and other health professionals." Luiz and Citeli (2000) contrasted results of women's satisfaction of sterilization option with the arguments that medical doctors use, where they disagree with the minimal age established by law and argue that women may regret their decision, once it is an irreversible option. The authors then, based on several studies about women's satisfaction with surgical sterilization, which were developed before the implementation of regulations in 1996, show that the percentage of dissatisfaction of women with sterilization was between 11 percent to 20 percent, which indicated that out of five women, four were satisfied with their sterilization decision. Thus, according to Luiz and Citeli (2000) the medical doctors' argument does not justify their "systematic refusal to follow what law establishes" (Luiz and Citeli 2000, n/a)

women, the most risky option (since in their circumstances, abortions do not necessarily follow biomedical procedures).

From these data, it is evident that in the contemporary Brazilian context, there is a dispute between biomedical power and state power over women's (in)fertility control. It seems that what has been more subject to surveillance is not women's fertility per se, but women's infertility option control, in which the female body has been under regulatory governmental omission/intervention and biomedical confrontation. The high rate of Brazilian population growth has dropped considerably in the last few decades as a consequence of women's control over their fertility, with a high cost to their health and lives.

The biomedical public health system was already providing sterilization options through arbitrary and non-legislated circumstances. It was one of the reasons for extremely increased rates for women to opt for caesarean deliveries, which became a vehicle for sterilization during delivery. This biomedical practice led to a reproductive health problem in Brazil, because of the higher health risks of caesarean delivery (Leal 1997). Contemporary legal regulations for sterilization establish restrictions when it is performed during caesarean delivery. It is also required that the individual has to have at least two (living) children or be more than 25 years old (and not necessarily have had any children), to be informed by a "multidisciplinary service" about contraceptive methods, and also to have the consent of the companion, in the case of conjugal union (Luiz and Citelle 2000). Thus, it is these norms of sterilization that medical doctors have 'resisted' following, in which women can opt for sterilization even if they have not had children.

Sterilization still reflects, however, a complexity related to the (de)naturalization of the reproductive female body function. It is an option that when

selected as method of birth control in context of the majority of poor Brazilian women, relates to how they have negatively experienced reproduction (with several undesired pregnancies), and associated health problems (from the use of birth control pills, the consequences of clandestine abortions, and others). Sterilization can then be considered as a radical decision resulting from the pressures to bear many children, which some Brazilian women choose not to follow, and thus, it is a matter of resistance. I particularly believe that it will become the most used birth control method option among Brazilian women, without its institutionalization (which has only very recently been available as a birth control procedure through the public health care system). It has been the second most widely used contraceptive method by women in Brazil.

It is also a resistance to the context of patriarchal characteristic of the Brazilian culture. Parry Scott (1996), who has studied the development of the domestic cycle through anthropological fieldwork in “Coelhos” shantytown (Pernambuco), found that male and female strategies are basically different concerning representations and experiences of the reality of the home (“*casa*”), where it is expected that women actively control, while the men present the “home” as “under control” (Scott 1996, 291). I agree with Scott’s (1996) observation, because in several studies (DaMatta 1985; Scheper-Hughes 1992; Victoria 1995, 1997), and from my experience, “home” is a fundamental “component in female identity formation for most Brazilian women” (Scott 1996, 291) where constructs of “self-evaluation” status and “articulation with the world ‘*rua*’ [street]” is established (Scott 1996, 291). A patriarchal characteristic within this context is reflected in women’s

responsibilities and pressures on their reproductive function and domestic sphere. Thus, if sterilization is a reinforcement of the patriarchal nuclear family notion, where the domestic sphere is reinforced as the female space, on the other hand, it is a control women assume through their bodies for not continuing to procreate when the power of controlling their fertility is expressed and experienced through sterilization. It is a decision usually related to their option to have one or two children, which has become a desirable family size in all social classes in Brazil (Scheper-Hughes 1992), but which women from middle and upper classes have been able to control. Although I do not have sufficient data, information presented about Kariri-Shoco women discussed above indicate that they often opt for a family size of two or three children.

Iris Lopez (1998) developed research on the medicalization of Puerto Rican women's reproduction in New York City, and shows how tubal ligation is an option women exercise in order to free themselves from economic and political oppression, reflecting situations of agency, resistance, empowerment, and constraint. The context Lopez (1998) described has a crucial difference with Brazilian women's medicalization of fertility. The 'apparent consensus' between women's option for sterilization and state encouragement (whose fertility is a burden for the United States government because they depend on welfare), differs considerably from the Brazilian case. Only very recently, the 'right' of sterilization was approved in Brazil by the public health system, which demonstrates that the Brazilian government has not implemented policy on control over women's fertility.¹¹² Thus, I do not consider that

¹¹² According to the Ávila (1992, 16) there is "an official and medical discourse on blaming the lack of accurate information about the correct use of contraceptive methods" (Ávila 1992, 16). Ávila (1992) points out that the Brazilian

the Brazilian government have encouraged sterilization, nor in a lesser degree do the biomedical practitioners who have confronted the law.

Scheper-Hughes (1992) describes several examples where Alto women, from Northeast Brazil, “manipulated ambiguity with respect to induced abortion” (Scheper-Hughes 1992, 335). According to Scheper-Hughes (1992), Alto women induced abortion either with the use of “herbs, berries, nuts, roots” (Scheper-Hughes (1992, 335)¹¹³ or biomedical drugs, such as Depo-Provera, which had abortive properties. According to Scheper-Hughes (1992), Alto women’s perception of their usage of abortive methods was more related to regulation or control of menstrual cycle rather than as a conscious attempt to induce abortion. In the case of Kariri-Shoco women, I have observed that they have different experiences with pregnancy loss. Whenever they make use of “bush” remedies, it is often expressed as an option to regulate the menstrual cycle. In three cases where I registered Kariri-Shoco women who made use of Cytotec (biomedical drug), they reported it as an option to induce abortion, which reflects their notions on legal aspects of interrupting a pregnancy. Two of these women, who are reproductive case studies, say they explicitly regret their decisions. On the other hand, those cases of women who shared with me their experiences of using “bush” remedies because they knew that were pregnant, when they were

governmental public health system introduced new contraceptive technologies in an arbitrary way, without information and/or medical assistance” (Ávila 1992, 17) and has produced or recreated “mythologies on contraception,” which interfere in the use of contraceptives. Ávila (1992) also points out that “the precarious way in which contraception is lived by women in poor material conditions has led several women to opt for the radical decision of sterilization” (Ávila 1992, 17) a practice which is conducted through public health assistance.

¹¹³ Scheper-Hughes (1992) mentions that she did not have information about how effective these methods were.

already in advanced pregnancy (more than three months), said they had no regrets that they had taken those remedies.

I understand that options of contraceptives use relate to the way Kariri-Shoco women exercise a power over their reproductive body, which also includes their control over menstrual blood fluxes. Sterilization (tubal ligation) for women is the option of reproductive disability, which much more than abortion (that only involves a pregnancy interruption), it is a radical change for the female body's naturalized character. It involves a denaturalization of the female body, where through biomedical knowledge use, according to Citele, Souza and Portela (1998) a new naturalized biological cycle pattern for Brazilian women such as "menarche-conception-pregnancy-delivery-sterilization" is experienced (Citele, Souza and Portella 1998, 75). I consider that data registered during field research about tubal ligation may suggest that this new naturalized biological cycle pattern has influenced Kariri-Shoco women's decision for tubal ligation. Still, I do not have sufficient data to confirm if it is the case for Kariri-Shoco women's options for sterilization.

I consider that the among Kariri-Shoco women tubal ligation rate is significant since there are women who are planning to have it despite their awareness of those who chose it and who have experienced consequences, in that they report how it has interfered with their sexual desire and/or menstrual cycle. As already mentioned, I consider that Kariri-Shoco women have control over their fertility, on the basis of data that shows that younger women have had less children. This control is expressed through the use of indigenous or biomedical contraceptive methods.

There is a high rate of experience with abortos/miscarriages in both surveys, and to a lesser extent, several women have chosen tubal ligation.

It is through the case studies in the last section that I continue to discuss and describe qualitative data about Kariri-Shoco women experiences with reproductive processes. Information gathered and presented here about Kariri-Shoco women's experiences with reproductive processes focused on birth control methods (contraceptive uses, abortion/miscarriage, and tubal ligation).

8.2. "Dor de Mulher," "Dona do Corpo," and Menopause

It was with the interview schedule B (Appendix B) that I investigated aspects of Kariri-Shoco women's experiences and perceptions that I had previously already often heard. For example, I included structural questions related to post-menopausal women, where the expression "to tie up the big knife" ("*amarrar o facão*") is used, and experiences and perceptions on other emic expressions related to what they call "dor de mulher" and the "Dona do corpo," which I have already mentioned when presenting information that a shamanic specialist provided about ethnophysiological concepts related to the female body.

Table 7. In-Depth Questions about “Dor de Mulher” and Knowledge about the “Dona do Corpo” (Survey2):

Age	21-40		41-60+	
	<u>N</u>	(%)	<u>N</u>	(%)
Have You Ever Felt Dor de Mulher? (Yes)	11	92	8	89
*Have You Ever Felt the “Dona do Corpo”? (Yes)	3	25	6	67
* Women Who Never Felt, but Heard About the “Dona do Corpo”	9	75	3	33
Total	12		9	

* The question 10 in interview schedule B asked if the interviewee had felt or heard about Dona do corpo. During the interview I registered whenever the woman had or had not felt it. That is the reason why I have decided to present this information separately.

According to Table 7, ninety-two percent of reproductive women and also women above age 41 (eighty-nine percent) reported that they had experienced dor de mulher. They usually explained that “dor de mulher” is a pain they feel or felt inside their belly before or after delivery, when they menstruate, or during pregnancy. Some of them also feel “dor de mulher” in different parts of their body, such as in their legs, stomach, intestines, and head.

Regarding the “Dona do corpo,” three (twenty-five percent) reproductive women interviewed, told me that they felt “her,” especially after delivery, while nine (seventy-five percent) of these reproductive women, had heard about the “Dona do

corpo,” but had never felt her. Among women older than 41, six women (sixty-seven percent), said that the “Dona do corpo” was mostly felt. While nine (seventy-five percent) reproductive women told me that they had heard about “her,” although they had never felt the “Dona do corpo,” three (thirty-three percent) older women had also heard about her, and had never felt her.

One of the three reproductive women who had felt the “Dona do corpo” inside her body, described that “she grows with the child inside the belly” (“*ela cresce junto com a criança dentro da barriga*”) and that “she walks inside the body” (“*ela anda dentro do corpo*”). Women interviewed usually associated the “Dona do corpo” with “dor de mulher,” because “she provokes pain” (“*ela provoca dor*”) especially after delivery when “she searches for the baby inside the belly” (“*ela procura pela criança dentro da barriga*”). They often reported that they “felt a round thing” (“*uma coisa redonda*”) like a “round cake” (“*um bolo*”) or an “orange” (“*uma laranja*”), which moves inside their belly. Some women also explained that they could even hear “her” making a sound like a “roar” inside their belly after delivery. Several women, even those who had never felt the “Dona do corpo” inside them, considered that the “Dona do corpo” can walk inside the woman’s body and, if she gets out of the body, the woman dies, because no woman can live without the “Dona do corpo” inside her body.

When I used the second interview schedule (B), I investigated Kariri-Shoco women’s perceptions of menopause. The use of a structural question with the expression “to tie up the big knife” (“*amarrar o facão*”) in interview schedule B was a way to hear their explanations about whether they had already experienced

menopause or what they knew about it (when they had not experienced menopause yet). Among these twenty-one women interviewed, four gave me explanations about their experiences with menopause. One of them, a married woman of 53 told me, “I have already tied up the big knife [*eu já amarrei o facão*] and now I am like a male [*e agora eu tô como um macho*].” After I asked her why she became like a male, she explained that this happened because she does not menstruate anymore, and because she does not have children anymore. Among the other three post-menopausal women, one who was separated from her husband explained that she became more “fogosa,” while two married women reported that they had less sexual interest in their husbands after menopause. During these interviews, when I asked them, even for the ones who were not post-menopausal, if they knew about any change when a woman “ties up the big knife” (“*amarra o facão*”), they usually mention that the woman changes. I noticed that the advent of menopause for them seems related to a sex-gender identity change, when they become similar to man. I have understood that menopause brings to Kariri-Shoco women maleness to their body. This may be associated with sexual practices and desire, since they very often report that women lose sexual interests for their husbands, and do not feel sexual desire like they did previously when they used to menstruate.

Once I asked to Dona Maria Velha if man had also menopause, she answered that they do not have, “Because he is closed, he doesn’t have blood in his belly to provoke pain!” She also told me, “When he comes to bleed, it is because he is very sick inside with a venereal disease.” Thus, from her point of view, menopause is associated with female’s menstrual blood and ‘closedness’ after a woman stops

having the menstrual cycle. Then Dona Maria Velha continued speaking about female menopause:

“When the woman comes to the menopause the fire [excitement] diminishes more because it is related to the blood.”

One woman of 68 who was interviewed, when she said that she noticed “a big change” in her body after she “tied up the big knife,” explained a similar perception to me. She explained:

“A woman becomes male because who commands [as who is in control of the body] is the blood! A woman who tied up the big knife [amarrou o facão] serves [has sexual intercourse] her husband, but she doesn’t have the pleasure that she used to have anymore.”

It is interesting because the capability of the female body to produce offspring is very much intertwined, among Kariri-Shoco women, with sexual desire. Most of women who had had tubal ligation told me that they had noticed “changes” (“*mudanças*”), which mostly refer to menstrual cycle (more or less blood fluid fluxes during menstruation, or irregular menstrual cycle). Very often Kariri-Shoco women explained that they started to feel less sexual desire after they had had tubal ligation.

8.3. Kariri-Shoco Women as Case Studies

As I have already mentioned, reproductive women were selected as case studies from interview schedules (A, B) conducted among the total of fifty women. While I was meeting and becoming more acquainted with Kariri-Shoco women’s reproductive experiences and perceptions of the female body, I started to select case studies from those with whom I had established more significant contacts, considering different reproductive experiences, fertility, and marital status in the

selection. As I became closer to selected case studies, several private and sensitive issues were shared with me, as we also shared friendship. Although I made an effort to gather systemic qualitative data about their experiences for comparative purposes, I intend to be more descriptive. I describe and explore their particularity in terms of differences in reproductive and gendered experiences, rather than make a comparative analysis. My focus is on their life histories, particularly regarding their experiences with conjugal relationships (marriage) and reproductive processes (pregnancy, aborto/miscarriage, and delivery). I also describe their experiences with *dor de mulher* and *Dona do corpo*.

Table 3: Kariri-Shoco Women as Cases Studies:

Woman	Age (±)	Marital Status
Ann	±60	Married
Betty	±50	Married
Christie	±45	Married
Diane	±40	Married
Ema	±40	Common Law
Faye	±35	Single
Gilda	±30	Married
Hilda	±25	Common Law
Ina	±25	Common Law
Julie	±20	Single
Lila	±20	Common Law
Marian	±20	Common Law

I decided to show Table 3 again, which was already presented in Chapter IV, to provide more details about the Kariri-Shoco women selected as case studies. These were code-named with fictive English names, organized in alphabetical order from the oldest to the youngest one. According to my research proposal, I planned to select nine adult women as case studies, but during field research I decided to add three

additional cases who, although they identify themselves and are identified by others (indigenous and non-indigenous) as Kariri-Shoco women, and therefore receive assistance (including biomedical) like any other Kariri-Shoco person, do not participate in Kariri-Shoco shamanistic rituals related to Ouricuri. These three women live in the Porto Real do Colegio town. They maintain close relationships with Kariri-Shoco relatives (like aunts, uncles, cousins) who live in the reserve Sementeira area. These three women use the Sementeira clinic health assistance, and also they often use rezador/rezadeira or curandeiro shamans for indigenous health care. The reason why they do not attend Ouricuri rituals is mostly related to their father, mother, grandfather or grandmother, who did not participate in the Ouricuri and did not care to send them to a relative who did participate and who could take them to Ouricuri when they were children. All three women said they usually feel sorry that they do not take part in this ritual.¹¹⁴

The twelve case studies I selected from Kariri-Shoco women with diversified reproductive experiences fit this profile:

- Two were postmenopausal (Ann, Betty),
- Two (who I considered infertile) had had tubal ligation (Gilda, Hilda),
- One was presumed infertile (Christie)
- Three were fertile but not pregnant (Diane, Faye, Ina),

¹¹⁴ During the field research I observed cases of children who had only one Kariri-Shoco parent who brings the child to this ritual, although the parents are married to or separated from a non-indigenous person who does not participate in the Ouricuri ritual. Thus, in mixed marriages (when one of the spouses is not Kariri-Shoco and does not participate in the Ouricuri ritual), the other parent brings their children to this ritual. I met a nine year old girl who lived with her non-indigenous mother in Porto Real do Colegio town, whose mother had let her go to the Ouricuri since she was a baby with her Indian father (who was married to a Kariri-Shoco woman). The three women I mentioned above, who were case studies, did not have parents who attended the Ouricuri ritual. In these cases, they could have been brought to the Ouricuri by an uncle, aunt, grandfather, or grandmother.

- Four were pregnant (Ema, Julie, Lila, Marian).

During field research, of the three fertile but not pregnant women case studies, one became pregnant (Ina) and another only discovered her pregnancy when she was already more than three months pregnant (Faye). Thus, the research involved a total of six pregnant women, four of whom began lactating after delivery (Faye, Julie, Lila, Marian) when I conducted field research. Two of the pregnant women had tubal ligations (Ema, Faye) after they delivered, while two others intended to have tubal ligations (Ina, Julie). Among the case studies, only one fertile woman did not use any contraceptive method (Diane). Christie told me that for more than twenty years she had unsuccessfully tried to become pregnant, and this is the reason why she suspected that she was infertile.

Because I respect confidentiality and anonymity I decided to present data in this section in a more descriptive but distant way, instead of presenting details about our friendships, as I did when I described the shamanic specialists in the Chapter V. Most of these women became close and good friends of mine. Some details about their life experiences I omit because they could be identified.

From my observations, Kariri-Shoco women live within patriarchal relationships, which is characteristic of Brazilian culture. By patriarchal relationships, I use Avila's (1992) explanation, which she describes as women's responsibilities and pressures on their reproductive behavior, childrearing, domestic work, attention and care of family health, and husband's needs. All Kariri-Shoco women whom I met, particularly those engaged to conjugal relationships, assume several duties within their homes. These duties relate to cooking and housekeeping, taking care of children

and husband, protecting the health of the family, and being available to their husbands for sexual intercourse. Most of these women explain that as a wife they have to fulfill the husband's needs. Thus, I consider that they are immersed within a patriarchal system, which is characteristic of the Brazilian culture (Freyre 1986; Ribeiro 1978; 2000), where much of their activities and responsibilities relate to the domestic sphere where man (father, partner, or husband) have had it under control.

8.3.1 Marriage, Pregnancy, Aborto/Miscarriage, Delivery:

Kariri-Shoco women usually marry very early. The formality of marriage may vary; some even at the present time get married or run away with a boyfriend when they are still teenagers. For example, in several cases when I asked the question (using interview schedules A and B) if they were married, usually if they had no formal marriage (in a church or in a *cartório* official governmental office), they answered that they were not married, although they had been living for a long time with the same partner. In these cases, usually they are considered *amigada*, which is a pejorative term used for a woman within a common law relationship. *Amigada* was the status of five cases studies, which I registered in Table 3 (Ema, Hilda, Ina, Lila, Marian) as having a common law marital status.

Among these women who were living in a common law situation, only the youngest ones (Lila, Marian) were engaged with their first partner with whom they

had lost their virginity.¹¹⁵ Other cases studies (Ema, Hilda, Ina) in a common law situation were living with a man who was their second or third partner.

The first case study (Ann) is a post-menopausal woman who explained that although she noticed that she has changed after menopause, because she has less sexual desire, she still is satisfied with having sexual intercourse with her husband. She told me that she married a man who was very close to her family, and particularly to her father. He started to be interested in her while she did not consider him as a possible husband. She explained that he was her boyfriend although he never touched her. When he was building a house for them to live in after marriage, she decided to ask her father to tell him that she was not interested in him, although she knew that her father liked him very much. Ann told me that although her father tried to convince her, saying how important it was to marry a man as responsible as her boyfriend, she decided not to get engaged to him. She explained to me that she “could not stand him,” that she got “*enjoada*” (“feeling nausea”) with him. After her father told her boyfriend that his daughter did not want to marry him, he became very desperate, and even wanted to take his own life. Thus, after she was informed about that, she went to see him. I found this amazing, because she told me that after she saw him doing “something” (“*uma coisa*”) related to his shamanistic knowledge, she told me that she could not resist and accepted his will to get married. She says that she does not regret her decision, and that they became very close and have already been married more

¹¹⁵ The expression “to lose the virginity” (“*perder a virgindade*”) or “she has lost herself” (“*ela se perdeu*”), are often used as expressions which mean that the woman is not a virgin anymore.

than forty years. Her husband has always been very responsible, and has always provided their support.

Ann had eight children, although she used an indigenous contraceptive method with the use of oil extracted from a male animal. She explained that she prepared and drank one tablespoon twice a day of this oil for six months, which worked as a contraceptive that lasted for five years. She explained that this is why she had no pregnancy for five years. Although she never took any remedy to “make the blood come down,” she knew several cases of women who had She said she never had a pregnancy loss, and that all her deliveries were normal although she felt lots of pain during delivery. Ann said that during her deliveries she always had the help of a midwife, that her husband was present and that he buried the placenta in their backyard. It is interesting that very often I heard women’s explanations of the placenta. Ann explained, “First, the child is born” and then it is when “the delivery comes out” (“*o parto sai*”) and “the delivery happens” (“*o parto acontece*”), referring to when the placenta comes out.¹¹⁶

After all her deliveries Ann was very careful with her *resguardo* (confinement), which she explained has certain rules women follow during one month after delivery.¹¹⁷ Thus the rules of Ann’s *resguardo* were related to kinds of food that she could not eat (birds, some kinds of fish, pork) and also avoiding activities, such as carrying anything heavy, bending down for housekeeping activities, not walking

¹¹⁶ This information was mentioned also in an ethnographic interview described in section 6.1, when I explained how Frederico used the cover term *despachar* to refer to menstrual blood fluxes.

¹¹⁷ I translate *resguardo* as confinement because it is the post-delivery period when a health care regimen related to forbidden food and activities are followed.

around with bare feet, and especially not having any sexual intercourse with her husband. During the *resguardo*, which lasts one month after delivery, it is a time when the woman's body is opened. Ann explained to me that if you "*quebra*" ("break") the *resguardo* by not following health care of the body after delivery, you can have "horrible consequences," and even "death" might happen. She explained that sometimes the consequences could "last for the rest of a woman's life," making her "become often sick, nervous," and vulnerable to catch diseases. She told me that everyday during the *resguardo* she drank a remedy made from medicinal plants with which she also bathed herself, especially the lower part of her body. These procedures helped to clean her and keep her healthy, avoiding any inflammation after delivery.

Kariri-Shoco reproductive women interviewed who gave details about their experiences with deliveries, explained that they followed their *resguardo* very carefully, which is part of their health care after delivery. Usually the mother of a woman under *resguardo* comes to her daughter's home and helps with housekeeping duties and provides medicinal plants.

Ann complained that she always felt "*dor de mulher*," which sometimes affects her legs and intestines. She also told me that she felt the "*Dona do corpo*" during all pregnancies and that after delivery she used to touch her belly and feel "her" searching for the child. She said that the "*Dona do corpo*" was "round like the size of an orange." When I asked her once if she continued feeling her even after menopause, she told me that, recently, she had a problem of a very strong pain in her belly, and that was the "*Dona do corpo*." Ann said, when she was walking back home, she had to stop by the river to defecate and wash herself, because when she

feels “her” in the intestines she has to defecate quickly. When I asked her if it was possible that “she” comes out of the body when “she” is in the intestines, Ann answered, “No,” that this could not happen because “she lives inside the body” (“*ela vive dentro do corpo*”). I questioned if it was not “dor de mulher” that she felt, and she said, “They are the same,” because the “Dona do corpo” is responsible for “dor de mulher.”

The second case study (Betty) is also a post-menopausal woman and married for over forty years. She told me that when she met the man whom she married, he used to have lots of girlfriends, and that he even had lived with different women before they met. One day he came to her and asked if she wanted to marry him. She said that he told her about how he used to be, and that with her he had all good intentions and was willing to get married legally. Then she decided to marry him.

Betty told me that although her husband used to work very hard he had already lost almost everything because of “the envy of others” (“*a inveja dos outros*”). They used to have different houses, cows, and pigs. Among her children, one had a problem that he caught from a terrible evil eye, which made him become weak, lazy, and without strength to work. Her husband’s loss of what they used to have, she explained as “a curse” (“*uma praga*”) that was sent upon him and her family.

Betty told me during interviews that she suffered a lot because after marriage her husband continued to drink and to have other women. She said that she has always suffered and that she still lived feeling insecure, particularly because, when her husband drinks, “something bad can happen,” when he “gets out of control.” She

is very faithful to her shamanistic prayers and knowledge from which she finds “força.” I observed that she is daily concerned with problems related to family members, which very often she attributes to others who have “envied” how wealthy they used to be. Thus, the explanation she gives as to how they became poorer is because of the “big eye” (“*olho grande*”) that “was put on her family.” One day she told me who caused her son’s health problem by cursing her family, since her father argued with this powerful shamanic specialist a long time ago. That is the reason why she follows very carefully her duties related to the Ouricuri ritual, which is the strongest way to ward off the evilness that was sent to her family.

Betty had several pregnancies and she had an obstetric surgery, which I understand was a hysterectomy, after which she stopped menstruating. Thus, she mentions that she did not experience menopause. Despite Betty explanation that she did not have menopause, she mentioned that after her surgery, when the doctor took out everything inside her, she did not have sexual desire anymore, although she has always served her husband whenever he looked for her.

Betty had an infant death during a cesarean, when a tubal ligation was done after she had been diagnosed as having a high-risk pregnancy. She blames the doctor for what happened with her newborn, and told me that he killed her baby. Betty has nine children and she had experienced an aborto/miscarriage, which she told me happened when she was more than three months pregnant. She consciously decided to make a remedy that she knew would induce menstruation. Remedies that induce menstruation are ones made from plants which have a bitter taste, she explained. She told me that she had the aborto/miscarriage when she was working in a rice field by a

lake. When she felt that the fetus was coming down, while she was feeling strong “dor de mulher,” she took and put the fetus into the lake. Betty described that her decision to make and take the remedy related to how angry she felt with her husband one day when he argued with her. She told me that she thought: “He [her husband] thinks that I will have his child, I won’t!” That is why she decided to drink the remedy that she made to induce menstruation. She also told me that her husband did not know that she was pregnant, nor about her decision to make and drink the remedy. After the aborto/miscarriage, she finished her work in the rice field and went back home. Because she continued to have strong hemorrhage and pain, she had to be hospitalized. It was her husband who rented a car to take her to Propria’s hospital, and there they made a curettage on her and sent her home. She said that she followed a resguardo and used medicinal plants to make sure she would be fine. Although her husband suspected that she had a pregnancy loss, they never talked about it.

Betty explained that she always felt “dor de mulher.” About the “Dona do corpo,” she only heard her mother tell about “her.” The dor de mulher she felt before and during her deliveries, but sometimes she has headaches, which she explains as also “dor de mulher.”

The third reproductive woman (Christie) has had a stable marriage for over twenty years. This case was interesting because she had only one child and, although she wanted to have more children, she had never had another pregnancy. She said that she never tried to use any indigenous treatment for infertility.¹¹⁸ She did, however,

¹¹⁸ Kariri-Shoco shamanic specialists treat female and male infertility. Candara told me once how he uses medicinal plants for infertility, which he

take several biomedical exams eight years ago, from which the doctor told her that she did not have any fertility problem. Although the doctor suggested that her husband should take some exams, she said that he never wanted to do so, and that is why she does not know if he has a problem. From the interviews, I noticed that she suspected that she was infertile, although the medical doctor told her that she was normal.

By the end of my field research, Christie wanted to take biomedical exams because she said that she had had a constant inflammation in her womb, and the specialist doctor used to prescribe a “cream” (“*creme*”) for her to use. Thus, she discovered through exams that she had a “*fibroma*” (fibroid) in her womb, which required surgical intervention. She does not believe that she can get pregnant anymore, and her surgery was scheduled when the field research would be already finished.

Christie married a man who was her first boyfriend when she was twenty-four years old. It was after her first kiss that she decided that she had to marry him and become his wife.¹¹⁹ She told me that she met and started to date him hidden from everybody. Her parents liked him very much because he was a very hard worker,

prescribes to a couple (both husband and wife) who have problems on producing offspring.

¹¹⁹ This was not the only Kariri-Shoco middle-aged woman who reported that after the first kiss she felt that she had to get married to the boyfriend. One of the female shamanic specialists told me that when she experienced the first kiss with the man who became her husband, she was scared so much that she even became afraid that she had become pregnant from the kiss. There are other examples similar to those ones, when middle age women report their experiences with the first kiss as a reason for engagement and as a frightening experience. During an ethnographic interview a shamanic specialist explained uses the expression “to kiss the husband” explaining about having sexual intercourse. Thus, there are possibility that the “first kiss” may be a metaphor for first sexual intercourse.

although he comes from a family without much education. She said that it was after marriage when they had their first sexual intercourse that she became pregnant.

Christie told me that she used to feel “a lot of dor de mulher” (“*muita dor de mulher*”) especially before and during menstruation when she was single. After she gave birth, which happened in a hospital, she told me that she never felt it anymore. When I asked her once about the “Dona do corpo,” she told me that “it was her,” referring to the “dor de mulher” that she used to feel when she menstruated. She said that she also felt the dor de mulher “on the hips” (“*nos quartos*”) before and after delivery.

Diane, who is the fourth case study, told me that she married a man who has a stable job and used to be a good husband and father. After ten years of marriage, he started to have an affair with another woman and had children with her. Since then he lives in both houses, and that is the reason why she fights with him and sometimes tells him to take all his clothes and move to his “*rapariga*’s [“bitch”] house and never come back. I observed that it was very difficult for her to take this radical decision, since she told me that if she really sent him away she would be letting him go to his mistress, who would get all the advantages of her husband. Diane suffers enormously with this situation because constantly he would not give her enough money to buy food for her children or other items they needed.

Diane delivered all six of her children in Propria’s hospital, where she explained that she was “always afraid of dying.” She said that she “always felt dor de mulher” on the “belly’s foot” (“*pé da barriga*”), which means on the lower abdomen, and also monthly “at the time” (“*nas data*”) of her menstruation. I found that her

description of “dor de mulher” during delivery is similar to those provoked by the “Dona do corpo,” when she described that she usually felt “a cake like this” (“um bolo assim,” showing me that she felt like a small ball inside her belly). When I asked her if she had ever felt the “Dona do corpo,” she explained that she had “heard about her,” but she had “never felt her.”

Diane told me that she had three abortos/miscarriages, and one induced abortion in the hospital because of a dead fetus. Her first aborto/miscarriage happened because she had the desire to eat fish for several days and that, because this desire was not satisfied, she lost the child. Diane explained that another miscarriage happened because she used to be very sick (with “nausea,” “vomiting” and feeling “weakness”) and that is why she had an aborto/miscarriage before two months of pregnancy. A third pregnancy loss was caused by “a startle” (“susto”), when a car almost hit her when she crossed a road. She told me that after this happened the fetus “stayed dead” (“*ficou morto*”) inside her belly for about fifteen days. It happened when she was seven months pregnant and she was hospitalized. She told me that a remedy was given to her in the hospital, which made her have contractions and the aborto/miscarriage. Diane also told me that she tried to induce menstruation during two pregnancies, but because the children had “a goodness,” the “remedies never worked.” She said that she only used birth control pills for one month during her marriage. She attributes her lack of sexual desire to the problems she has with her

husband's involvement with a mistress. Diane told me that she only has sexual intercourse if her husband looks for her.¹²⁰

The fifth case study (Ema) has a partner who had already been married and had children from his previous conjugal relationship. She also had children with a first partner. Although she was living very well, I noticed that, because she became involved with a man who already had a family, she had a negative status among Kariri-Shoco women. I noticed that very often women mention that the worst thing a woman can do is to get into a relationship with a married man. Thus, I observed that while she could count on the help of closer relatives and friends, she was seen as a woman who did not have the respect of other women, because she had engaged in a relationship with a married man.

Ema told me that her five pregnancies were always normal, and that she always chose to give birth in hospitals. It was in the last pregnancy that she had a caesarean delivery and a tubal ligation, since the doctor from the Sementeira health clinic diagnosed her with a high-risk pregnancy. She also told me that she had never experienced any aborto/miscarriage, and that she sometimes used birth control pills.

Ema told me that she had never felt either “dor de mulher” or the “Dona do corpo,” although she knew about them. She said she had never “caught dor de mulher” (“*pegou dor de mulher*”), which is contagious, particularly when a woman who has it sits on the bed of a woman who has recently delivered, when the post-delivery woman has the body “opened.” Thus, because this never happened to her,

¹²⁰ I often recorded Kariri-Shoco women using verbs such as “to look for” (*procurar*) and “to care” (*cuidar*) when they refer to their husband's request for sexual intercourse.

she never felt or experienced “dor de mulher.” About the “Dona do corpo,” she told me that she had heard from her mother, who told about “her,” but that she never understood well what it was. She said that her mother used to tell her that if “she” comes out of a woman’s body, the woman dies.

The sixth case study (Faye) is a woman who had experienced several conjugal relationships with men older than herself, from whom she inherited houses. The first child to whom she gave birth, was already an adolescent who had for a long time lived with her sister in Porto Real do Colegio town. Her last child was born not long before I finished the field research. She became pregnant while she was living with her father on a farm where her father used to work. From what Faye told me about her life, her father had abused her, and a young man with whom she had a conjugal relationship also abused her.

Although Faye was more than thirty years old, she was still living with her father, who did not allow her to meet the man with whom she became pregnant. Faye also told me that her father said that, if she had a baby girl, he would make her give up the newborn for adoption. Faye is one of the case studies who lives in Porto Real do Colegio town, and does not participate in the Ouricuri ritual.

Faye had four pregnancies of which two were lost. She told me that her first pregnancy loss was an aborto/miscarriage that she described as a terrible experience, since she drank a “bottled” remedy that she prepared when she was already in an advanced pregnancy. She told me that she stayed for two days with the fetus dead inside her belly, and that she had the aborto/miscarriage at home, in the bathroom, and buried the fetus in the backyard. Because she started to have hemorrhage, she was

hospitalized to receive appropriate health care. She told me that she almost died. She explained to me that she became pregnant by a man with whom she became involved. It was an undesired pregnancy that she and her actual partner did not want to have and raise a child, so that is why she induced menstruation.

Regarding the other aborto/miscarriage, Faye said that it happened a long time ago, when she was living with a man who was very mean to her every time he was drunk. One day he got angry and hit her head with a chair when she was already seven months pregnant. Because of the anger and fear she felt, Faye explained that she started to feel lots of pain in her belly and went to the hospital where she delivered the baby who died and she had curettage. After this experience, she decided to not live with him anymore and separated from him.

After the separation, Faye decided to come back to Porto Real do Colegio, when she started to live and take care of her father, who began to control the rent that she received from a house that she owns.¹²¹ She first lived in the country, where her father worked for a farmer, and where she met the man by whom she became pregnant. Because her father had a serious accident, which made him become unable to work on the farm, he moved to the city with Faye to live in a rented house. Before I finished my field research, Faye had a baby and her father was willing to move to another city, where one of his daughters lives.

The father of Faye's baby was going to register their child, and she was meeting him without her father knowing about it. Faye had a caesarian delivery after which she also had a tubal ligation. She felt lots of "dor de mulher" during the

¹²¹ Another house that she used to own Faye gave to an ex-partner after they separated.

pregnancy and after delivery. After her child was born she was breastfeeding well and stayed at her sister's house where she was getting help for health care during resguardo.

The seventh case study (Gilda) has a conjugal relationship, although she has had several separations. She told me that when she started to date the man who became her husband, she was only fifteen years old. Although her father let her have a boyfriend, one night her father was drunk and wanted to hit him. Therefore she ran away with her boyfriend and they had sexual intercourse. They started to live with his parents and she became pregnant. She told me that she suffered a lot because she did not feel well either with his parents or with him. She mentioned that he did not treat her well, and that is why she decided to go back to her father's house, where she found comfort with them.

Gilda had her first child at home, where her grandmother helped to deliver her baby. She said that her grandmother gave her little bit of salt to put under her tongue and explained that would make everything come out from her belly, including the placenta. She also said that her grandmother stayed behind her while Gilda sat in a squat position on the bed and put her arms around her grandmother's neck when she delivered the baby. Gilda explained that she felt the "Dona do corpo" only after this first delivery. Her grandmother gave her a few seeds, which helped to avoid the pains caused by "Dona do corpo." Gilda told that it is incredible, because in both other deliveries she never felt "a dona do corpo."

Then, after the baby was already more than one year old, the baby's father came to her and asked her to live with him in a house where they could live together

by themselves. Because they used to fight very often, she separated from him again. After a while they started to meet and she became pregnant with her second son. She told me that she had his second son by herself at home, while her mother and grandmother went out to try to find a car to take her to the hospital. She said that it was her neighbor who came to help her after she had delivered her baby. Gilda told me that, after a time, she moved and lived again with her husband. Thus, her relationship was marked by these separations, and at the time of the field research, she complained that he did not take her out, and that sometimes he was rude with her and the kids.

Gilda said that she had an aborto/miscarriage because her husband complained whenever she got pregnant. She explained, “He could have been more careful... if he did not want more children,” by not looking for her for having sexual intercourse. It was from a woman from the city that Gilda obtained Cytotec pills to have an aborto/miscarriage. Gilda said that she had doubt about using this biomedical drug. She said that when she asked for the remedy from this woman she was a month pregnant and, when she gave her the pills, she was already four months pregnant. It was after her husband had a fight with her that she decided to use them. Thus, it was an impulsive decision to put one pill inside her vagina, and to swallow the other one in order to have an abortion.¹²² She told me that it was a baby boy, and she noticed because she was already four months pregnant and she saw when she held him on her hand. She regrets having had this aborto/miscarriage and she also blames the woman

¹²² I asked Gilda from whom she learned this procedure on using the Cytotec pills (to swallow and put inside her vagina). She told me that “most of women here they do that when they want to have an abortion,” but the woman who gave her the pills explained how she should use them.

who gave her the pills, telling me “she was mean to distribute an abortive drug.” She had to go to the hospital after her pregnancy loss because of a hemorrhagic problem. Gilda used medicinal plants to bathe and drink after she came back from the hospital as a resguardo procedure.

Then, not a long time after her pregnancy loss, Gilda became pregnant and had a baby girl. She told me that she suffered because her husband traveled to work in a city in Southeast Brazil during the time that she was already more than eight months pregnant. This last child she had in a hospital and told me that it was difficult because she did not feel pain to give birth. Gilda explained that she decided to opt for tubal ligation because of her husband. The tubal ligation caused a different menstrual cycle, and she explained that now she menstruates more often than before. She regrets that she had a tubal ligation because she wanted to have one or two more children. She also explained that she regrets the tubal ligation because of the aborto/miscarriage she had. Gilda is still a young woman in her twenties. Both aborto/miscarriage and tubal ligation she attributes to impulsive decisions she took within the troubled relationship she has with her husband.

The eighth case study (Hilda) is a woman who had an affair while she was still married. Her lover became her partner and the father of her son. Her ex-husband does not live in Porto Real do Colegio anymore, and she had four pregnancies when she was still married to him. She said that he used to hit and treat her badly. Thus, she explains that she does not regret that she was not faithful to her husband, because he deserved it. She also told me that she started to date before her breasts started to grow, when she was still a child. She said that when she became a teenager her father

did not care about her dates, because for him the worst would be if she lost herself with a boyfriend, thus she could fool around (*namorar*) dating without getting intimate. Thus, when she met and dated for six months the man who became the father of her children, she decided to run away with him by the time she was eighteen years old. She said that he still loves her very much, but because of his drinking problem, which made him beat her, she lost the love that she had for him. Thus, she says that the lover she found was a punishment for her ex-husband.

Hilda said that her ex-husband used to drink a lot and she started to have an affair and date her current partner when her husband was lying down drunk. She used to kiss her lover in front of everybody. Then, she decided to separate from her husband to live with her lover, who took care of her son when he was still a baby. That is why she considers him her son's father, and actually the boy, who was six years old by the time of the research, calls her partner "father."

Hilda lives in a small village house in Porto Real do Colegio, where the municipal government built houses and distributed them to people who needed a house. As she applied for the house, she was able to obtain it. She usually fights with her partner, because he likes to go out at night and comes back late after drinking. Thus, she is very jealous of him, because she says that he is with the raparigas, spending money with them.

From the four pregnancies that Hilda experienced, only two children are alive. One of her children she gave to her mother, and the youngest one she kept and raises him with her partner. Although she gave her daughter to her mother, she still has influence and a relationship as the mother of her child. She told me that she had a

seven-month old infant who died because of health problems. She had experienced also a seven-month premature delivery caused by *susto*, from which the baby did not survive. She explained to me that she had serious problems with high-blood pressure during pregnancies and that the doctor told her that she had eclampsia during deliveries. Thus, all her deliveries were in hospitals, where she had to go under special care. It was in the last pregnancy that she had a caesarian and decided to have a tubal ligation. She told me that during pregnancies she used to be sick all the time, and during all deliveries she “put [her] life at risk” (“*arriscou a vida*”). She explained to me that she had used birth control pills for six months, but she decided that it would be better to have tubal ligation, not only because of the problems she had during deliveries, but because she was “a very nervous person,” and did not have patience with her children.

Hilda told me that since she had the tubal ligation, she noticed that she feels less sexual desire, and that her menstrual cycle has been altered. Now she is *desregrada*, which means that her menstrual cycle does not “come regularly.” She says that sometimes she regrets having a tubal ligation because she misses having a baby. Although she has a tubal ligation, Hilda suspects that she is pregnant sometimes.

The ninth case study (Ina) is a woman who also suffered considerably with her first partner. She even had a miscarriage from a frightening joke he did with her when she was four months pregnant. She said that she fell in love with him when she met him at an Ouricuri ritual, when he came to participate from another indigenous area. After they met, it did not take long for him to move to Porto Real do Colegio, and

they started to live together in a house that a friend lent to them in the Sementeira reserve area. Because he was very “*mulherengo*” (“lady’s man”), she could not stand how unfaithful he was to her. She experienced four pregnancies with him, from which she had three miscarriages. She told me that she never induced menstruation and during her pregnancies she had always felt very sick, vomiting a lot in the first months. Ina thinks that her miscarriages were all related to anger she felt about her partner’s behavior, and a *susto* when he put a lizard on her leg when she was four months pregnant. It was only in this miscarriage that she had to go to the hospital, where she had curettage.

After she separated from her partner, he went back to his indigenous area, and she decided to leave her daughter with her mother while she went to another city, where she worked in a house to get income to help her mother to raise her child. She said that she had been very ill during this time, and had to come back to the reserve where she looked for indigenous health treatment. The disease-illness that Ina caught was related to an evilness, which was sent upon her by a shamanic specialist who was sexually interested in her. Ina described her disease-illness as a health problem related to “Indian’s disease.”

It was during the field research that Ina established a conjugal relationship with a man to whom she became attached. She said that it was a surprise when he asked her suddenly if she wanted to live with him. She told me that because he used to come to her parents’ house, and was a friend of her brothers and sisters, she used to like him, although she never thought that he could become her boyfriend. Because she knew that he was a nice person, she started to date him and soon she accepted his

will to live together. She was planning to take birth control pills, but before it happened, when they were already living together, she became pregnant. During the first months she constantly had morning sicknesses, headaches, and vomited very often. She was very afraid that she could have an aborto/miscarriage, and after her third month she had an ultrasound, which for her was the confirmation that her baby was alive.

The tenth case study (Julie) is a single mother of three children and lives with her parents and sisters. Julie had experienced a dangerous “doença de índio,” when she was a teenager. She explained that she caught it from a very powerful male shamanic specialist, who asked her to touch her breasts (when she was fourteen years old) and she reacted against it by cursing his mother. Thus, she became severely sick for several years during which she used to have convulsions, and “lose” (“perder”) her head.

Julie had three children and one aborto/miscarriage. All her deliveries were at home, with the help of a midwife or neighbors. The two older children had unidentified fathers. The aborto/miscarriage and the youngest child were from the same man. About the pregnancy loss, Julie blames this man who made her do it. He was the one who bought Cytotec pills and told her to take them. She told me, crying, that she regrets it so much, because she was not strong enough to decide to keep the pregnancy. Julie said that when she had this pregnancy loss, she saw that the embryo was female. She had the aborto/miscarriage at home, and she buried the embryo in her backyard. She did not need to be hospitalized after she had it, and she kept the resguardo and used medicinal plants.

During the field research Julie was already pregnant by the same man who made her have the aborto/miscarriage. She told me that, for this pregnancy he could tell and do what he wanted, but she would keep the pregnancy. She wanted to have a baby girl, but when she had the delivery at home, another baby boy was born. Although she thought that she could have the delivery in a hospital, she felt the “dor de mulher” and decided to take a tea made with a seed which she said had “the power to decide the situation” (“*poder de decidir a situação*”). She told me that if it were not the time to have the baby, the pain would go away. After she had the tea, she decided to take a shower, but as the pain became stronger, she fell down during the shower and her mother helped her to go to bed. She told me that it was too late to go to the hospital, as she felt that the baby was going to be born. Her mother called a neighbor who came to help. When the neighbor arrived, Julie had already delivered her baby by herself. The neighbor helped her to deliver the placenta which was buried in the backyard by Julie’s mother. They called a nurse assistant who came to take care of the baby, and make sure that Julie was fine. She followed the *reguardo* taking baths and drinking remedies during one month and breastfed her baby well.

The eleventh case study (Lila) had established a conjugal relationship with a man who was more than twenty years older than she. She was not the first woman with whom her partner had established a marital relationship and with whom he had children. She told me that, although many other women were blaming her for being involved with a man that had already been married, she said that he was providing what she needed and she was satisfied with him. Thus, as he was a good partner, she said that the best thing to do was to stay with him and have their child, who needed a

father. Lila had a normal delivery at the hospital where her partner came with her and helped her to deliver her baby. Her partner told me that she was complaining too much about the pain, and that he started to tell her to “put strength” (“*botar força*”) when the pain from contractions came. He also told me that she was very frightened and afraid to die, but he helped her to see that nothing bad would happen. Because they were in a public hospital, they did not allow him to accompany her when she was removed to a delivery room.

Lila did not know what the “Dona do corpo” was and she said that she never felt “dor de mulher.” She explained that she had already felt pain related to menstruation and also before and after she delivered her baby. She was very happy with her newborn and took care of her resguardo, using medicinal plants. After her resguardo her partner used condoms as a contraceptive method because he did not want to have more children.

The twelfth case study (Marian) ran away with her boyfriend when she was sixteen years old. They went to her partner relative’s house, where they stayed for three months. Afterwards, they moved to a house that had been a storehouse, which had several divisions inside, and they lived in one of the rooms. They used to go to the same school and they decided to get married by running away. She became pregnant one month after they started to live together. She had a sad experience with a three-month pregnancy loss. Thus, she was hospitalized and had curettage. She explained that people told her that she had a miscarriage because she used to play sports, which she did not think could cause it. She stayed three days with pain and hemorrhage before she had the aborto/miscarriage. Ten months later, Marian became

pregnant again. She said they used a natural contraceptive method that her partner learned from a book from school, by avoiding sexual intercourse when she was in a fertile time. She had her child several weeks after the time that was predicted by the ultrasound exam. The medical doctor from the Sementeira health clinic wanted to send her to the hospital for her to have a caesarian. Marian's mother did not let it happen. She told me that her mother said, "Doctors are not more than God" ("*Os médicos não são mais que Deus*"). Marian explained that because her mother had several children, from her experience she knew how it was. Thus, Marian's mother did not let her go to a hospital to be submitted to a caesarian. Both her partner and she were students, although she stopped her studies after she had her baby. She was planning to continue her studies after her baby grows. Her partner works during the day, and at night he goes to school.

Because Marian is very shy, I never talked to her about sexual desire. She was happy with her baby, and her mother helped her, assisting her during her resguardo after delivery. Actually, Marian moved to her parents' house during her resguardo, where her mother provided medicinal plants and assisted her to follow and take care of her resguardo and the newborn. Marian told me that she thought "dor de mulher" was the pain she felt from menstruation and before and after delivery. Although she had heard her mother talk about the "Dona do corpo," she never felt "her."

After researching reproductive women cases studies, I realized that Kariri-Shoco's women's idea of a kind of pain which is only felt by the female body, perceived as "dor de mulher," codes more than a characterization of women's experiences with physiological reproductive processes. The notion of "dor de mulher"

also reflects the relationship Kariri-Shoco women experience with their husband or partner which very often is characterized by emotional suffering. Thus, I consider that “dor de mulher” and to some extent the “Dona do corpo” (which provokes “dor de mulher”) expresses Kariri-Shoco women’s sufferings.

Bordo (1989) and Scheper-Hughes and Lock (1987) can be examples of authors who consider the body as metaphor of culture. Bordo (1989) emphasizes how the body “operates as a metaphor for culture” (Bordo 1989, 16) and is a “practical direct locus of social control” (Bordo 1989, 16). The unit of analysis of her discussion concerns gender as a historical construct. She uses Foucault’s (1979) concept of power as a network of practices and a constitutive mechanism related to a discourse. This notion of power Bordo (1989) uses to focus on historical gendered-related disorders (such as hysteria, agoraphobia, anorexia) to which middle and upper-class American white women are more vulnerable. Those gendered disorders (practices and discourses) are seen as “potential resistance,” which maintains and reproduces the existing power relations, and also as “textuality in which symptomologies have symbolic and political meanings” (Bordo 1989, 16). In this sense, Bordo’s (1989) analysis comes close to Scheper-Hughes and Lock’s (1987) idea of sickness as “a form of communication through which nature, society and culture speak simultaneously” (Scheper-Hughes and Lock 1987, 25). I consider that the female Kariri-Shoco emic organ can be considered as expressing a metaphor of the historical process of colonial oppression in which indigenous peoples were submitted under Catholic and governmental surveillances.

As it was already described in Chapter V a VII, the “Dona do corpo” is also experienced as a congenital or contagiously gender-transmitted female *doença*. I found in Kariri-Shoco women’s discourses analogy between their use of the expressions “Dona do corpo” and symptoms of pain referred to as “dor de mulher,” from which the expression “Dona do corpo” intersect semantic meanings of a female health problem, a female symptom of pains, and a gendered female emic organ. Thus, this Kariri-Shoco female emic organ belongs to an ethnophysiological reproductive process domain from which it constitutes also a female naturalistic health problem. I argue that Kariri-Shoco women experience this emic organ as a matrix of a displacement reflected and produced within a historical process from which they have been immersed in a Western patriarchal system of male oppression. Cases studies described above show evidences how patriarchal conjugal relationships have characterized women’s experiences among the Kariri-Shoco.

8.4. Some Observations on Authoritative Knowledge and Medicalization Related to Physiological Reproductive Processes

Here, I discuss medicalization of reproduction as a process from which biomedical assistance has made efforts to exercise control over the female reproductive body. First, as an example how Kariri-Shoco women have complied, resisted, or challenged biomedical intervention, I focus on the lower abdominal and perineal surgery, which Kariri-Shoco women often refer as “*operação de perino*.” I also consider how authoritative knowledge relates to decisions that Kariri-Shoco women make on using indigenous and/or biomedical assistance, which reveals which medical knowledge is more valued.

From what I observed and experienced during fieldwork, Kariri-Shoco women very often make use of indigenous health care treatments to keep them healthy in terms of gynecological and obstetric health problems. I interviewed two indigenous nurse assistants, who work in Sementeira health clinic, about those treatments. There, they explained their own use of remedies for gynecological health care. One of them told me that recently she “felt a strong pain,” which she did not explain as “dor de mulher,” but said it was “*cólica*” (“pain”) inside her lower belly. She described it as a strong pain, and said, “I could not even walk well because it was too painful.” Then, she told me that she decided to take a treatment “making a tea,” using two different kinds of medicinal plants, and “bathed” herself with this remedy “by sitting in a *bacia* [washtub] for about ten minutes.” She told me that she also made a douche (“*ducha*”) with this remedy, and that on the following day she was already well as she did not feel pain anymore. This indigenous nurse assistant said that last year she had the *citologico* (cytology and colposcopy) exam, which is a gynecological preventive procedure that Kariri-Shoco women regularly take.

Another indigenous nurse assistant told me that she only goes to the doctor after she tries all herbs and bush remedies for cure-healing a health problem. Thus, only after she discovers that bush remedies are not working, does she decide to use the biomedical health care system. She follows similar procedure for her children’s health problems. She explained:

“Health problems that I can cure using herbs from the Ouricuri, I use them. My father makes remedies and mother also. The remedy depends on the association of the herbs.”

When I talked to Dona Maria Velha about women's health problems, particularly related to gynecology and obstetrics, she explained that Kariri-Shoco women are very "smart" ("*sabidas*") that usually "they do not speak about their health problems because they do not want everybody to know about them."¹²³ Then, she told me about a doctor who suggested that she should have an *operação de perino*, but she explained to me that she would "never have it."

I understand that what Kariri-Shoco women refer as "*operação de perino*" is a lower abdominal and perineal surgery, which is a common female surgical procedure in Brazil. They often describe that the medical doctor explained that this surgery "lifts the bladder and the womb" to correct the position of those organs, which are "fallen." Kariri-Shoco women also tell that this "fallen womb" health problem is dangerous because the "womb can come out of the body," and also cause urinary incontinency. I also understand that a perineal hernia is corrected since incision is made through the vaginal wall, from which Kariri-Shoco women often describe that they "become more closed" ("*fica mais fechada*") after this surgery.

I have transcribed and translated the conversation I had with Dona Maria Velha, when she mentioned information about this surgery and also about tubal ligation:

"[D. Maria Velha:] There are many young *caboclas* who had [tubal] ligation to not have babies, lots of them did. And they have problems [consequences], they go to the doctor, but they do not tell anybody. I have delivered so many children, and then I told to my friend that the doctor said that I should have *operação de perino*. He told me that I should have this surgery forty-five days after I had my last delivery, because I have a problem that it is dangerous with age and it can also cause a lot of pain. Then, I talked to my friend and she said, 'Maria, you should be careful with this, because I know how

¹²³ Dona Maria Velha explained that "in a fight" a woman could "tell out loud the problem that the friend had told, and make it public and shameful for the friend."

the operação de perino is.’ The person doesn’t get well ever [she laughs telling me this]. My friend had done this surgery. Because there are women who take this surgery and become almost closed. She stays like a virgin woman, and when the husband goes to *transar* [to have sexual intercourse], it is very painful. It is necessary to put a remedy, like a cream, or take baths [with medicinal plants].”

“[I asked:] Did it happen to her?”

“[D. Maria Velha:] Yes, [and told me her name and explained:] She is my friend, I like her very much and she likes me, it is a secret. She told me, ‘Maria, don’t have this surgery, take some baths with remedies, don’t take this surgery because you will for sure be in a bad situation.’ Another cabocla told me, ‘I regret it so much after I had this *perino* [perineal surgery], I regret it so much.’ And I told her: ‘You became younger!’ And she said, ‘Yes, I became younger, but now I cannot work in the field [rice plantation].”

Dona Maria Velha showed to me how working in the field the person has to bend the body while harvesting crops. This woman told Dona Maria Velha that when she returns home from this work, she comes back “swollen” (“*inchada*”). We continued our conversation:

“[I said:] Hail Mary! So you decided well for not having this surgery! [She laughed]”

“[D. Maria Velha:] A nurse told me that it is a very dangerous surgery. The woman keeps the legs up to take remedy in the vagina. When the woman has a good flesh, it is good because it heals quickly. But when it is on a bad flesh, the woman is going to suffer very much. She is going to walk like she had hatched an egg.¹²⁴ A nurse told me!”

Then, Dona Maria Velha explained why the doctor prescribes this kind of surgery. She also told me about treatments using “bush remedies” that Kariri-Shoco women use in order to be healthy.

“[D. Maria Velha:] It [‘perineal surgery’] happens because when the child comes forcefully and there is a little piece of flesh [hernia] that comes out. Thank God, I am not going to take this surgery...”

“[I asked:] Do women complain about this problem related to this piece of flesh?”

“[D. Maria Velha:] Didn’t I tell you? They don’t speak about their problems. There are several remedies with baths. When we go to the Ouricuri, what you see most is many women collecting bush remedies from roots of trees to make remedies. Then you take a bath today, other tomorrow, and another the day after tomorrow. That flesh is healed

¹²⁴ Dona Maria Velha tells me this laughing, as a humorous way to describe how the woman was post-surgery.

and closed. Then you're healed inside. It is a lot about our body. And that is why I say. Women, like old ones that I know, who had this surgery, they became like *moça* [virgin], because she has closed. But a woman who makes this surgery and still have a husband! She is going to suffer a lot!"

The suffering that women go through after perineal surgery, as Dona Maria Velha previously mentioned, also include dyspareunia, which is pain during sexual intercourse practices that women feel after they are submitted to this kind of surgery.

"[I asked:] How many women here do you know who had this surgery, D. Maria?"
 "[D. Maria Velha:] I think about five or six women did it. That is why I say; I only take it if it is a case of death. If I have the option of not doing it, I won't. To prepare my luggage, healthy, to come back home striped, sowed by somebody's hand? Me, Maria Tenorio? Only if it is something given by that Divine Father! [She laughed]."

Thus, Dona Maria Velha's decision not to have *operação de perino* shows how, despite the medical doctor's diagnosis, she decided to take indigenous treatments using "bush remedies" as indigenous gynecological or obstetric health care. This shows that the authoritative knowledge she trusts most is the indigenous medical treatment.

I interviewed a sixty-eight year old woman. She also explained to me that a medical doctor told her that she should have *operação de perino* because her "womb was fallen" ("*útero caído*"). She decided to treat herself with "bush remedies," which she uses daily by bathing herself with them. This elderly woman explained that her husband was always very "*raparigueiro*" (which means that he used to be a lady's man) and because of that she had always been very careful of her (gynecological) health by the use of those "bush remedies."

Hilda, who is a young woman, told me that she was diagnosed for *operação de perino*. She said that a medical doctor told her, during a gynecological exam, that she needed it because she has "low womb and low bladder" ("*útero baixo e bexiga*

baixa”) and additionally, for a “perino” (perineal hernia). Although she does not understand why she needs this surgery for “perino”, since she only had three children, she recognizes that she is “a little bit *folgada*” (loose, as she has her vaginal muscle stretched). Hilda explained that her stretched vaginal muscle problem is the reason why she plans to have this surgery. According to her, this problem interferes with sexual intercourse, which makes both her husband and herself feel less pleasure. I asked if she had urinary incontinence, and she answered that she did not have it. Hilda explained that during the gynaecological exam, the medical doctor asked if she was feeling that she was urinating, and she told him, “No.” The doctor said that she was. Thus, she plans in future to have this surgery. Hilda also told me that she does not understand why she needs to take this surgery because, when she had her last delivery, the medical doctor had already done a surgery. She described that she was “sewed” (“*costurada*,” stitched). I understood that she had an episiotomy done by the doctor, which was a medical procedure not explained to her.

I interviewed a twenty-one year old woman who had this operação-de-perino. When I met her, she was still in a forty-five day resguardo for a tubal ligation, which she had the previous month. She explained that she already had two children and, because she felt lot of pain during pregnancy and she had caesarean deliveries, she opted for tubal ligation. I was impressed that she had a tubal ligation so young. Regarding her forty-five days of resguardo for a tubal ligation, I told her that I often heard that usually resguardo lasts thirty days. This young woman explained that she had operação de perino in the previous year, which was for “perino, and womb and bladder’s lifting.” Through information about this surgery, she explained that she had

followed an even longer resguardo which lasted for ninety days. During these three months she followed health care related to restrictions on food and activities. She also used “bush remedies,” drinking them and bathing her lower abdomen with them, and avoided sexual intercourse.

When I asked this interviewee if she had ever felt “dor de mulher,” she explained that she used to feel it considerably during pregnancy, before and during menstruation, and after the caesarean deliveries. After I asked her about “a dona do corpo,” she explained that it was “she,” whenever she felt “dor de mulher.” She said that after the caesareans:

“She [a dona do corpo] wanted to come out because I could feel her while I was lying down on the bed. She [a dona do corpo] got that strength [força] searching for the child in the surgery [incision].”

This young woman described that she “put” her hand on the incision, and could feel that “ball” (“bola”) and said: “She [a dona do corpo] was crazy!” She told me that she “used to take baths [with ‘bush remedies’], because when you bathe yourself you renew yourself.” She mentioned that several times she asked Dona Maria Velha to pray on her for “a dona do corpo.” This interviewee uses several different kinds of medicinal plants for baths as indigenous treatments, including before menstruation when she still feels “dor de mulher.”

All cases mentioned above show how Kariri-Shoco women, even younger ones whom I consider are more susceptible to comply with biomedical interventions, use indigenous medical treatments during cure-healing processes for gynecological and obstetric health care. Those cases also suggest that Kariri-Shoco older women are more

resistant to biomedical interventions and take decisions that challenge biomedical knowledge.

The biomedical local clinic provides primary biomedical healthcare. According to one of the nurse assistants, the Sementeira medical doctor does not maintain pregnant women's files about their prenatal health care. This nurse assistant told me that prenatal care depends on how often pregnant women go to the health clinic for this biomedical assistance. Once, I had the opportunity to interview three pregnant women who were waiting for the medical doctor outside the Sementeira health clinic. These three young women spoke about their experiences with prenatal health care, when biomedical exams were taken after they discovered their pregnancies. All of these three women told me that they were planning to give birth at the hospital. The reason why they choose this option relates to the fact that at the hospital they would have more privacy, since at home several neighbors come to see them and they are more exposed. They also mention their fear of maternal death, reported by several Kariri-Shoco women whom I had previously interviewed. This concern for dying when they decide to deliver in hospitals is very widespread. They very often speak about cases of Kariri-Shoco women who had died in Propria's hospital, when it used to be the hospital used for obstetric biomedical assistance.¹²⁵

¹²⁵ Information about Kariri-Shoco maternal deaths was only obtained from Kariri-Shoco women's commentaries that they were afraid to die when they decide to give birth in hospitals. Through the National Research on Demography and Health-*Pesquisa Nacional de Demografia e Saude* (PNDS), national governmental research conducted in 1996 on health and reproductive rights, the medical anthropologist Ignez Perpétuo (2000) explored data to understand and situate factors (such as socio-economic context, sexual reproductive experience, contraceptive assistance, and prenatal assistance), which she could relate to racial issues. Regarding maternal mortality, Perpétuo (2000) demonstrated that the higher rate among black women is

In July 2002, Mota (2002) sent an electronic message placed on the website in Studies and Research Ethnicity Nucleus-*Núcleo de Estudos e Pesquisa sobre Etnicidade* (NEPE). In this message, Mota (2002) informed readers of the tragic death of a Kariri-Shoco woman who was sent to *Casa da Misericórdia* Hospital in Penedo to have a caesarean delivery prescribed by a medical doctor from the Porto Real do Colegio health clinic. Marcia, who already had a two-year-old son, was pregnant with twins. Although Marcia's mother went in the ambulance to accompany her daughter, she was not allowed to stay with Marcia in the hospital. The newborn twins died right after surgery and Marcia died a few hours latter. No explanation was given to Marcia's mother about the causes death. Later, she received a death certificate where it was written that Marcia's death was caused by cardio-respiratory failure and kidney malfunction after the surgery. The deaths of Marcia's twins were ascribed to "congenital infection" (Mota 2002, n/a). This tragedy that happened with Marcia and her infants confirms to Kariri-Shoco reproductive women how they can be exposed to

related to less access to health services, where much of the mortality rate is a consequence of high blood pressure. She evaluated that 89 percent of the causes of maternal death in Brazil are directly related to obstetric causes (high blood pressure, hemorrhagic syndromes, abortion and infections during puerperium), which reveals that many of the deaths are the "responsibility of deficient obstetric health service" (Perpetuo 2000.) Eleven percent of other maternal deaths are caused by indirect obstetric factors (non-specified diseases during pregnancy, delivery and problems during puerperium) that could be prevented by obstetric services. Thus, maternal deaths could be avoided by efficient preventive biomedical practice through better quality public health services. It has been estimated that in 1997 from 100,000 newborns delivered alive, 110 maternal deaths occurred in Brazil, which represents 6 percent of women's (from 10 to 49 years old) cause of death (Tanaka 2000). These data show the failure of the Brazilian biomedical public health practice. The public health care system has been unable to provide preventive medicine and health promotion. This deficiency is directly related to the quality of services for reproduction, which has been responsible directly (89 percent) or indirectly (11 percent) for maternal morbidity and mortality in Brazil (Tanaka 2000).

maternal death when they decide to have biomedical obstetric assistance. This contributes to their decisions to have children at home, when they are afraid of dying if sent to hospitals.

Several reproductive women case studies opted for biomedical assistance, as they wanted to deliver in hospitals -- Kristy, Diane, and Gilda. Several women -- Betty, Ema, Faye, and Hilda -- told me that they gave birth in hospitals when a medical doctor diagnosed them as having a “risky pregnancy” (“*gravidez de risco*”). Some of these women already had obstetric health problems. Betty had a caesarean from which her newborn died, had a tubal ligation and later had an esterechtomy. Ema and Faye who were about forty years of age told me that they had problems with high blood pressure, which was also the health problem that Hilda told me that she had.

Delivery for Kariri-Shoco women seems to be a situation that often happens unexpectedly. I found several cases of women who have delivered without anybody’s help, and only after the delivery a neighbor, a nurse assistant, or a midwife arrived at their homes. I believe that this decision to be by themselves during delivery is related to their need for privacy during labor. In several of those cases -- Gilda, Julie, and Dona Maria Velha -- the women explained that they had delivered at home because they did not have time to go to the hospital. In my point of view, this information demonstrates how there was already an implicit option for those pregnant women to have the delivery at home.

Dona Maria Velha described her decision to have a child by herself, when she did not tell anybody that she was having contractions and stayed quietly at home. It was Dona Maria Velha’s sister who suspected that she was in labour and called an elderly

friend who came and helped Dona Maria Velha. This happened, though, after Dona Maria Velha had already delivered a son. She told me about this experience very proudly to show how courageous was her decision to have a baby alone. It was her friend Dona Maria Curi who came and helped her to deliver the placenta.

Although she does not consider herself a midwife, Dona Maria Curi had already helped several Kariri-Shoco women to give birth at home. She told me that she had “handed” (*pegou*) more than ten children, as she explained that helped several Kariri-Shoco women to deliver their babies. Dona Maria Curi also told me that “at a time of a need, anybody can be a midwife,” which I had already heard from other women who had also helped women to deliver, like Dona Ivete. Both Dona Maria Curi and Dona Ivete are “Avós” shamans.

A sixty-eight year old woman told me about her own experiences with twelve pregnancies. She said that “for sure,” if she had those children today, she would have to be transferred to deliver them in hospitals. She said that during labor she used to feel lots of pain when she usually waited two or three days before giving birth. This elderly woman’s explanation relates to Kariri-Shoco women’s perceptions that how long labor lasts determines their option for biomedical assistance. There would be enough time for them to be taken to a hospital. Still, Julie, who is a young Kariri-Shoco woman, had all her three deliveries at home. She is one of the case studies who live in Porto Real Real do Colegio town. When Julie started to feel “dor de mulher,” instead of searching for biomedical assistance, she decided to take a “bush remedy” which would give her more contractions, and therefore, it would make her deliver faster, or it would stop the pain. As the “bush remedy” caused more contractions, she had her baby by herself at home.

Only after she delivered her newborn, did a neighbor arrive and help her with the placenta's delivery. Julie's neighbor told me that it was the first time that she assisted a woman during delivery. Thus, my observation, from information I gathered about delivery and midwifery, is that very often as Dona Maria Curi had told me -- when necessary, any woman might be helpful for a delivery. A nurse assistant from the Porto Real do Colegio health clinic only arrived later to help Julie with her newborn.

I registered during fieldwork four different names of midwives who had worked among the Kariri-Shoco. Every time I asked an interviewee who helped her during delivery, they named the midwife. I conducted several interviews with Vanda, who is the only traditional midwife among the Kariri-Shoco today. Vanda does not receive any support from the local medical doctor of the Sementeira health clinic to follow her work as a midwife. She told me that she needs disposable pharmaceutical materials, like rubber gloves and antiseptics, but the medical doctor does not authorize their provision from the Sementeira health clinic pharmacy, where these materials are available.

Vanda has a notebook where thirty cases were registered of women whom she had helped to deliver at their homes or in the Ouricuri village (where during rituals a pregnant woman may give birth). She has worked as a midwife relatively recently among the Kariri-Shoco. She decided to move in with her mother in 1993.¹²⁶ Vanda

¹²⁶ Vanda moved from Aracajú, capital of Sergipe state, to live in Sementeira reserve area after her mother had a stroke and decided to live among the Kariri-Shoco. Vanda, her mother, and sisters, are example of cases of Kariri-Shoco people who were living in other northeastern cities and returned to live among the Kariri-Shoco in the reserve. The reason why her mother decided to return after the stroke is very significant, since according to their understanding the stroke is a very dangerous

explained that her knowledge of midwifery was obtained by her own curiosity and vocation to help women during labor and delivery. She also mentioned that she discovered much of what she knows by her experiences with her pregnancies and observing and touching her own body.

Jordan (1978) observed:

Traditional midwives... have acquired what they know *empirically*... in the actual doing of it (Jordan 1978, 81).

This is the case of Vanda, who did not have any biomedical training for her work as a midwife. She now studies in a school in Propria to have a high school degree in order to be able to take a technical degree in nurse assistance. Thus, she plans to become one of the nurse assistants in the Sementeira clinic health team, working as a midwife.

During the first interviews conducted with Vanda, she explained to me about the ‘openness’ and ‘closedness’ of the body. As I asked her about how vulnerable women are when menstruating or after delivery, she talked about cases to illustrate how women are more exposed to the “bad will” (“*má vontade*”) of others when they are with the body opened. She told me about a menstruating woman who became very sick because another woman had done an “inversed prayer” (“*reza invertida*”) against her.¹²⁷ It was in the Ouricuri where this woman was treated after she became with her body closed (when not menstruating anymore). About another case, Vanda explained: “After delivery the woman has to take care of her resguardo for at least

disease, caused by an evil spirit. Thus, Vanda’s mother came back in order to have the treatment and protection she needed.

¹²⁷ Pajé Júlio explained to me that “inversed prayer” is when somebody prays a prayer through an inversed way to send something evil to somebody. He defined this as “the prayer to dominate others” (“*a reza para dominar os outros*”).

ninety days.” According to her, this is the period that the woman is still with the body open and vulnerable to catch evilness. She described a case of a woman who ”became crazy” (*“ficou doida”*) after she gave birth. The reason why this happened was associated with a “reza invertida” that was done by another woman. Vanda told me that the woman who used an “reza invertida” was the one whose ex-husband had moved to live with the woman who became “crazy” after delivery. By “reza invertida,” I understand it to be actually prayers that can be used to harm others, as those that are found in the book of Saint *Sipriano*, where recipes of magic are also found. Vanda was the only health practitioner who mentioned “reza invertida.”

One of the female shamanic specialists told me once about her own experience of “becoming crazy” after she delivered a baby. In this case, the old Pajé Suíra treated her with the use of reza rituals and remedies for three days with the help of other shamanic specialists. The health problem that this female shaman reported did not relate to witchcraft work. She told me that it was caused by a “weakness” because she “had lost a lot of blood,” but she also mentioned that she had “broken” her resguardo.

Thus, the period after delivery, which is followed by health care called resguardo, is an important period when women respect several restrictions related to diet and activities, and also practice sexual abstinence. As I have already mentioned on previous sections, a woman who has her resguardo “broken” may have serious consequences, which can be related to “craziness” or even death after delivery. I met a few women who told me they became “nervous” because they had “broken” their resguardo in the past. They usually mean that a resguardo is “broken” when women do not follow those rules, or when it happens that she has a susto or a strong anger during

this post-delivery period. Both *susto* and anger are considered dangerous emotions that are often pointed out as causes for aborto/miscarriages, which I have already described.

What called my attention to *resguardo* was that I have registered little similar data on how those rules must be followed. For example, information on food restrictions varied considerably according to what a postpartum woman should eat or avoid eating, although chicken is usually considered the appropriate meal. According to activities, there is a restriction for women not to take a full body bath, particularly not to wash the hair, for at least three days after delivery. Some women told me that this restriction should last for a month, when they would go to take a bath in the river. All of the Kariri-Shoco women interviewed start to bathe their lower abdomen with “bush remedies” as soon as they can after delivery. I noticed, though, that despite the varieties of rules followed concerning how long and what to follow during *resguardo*, the mother of the post-delivery woman plays a fundamental role in supporting the daughter’s health care.

What I find important about the *resguardo*, as indigenous healthcare, is that it shows how, despite the option which Kariri-Shoco women take to give birth in hospitals or at home, they still follow this kind of indigenous health care. Thus, I had information on women who had given birth in hospitals and, despite the doctor’s demand for them to take a bath after delivery, they would only wet their hair to pretend that they took a shower. About this, Dona Maria Velha said: “The caboclas are smart!”

I also registered cases of women who brought medicinal plants to the hospital, such as tobacco or *velandinho*, which they use for their protection, hiding them under the pillow and smelling it. Thus, the *resguardo* is followed and “bush remedies” are

frequently used, even when Kariri-Shoco women decide to utilize biomedical health care assistance. I realized, after gathering this information, although there is a medicalization of reproduction related to biomedical obstetric procedures, Kariri-Shoco women continue to use their own indigenous practices in terms of health care. This also reveals that in terms of authoritative knowledge, Kariri-Shoco women find ways to continue taking procedures from their indigenous medical knowledge.

In this section, I raised observations on data that provided a basis to focus on medicalization and authoritative knowledge. My observations are limited to illustrative experiences that I have described from Kariri-Shoco women who have used indigenous and biomedical health care systems. I have noticed that Kariri-Shoco reproductive women very often make use of biomedical exams, although they have resisted biomedical interventions when they perceive that indigenous treatments are effective. The failure of biomedical assistance, which is reflected in maternal deaths that still occur, contributes to their option to give birth at their homes. My research found evidence that Kariri-Shoco women, even when they are under biomedical assistance, still follow indigenous health care. This shows that, although they apparently comply with biomedical interventions, they resist them through their use of indigenous medical knowledge.

CHAPTER IX

CONCLUSION

The paradoxical truth, in fact, appears to be that if there is an essential characteristic of embodiment, it is indeterminacy. (Csordas 1994a, 5)

9.1 Embodiment: The Body as Object and/or Subject of Knowledge

Lock (1993, 133-34) argues that recently no substantial review about the anthropology of the body per se has been done, while significant developments have been conducted, which, according to her, reflects an ambivalence toward theorizing the body. Both Strathern (1999) and Csordas (1990, 1994a) have discussed the notion of embodiment and the body, exploring, as Lock (1993) did, topics in a literature review about the anthropology of the body. Lock (1993) mentions:

This type of research has brought us to a radical position with respect to the truth claims of the medical and epidemiological sciences... [and her intention is] to move toward an improved dialogue, while remaining inherently suspicious of universal truths, entrenched power bases, and intransigent relativisms (Lock 1993, 134).

Strathern (1999) argues that “the stress on embodiment constitutes... a muted universalism at the back of an emphasis on local knowledge and local constructions of the person” (Strathern 1999, 195-196). In this sense, for Strathern (1999), embodiment expresses “a new humanism... that is intended to bring us back to ourselves... a reaction against disembodiment... [it] is a post-Weberian and post-Marxian concept that nevertheless is able to draw on the themes of asceticism and

exploitation advanced by these two grand theorists seen, as it were, through the eyes of Michel Foucault” (Strathern 1999, 198).

I use Foucault’s (1979; 1983) theory of power considering how Kariri-Shoco shamanism has been a form of resistance to a history of colonial oppression. Further, I also consider Foucault’s (1979; 1983) concept of power to focus how Kariri-Shoco women have resisted to historical process of male oppression. According to Foucault (1979; 1983), power is something fluid and exercised rather than possessed. In this way power is something primarily productive. Also, in order to focus how power is displayed, it is necessary to analyze it as something that comes from the bottom up (Foucault 1979; 1983). Foucault (1979; 1983) interrelates power and resistance, since he considers that where power relations are implemented there is resistance. In this perspective, resistance characterizes the dynamics of power and the relation of power can always be modified. This vision leads to a perception that it is exactly because individuals hold power that they are able to exercise it and modify its hold (Foucault 1979; 1983).

In previous chapters I have selected from Father Martinho de Nantes’s book, *Relação de uma Missão no Rio São Francisco* ([1706] 1979), examples to illustrate what this missionary of the seventeenth and early eighteenth century described about indigenous Kariri peoples located in missionary settlements in São Francisco Valley. From my research, I see parallels between his observations three centuries ago and my present contemporary perspective.

In one of Father Martinho de Nantes’s ([1706] 1979) observations, he mentions that “among them [indigenous people]” there were “witches,” whom he

considered to be “impostors” ([1706] 1979, 4). According to him, those indigenous “witches... guessed what they thought” and were able to predict “future things,” to cure “diseases,” and also “to produce them [diseases]” (Nantes ([1706] 1979, 4). This Catholic missionary revealed information connected with what I have found three centuries later among the Kariri-Shoco. Considering that Nantes ([1706] 1979) referred to shamans as “witches,” practices of foreseeing and cure-healing remain contemporary traditional methods that Kariri-Shoco shamanic specialists use through Kariri-Shoco shamanism as a form of medical knowledge.

In analyzing the anthropology of the body, Csordas (1994a) calls attention to three different fields or directions through which investigations have been conducted. Csordas (1994a, 4-6) classifies these studies as those that focus the “multiple body” (where different aspects of the body are recognized), the “analytic body” (perception, practice, bodily processes, etc.) and the “topical body” (when the research focuses on the relation between the body and specific domains like the body and gender). My research can be considered as belonging to these fields or directions, which I intend to describe summarizing and theoretically discussing these different aspects.

My research focused on social and political aspects related to Kariri-Shoco medical knowledge and practices, which reflects their knowledge and usage of their knowledge of the body. Kariri-Shoco shamanic specialists have knowledge from which they conduct cure-healing ritual performances when indigenous or non-indigenous people search for their help. Ethnographic data recorded and described in Chapters V and VI illustrate that practices that may be associated with Nantes’s ([1706] 1979) descriptions are still contemporary practices in Kariri-Shoco culture.

Nantes's ([1706] 1979) descriptions raise questions about how the indigenous shamanistic traditions and practices constitute cultural resistance to a process of colonial oppression. During the history of colonization of Northeast Brazil, indigenous peoples were submitted to political domination under surveillance of missionary and other tutelage systems. Despite the colonial history of oppression, shamanic practices have not vanished during history in northeastern Brazil. Contemporary Kariri-Shoco shamanic specialists' practices demonstrate how shamanism has been a dynamic process from which the Kariri-Shoco exercise power among themselves, among other indigenous peoples, and among non-indigenous people. This power is utilized through shamanic specialists' knowledge when they cure-heal indigenous and non-indigenous people. In this context, those shamanistic practices are characterized as resistance from which Kariri-Shoco shamanism has confronted cultural and political constraints during this historical process of domination.

Different shamanic specialists occupy different positions among the Kariri-Shoco from which their roles and practices form the basis to compose Kariri-Shoco shamanism as a sociological institution. During my field research, following shamanic specialists' daily activities, I could recognize that Kariri-Shoco shamanic specialists differ among themselves basically in activities related to Ouricuri secret and sacred ritual practices, and also during daily life within or outside their reserve. It is inside Ouricuri rituals where shamanic specialists work as Pajé's helpers and it is also from Ouricuri rituals that shamanic specialists occupy cognatic kinship statuses to perform roles through ritual kinship ties (such as Pai, Mãe, Avô and Avó) where

celebrations are commemorated and relationships are established among the Kariri-Shoco. In this way, my research has confirmed what Langdon (1992a) has observed about South American shamanisms, where she points out that shamanism can be considered as a sociological institution despite cultural differences.

I focused my research on rezador, rezadeira and curandeiro shamans as gendered shamanistic specialized roles. Data recorded, gathered, presented, and analyzed indicates that these shamanic specialists' practices, particularly for cure-healing purposes, require shamanic secret knowledge through their relationship and communication with spiritual beings and by their ethnobotanical knowledge. Rezador, rezadeira and curandeiro shamanic specialists selected as case studies use their knowledge and their own body, in an embodied knowledge, to feel, sense and discover the nature of patients' health problems and enable them to diagnose and treat diseases-illnesses. Among the Kariri-Shoco, shamanistic knowledge relates to individuals' subjective experiences, positions, and the roles they occupy within shamanism. Thus, not necessarily all shamans become specialized rezador/rezadeira or curandeiro shamans as health practitioners who assist indigenous and non-indigenous people.

From data gathered about Kariri-Shoco shamanism as a medical knowledge, diseases-illnesses have ethnic boundaries from which the contrast between "Indian's disease" and "white man's disease" demarcates those boundaries, and identifies the nature of health problems and which system is able to treat them. Kariri-Shoco rezador/rezadeira and curandeiro shamans are specialists in diagnosing and treating diseases-illnesses that are caused by evil, evilness, or related to (evil) spirits. I

discovered that Kariri-Shoco shamanism as medical knowledge is characterized by the power that Kariri-Shoco shamans have to treat “Indian’s disease,” “white man’s disease” and health problems caused by Afro-Brazilian religious practitioners. Following Good’s (1992) proposition that human suffering must be considered as human experience in social process, my research found that the way diseases-illnesses are conceived among the Kariri-Shoco have social and political aspects from which Kariri-Shoco shamanic specialists exercise power. The ability that Kariri-Shoco shamanic specialists have to treat “white man’s disease,” which are often ones diagnosed and treated by biomedical knowledge, provides grounds for Kariri-Shoco people to consider how powerful their shamanism is as medical knowledge. It is in the “Indian’s disease” domain that biomedical knowledge cannot be effective, when the indigenous patient has to be treated only by Kariri-Shoco shamanic specialists. Whenever it is an “Indian’s disease” provoked by a Kariri-Shoco shaman, only a shamanic specialist from another indigenous area, where Ouricuri ritual is also practiced, is able to cure-heal the Kariri-Shoco indigenous patient’s health problem. It is in this context of “Indian’s disease,” caused by Kariri-Shoco shaman’s work, that other Kariri-Shoco shamanic specialists do not have the power to cure-heal the indigenous patient. Thus, whether within cultural domains of “white man’s disease” or “Indian’s disease,” Kariri-Shoco shamanism is characterized as a powerful medical knowledge.

On the other hand, health problems caused by Afro-Brazilian religious practitioners’ work do not affect Kariri-Shoco people, although Kariri-Shoco shamanic specialists have the power to cure-heal non-indigenous people who are

affected by those health problems. In this way, diseases-illnesses among the Kariri-Shoco, or the absence of specific ones (such as those provoked by Afro-Brazilian practitioners' work), have ethnic boundaries from which indigenous medical knowledge has the power to treat health problems diagnosed by other medical domains (biomedical and Afro-Brazilian religions). In this cultural context, there are indigenous health problems, which neither biomedical nor Afro-Brazilian medical systems are able to diagnose and treat.

Thus, the plural medical context is ethnically demarcated by diseases-illnesses, which belong to different ethnic domains from which "Indian's disease" stands for health problems which only indigenous shamanistic knowledge has the ability to cure-heal. In this way, Kariri-Shoco shamanism is characterized by diseases-illnesses from "Indian's disease" but this does not restrict Kariri-Shoco shamanic specialists' ability to treat diseases-illnesses from other medical domains. The Kariri-Shoco concepts of "Indian's disease" and "white man's disease" demarcate different disease-illness perceptions and experiences from which the biomedical knowledge as a medical knowledge is characterized by the lack of efficacy within "Indian's disease" domain. Thus, the Kariri-Shoco experience health problems within social and political processes where Kariri-Shoco human suffering within the field of diseases-illnesses relate to the power of indigenous shamanistic medical knowledge.

As examples of this last field of literature which approaches the "multiple body," Csordas (1994a, 5) mentions Mary Douglas (1973), who speaks of the two bodies (physical and social), and who argues that the social influences how we

perceive the physical; Lock and Scheper-Hughes (1987), who propose the three bodies (the individual, the social and the body politic); and, John O’Neil (1985) who demarcates five bodies.¹²⁸

Csordas (1994a, 6) criticizes these approaches for calling attention that “to greater or lesser degrees... [they] study the body and its transformations while still taking *embodiment* for granted” (Csordas 1994a, 6). In his vision, the distinction that demarcates considering the body as either empirical thing or analytic theme is the consideration of embodiment as the existential ground of culture and self, which is the phenomenological basis of his methodological proposal (Csordas 1994a).

It was using a phenomenological methodology and semiotics that I have focused and described how Kariri-Shoco knowledge of the body relate to lived experiences through perceptions, practices, and bodily processes, which relate to fields that Csordas (1994a) has defined as studies about the “analytical body.” Csordas (1994a, 1-2) explains that “the new body... can no longer be considered as a brute fact of nature” (Csordas 1994a, 1). He observes “...in postmodernist times the concept of the body has become complex and multiple, essentially resisting definitions” (Csordas 1994a, 1). And he mentions:

¹²⁸ Csordas (1994a, 5) describes in detail O’Neil’s (1985) definitions on the five bodies: “the world’s body refers to the human tendency to anthropomorphize the cosmos,” [t]he social body refers to the common analogy of social institutions to bodily organs and the use of bodily processes such as ingestion of food to define social categories, [t]he body politic refers to models of city or country as the body writ large, forming the basis of phrases such as ‘head’ of state or ‘members’ of the body politic; [t]he consumer body refers to the creation and commercialization of bodily needs such as for sex, cigarettes... a process in which doubt is created about the self in order to sell grace, spontaneity, vivaciousness, confidence, etc., [and] [t]he medical body refers to the process of medicalization in which an increasing number of body processes are subject to medical control and technology” (O’Neil’s [1985, 16], mentioned by Csordas 1994a, 5):

In the wake of Foucault [e.g. 1979,1990], a chorus of critical statements has arisen to the effect that the body is ‘an entirely problematic notion’ [Vernant 1989, 20], that ‘the body has a history’ in that it behaves in new ways at particular historical moments [Bynum 1989, 171], and that the body should be understood not as a constant amidst flux but as an epitome of that flux [A. Frank 1991, 40] (Csordas 1994a, 1-2).

Good (1994) points out that studies of the body are an “important way of investigating the relation of meaning and experience [as an] intersubjective phenomena... conceiving the body as subject of knowledge and experience and meaning as prior to representation” (Good 1994, 55). Good (1994) gives a phenomenological treatment to experiences he conducted researching medical issues, which he explored as narrative, aesthetic and rational assumptions. Good (1994) used Schutz (1971) and particularly Merleau-Ponty (1962) as reference points for phenomenological perspectives.

Csordas notices (1994a, 4) that, “if indeed the body is passing through a critical historical moment, this moment also offers a critical methodological opportunity to reformulate theories of culture, self, and experience, with the body at the center of analysis” (Csordas 1994a, 4). He summarizes the characteristics of anthropology of the body approaches “in order then to distinguish a methodological standpoint more tailored to the aims... [not] of using the body as a methodological starting point, [nor] of objectifying bodies as things devoid of intentionality and intersubjectivity... [but] to add sentience and sensibility to our notions of self and person, and to insert an added dimension of materiality to our notions of culture and history” (Csordas 1994a, 4).

Strathern (1999), Good (1994) and Lock and Scheper-Hughes (1987) share with Csordas (1994a) this phenomenological departure point on approaching the

body. For Strathern (1999, 198) embodiment means "...a return to the sensuous quality of lived experience, and thus naturally bases itself largely on phenomenology, [it] can be seen from the fact along with the new analyses that stress a revised viewpoint on concepts of 'the person', [and] there is also a spate of works that stress the senses and the bodily sites at which these senses are activated ...this new empiricism embraces the emotions and their link with the senses by way of vision, touch, smell, hearing" (Strathern 1999, 198). Strathern (1999, 198) mentions a "new empiricism" and Stoller (1989, 151) a "radical empiricism," referring to this recent development of this usage of phenomenological methods.

In order to understand Kariri-Shoco cure-healing rituals I have used phenomenology as research methodology, describing how the patient and the shamanic specialist experience an embodied communication through the senses. As the cure-healing rituals belong to a cultural domain of medical practice, the interaction between the shamanic specialist and the patient through embodiment is a medical practice realized within shamanistic medical knowledge. Thus, cure-healing rituals as medical practices are expressed as a language enacted within experiences and meanings intertwined through the senses. I have discovered how Kariri-Shoco knowledge of the body, which they conceived that can be "opened body" ("*corpo aberto*") or "closed body" ("*corpo fechado*"), is essential for cure-healing practices and it expresses implicit dispositions of the body providing experience and senses to the body.

It was from observing, recording and analyzing diverse therapeutic cure-healing ritualized performances that I have researched cultural meanings and

definitions of sickness. I described three different kinds of Kariri-Shoco cure-healing rituals which have the purpose of closing the patient's body. The most common one, which is part of rezador/rezadeira or curandeiro shamans' daily activities, is the reza ritual. In this ritual through the use of words of power from prayers and the use of a bunch of leaves (which the shamanic specialist holds towards the patient), the shamanic specialist, praying on the whole patient's body, searches for what is causing the patient's health problem. During this ritual, the shamanic specialist experiences a light trance through his/her communication with spiritual beings. It is also during the reza ritual that the shamanic specialist embodies the patient's health problem, attracting it and expelling it from the patient's body. The reza ritual is one of the first steps that Kariri-Shoco people take towards cure-healing processes. It is through this ritual that the shamanic specialist discovers if the patient's health problem has been caused by something evil ("*mal*") or evilness ("*maldade*"), which is located inside the patient's body.

If in the reza ritual, the shamanic specialist discovers that the patient suffers from a health problem caused by an evil spirit, another more complex ritual therapy called mesa ritual must take place. The mesa ritual involves the use of the Jurema remedy, which the shamanic specialist and the patient drink. During this ritual there is an active participation of the curandeiro shamanic specialist, called mestre, along with four other people (two women and two men) called godmothers and godfathers (or "table sitters"), who sing chants evoking spiritual beings. It is during this ritual that an exorcism is realized when the patient has spirit possession. It is also through mesa rituals that the patient's body is effectively closed by the active ritual "table

sitter's" performances using words of power from sacred songs, lights (candle flames) and airs (when "table sitters" blow candle flames) on joints of the patient's body. The reza ritual for "open arcs" also illustrates Kariri-Shoco cure-healing rituals, when the patient's open thorax is closed during the ritual in order to provide for the patient protection and recovery of health.

Thus, the main purpose of cure-healing rituals is to close the patient's body providing protection against evil, which is felt by the patient as an embodied health problem and is sensed by the shaman through embodiment. Kariri-Shoco shamanic specialists experience embodiment during cure-healing reza and mesa, when the evil nature of the patient's health problem is discovered, diagnosed and treated. During the reza ritual for "open arcs" embodiment is experienced when the shamanic specialist closes the patient's thorax, while the shaman's thorax opens. Thus, Kariri-Shoco concepts of 'openness' and 'closedness' of the body work as a cultural theme of their knowledge of the body and cure-healing ritual practices in which Kariri-Shoco shamanic practices and gendered embodiment cohere. Shamanic specialists' powerful words of the prayers and airs (soft blows, suction) are effective channels and senses, which include (light trance), used and experienced for cure-healing.

Kariri-Shoco shamanic specialists explain that the body opens during sexual intercourse and when women experience menstrual and post-delivery blood fluxes. The drinking of alcoholic beverages also opens the body. The "open body" provides vulnerability, and therefore shamanistic cure-healing practices are avoided when the body is open. In this way, Kariri-Shoco female shamans exercise cure-healing practices intertwined with female embodiment in which bodily fluids and processes

interfere with their força to perform cure-healing rituals. Bodily fluids of male and female bodies from sexual intercourse and menstrual and post-delivery bodily blood fluxes provide a vulnerability of the body from which shamanic practices become dangerous.

In Chapter VII, I also quoted Nantes ([1706] 1979) where he describes elements about indigenous people's use of "tobacco smoke... prayers... [and] chants" (Nantes [1706] 1979, 4), which he observed were used as "remedies." Data recorded during field research and described demonstrate how Kariri-Shoco shamanic specialists use similar practices as traditional methods for cure-healing today.

Information about Kariri-Shoco use of "bush" remedies shows that Kariri-Shoco people are herbalists and share knowledge concerning a wide range of medicinal plants, which can be utilized for patients' health problems. Kariri-Shoco people still frequently use tobacco smoke through pipes (made of special kinds of wood) for protection. Several other plants are also considered for protection, such as velandinho and imburana-de-cheiro, which are currently used to prevent health problems in general and particularly ones caused by evil, evilness, and/or evil spirits. Medicinal plants considered for protection are used through smudges and widely conceived as having properties for cleansing the body, places and the environment.

In discussing disease-illness perceptions, I discovered how the Kariri-Shoco experience health problems through both personalistic and naturalistic models of causation. I have confirmed what Strathern and Stewart (1999) argue about how evil eye in Latin America is experienced as intersected by personalistic and naturalistic models. I suggest, based on Rodrigues' (1948) analyzes of Kariri language, that the

notion of evil and good already existed among indigenous peoples in pre-Colombian times in Northeast Brazil. I argue that diseases-illnesses caused by evil eye, evilness, and even evil spirits happen among the Kariri-Shoco through their perceptions that they can receive a “punishment” from their shamanistic realm (personalistic model), in which the possibility for this to occur is based on their concepts of properties of the body (naturalistic model). Thus, the notion of the opened and closed body permeates disease-illness causations in general. But it is within the naturalistic causation model that I found out how this theory of the body is more evident, when health problems or specific situations in which the body is opened, provides vulnerability of the body and, therefore, the naturalized possibility for disease-illness causations, even those from the spiritual realm.

By focusing on Kariri-Shoco shamanism as medical knowledge and practice my research has given a significant contribution to the medical anthropological field. I have demonstrated the importance of the use of the embodiment concept, from which I focused on cure-healing ritual performances and disease-illness causation perceptions. Thus, my research contributes to domains in which synchronicity occurs with cure-healings which are based on the knowledge of the body. That is also where I base my argument that personalistic and naturalistic medical regimens converge and intersect among the Kariri-Shoco. This intersection of disease-illness causation is provided within Kariri-Shoco knowledge of the body which is lived and experienced through embodiment. Thus, the senses are the channel through which embodiment occurs.

Csordas (1994a) starts his argument toward the phenomenological method with the explanation of Marcel Mauss's (1950) definition of the body as "at the same time the original tool with which humans shape their world, and the original substance out of which the human world is shaped" (Csordas 1994a, 6). Then, towards an explanation and usage of Merleau-Ponty's (1962) phenomenological notions of being-in-the-world and preobjective and objectified body in experience, Csordas (1994a, 6) questions:

Why not then begin with the premise that the fact of our embodiment can be a valuable starting point for rethinking the nature of culture and or existential situation as cultural beings? (Csordas 1994a, 6).

As a final commentary in his analysis discussing a phenomenological methodology for embodiment, Csordas (1994a) affirms:

Instead of Barthes's (1986) 'work' and 'text' [distinctions], I prefer 'text' and 'textuality' and to them I would like to juxtapose the parallel figures of the 'body' as a biological, material entity and 'embodiment' as an indeterminate methodological field defined by perceptual experience and mode of presence and engagement in the world (Csordas 1994a, 12).

In my point of view, Csordas (1990, 1994a, 1994b, 1994c) rehabilitates and reintroduces the existential ground of culture and self through the biological body as a factuality which at the same time must be considered as indeterminate, mindful, as a being-in-the-world experience and reflection. In this sense his perception differs from Lock and Scheper-Hughes's (1987), who propose also a mindful body, but consider it as a metaphor of culture, where sickness can be seen as the "language of the organs" (Lock and Scheper-Hughes 1987, 25). In Lock and Scheper-Hughes's (1987) view, representation overlaps experience. This is the crucial difference of researching using rather phenomenology or post-structural and semiotics perspectives. Csordas (1994a)

calls attention to this difference when he mentions that the term, being-in-the-world, captures precisely “the sense of existential immediacy... as temporally/historically informed sensory presence and engagement... and the sense of the preobjective reservoir of meaning” (Csordas 1994a, 10). Through this reflection, he mentions how the “distinction between representation and being-in-the-world is methodologically critical, for it is the difference between understanding culture in terms of objectified abstraction and existential immediacy” (Csordas 1994a, 10). Representation, then, is “fundamentally nominal,” and being-in-the-world, “fundamentally conditional, and hence we must speak of ‘existence’ and ‘lived experience’” (Csordas 1994a, 10). This distinction corresponds, for Csordas (1994a), to the difference between semiotics and phenomenology:

Thus within semiotics, broadly conceived there is the tension between text and discourse (Tyler 1987, Lutz and Abu-Lughod 1990), while within phenomenology there is the tension between phenomenology proper and hermeneutics (Ricoeur 1991, Caputo 1986). In anthropology, phenomenology is a poor and underdeveloped cousin of semiotics (Csordas 1994a, 11).

For Csordas (1994a, 12), this dominance of semiotics over phenomenology and hence the “concern with the problem of representation over the problem of being-in-the-world, is evident in the relation between the parallel distinction between ‘language’ and ‘experience,’” and also “in the predominance of the metaphor of textuality in contemporary cultural theory [influenced by Geertz 1973; Derrida 1976] and partisans of deconstruction, who operate under the motto that there is nothing outside the text” Csordas (1994a, 11).¹²⁹

¹²⁹ Csordas (1994a) calls attention to “Geertz’s (1973) version of the text metaphor leans toward the representational pole in so far as it is combined with the definition of cultures as systems of symbols and an extrinsic theory of thought that

When we attempt to learn or research the body we immerse ourselves in a field, as Lock (1993) suggests, that should “resist all pressures... to produce tidy answers... remain eclectic in our approach, and be content with a body that refuses to hold still” (Lock 1993, 148). This eclectic perspective is also mentioned by Deborah Lupton (1996) referring to the study of medicine as culture. She mentions that “there is much to be gained from an eclectic perspective which approaches the same research problem from different theoretical and methodological angles, while at the same time maintaining an awareness of the disciplinary traditions and rationale of the different approaches” (Lupton 1996, 19). I have followed this eclectic approach since I have used phenomenology, semiotics and post-modern epistemologies in my research and analysis.

In my research about the Kariri-Shoco, I have considered the phenomenological approach as a methodological path to exercise the process by which I have decided to scientifically investigate the Kariri-Shoco knowledge of the body. In this way I consider that, parallel or implicit to this enterprise, my own Western preconceptions had to be viewed self-critically. I had previously considered phenomenology a postmodern methodology. It is not. It is a modern epistemology. Phenomenologists still conceive the possibility of rediscovering reality in an objective sense, for example, through worlds of experiences (Schutz 1970; 1971) or through embodiment where the body-mind and subject-object dualities are considered and redefined (Merleau-Ponty 1962).

draws out dichotomies between cultural and biological/genetic, and between public and private sources of information” (Csordas 1994a, 12).

Departing towards complex fields of knowledge, approaching themes of embodiment related to medical and female embodiment, I have followed the argument stressed by Csordas (1990, 1994a), who, based on Merleau-Ponty (1962), considers that these themes are interrelated with the body-mind and subject-object dualities as representations, and also as the experience implicit in being-in-the-world. In my point of view, the anthropological existential dilemma for those who research the body is that it is through our body (our own intellectual and cognitive capacities) and historicity that we approach and, therefore, develop knowledge about the body. It is also through Grosz's (1994) phenomenological perspective that I have realized and experienced this dilemma, when she mentions:

I am not able to stand back from the body and its experiences to reflect on them; this withdrawal is unable to grasp my body-as-it-is-lived-by-me. I have access to knowledge of my body only by living it (Grosz 1994, 86).

9.2. Gendered and Female Embodiment: Corporeal, Ontological and Lived Realities

In my research project I have also considered the “topical body” (Csordas 1994a, 4) through the relation between shamanism and gender, and sexual difference and female embodiment. It is in Chapter VIII where I present two other observations from Nantes ([1706] 1979), in which he describes information about two different times of Kariri people who were recently under his missionary settlement in São Francisco Valley. Nantes ([1706] 1979) first mentions that indigenous women “used to dominate their husbands,” and that the children “do not respect” their parents and “were never punished” (Nantes [1706] 1979, 4). Later, indicating consequences of missionary actions, Nantes ([1706] 1979) observed that “the women are now submitted to their husbands and the children to their fathers, who punish them...

which did not happen before” (Nantes [1706] 1979, 17). I consider that those quotations from Nantes’s ([1706] 1979) observations on indigenous customs and changes illustrate how the gender relationships (and also parental relationships with their children) were characterized before missionary actions by the absence of patriarchy. Even if Nantes’s ([1706] 1979) observations are considered as a product of his preconceptions of indigenous people’s behavior as an eighteenth century European missionary, his observations reveal that indigenous traditions were not characterized by male domination over women, at least from the Western patriarchal perspective. Thus, those contrasting times that Nantes ([1706] 1979) described, when indigenous women became submitted to their husbands, illustrate a testimony of a radical cultural change that indigenous people experienced within historical process from which male domination and gender inequality became characterized by a new social-political order as a patriarchal system.

It was through researching Kariri-Shoco reproductive women as case studies that I found in their discourses, when they reported experiences of their conjugal relationships illustrate a patriarchal order. It was from their accounts of experiences of sufferings within gendered relationships that I observed how male domination has characterized their conjugal experiences. It is in this male dominant context that Kariri-Shoco women manifest great power over their bodies, when they exercise a control over the naturalization of their reproductive body for prolific function and over sexual desire. The research’s findings showed that since Kariri-Shoco women are immersed in a context of male domination, data analyzed about gender and female embodiment reveal how Kariri-Shoco reproductive women resist male domination,

when Kariri-Shoco women have control and power over matters of the female reproductive body, such as conception (when they may postpone orgasm or sexual pleasure during sexual intercourse), pregnancy (when they use indigenous and or biomedical contraceptives) and menstrual cycle (when they have the knowledge to induce or stop menstruation).

In Kariri-Shoco cultural context, I consider that aborto/miscarriage, particularly by the use of indigenous methods, has represented a form of resistance that Kariri-Shoco women use to confront and challenge what has been imposed as naturalization of their reproductive bodily functions. It is a matter of empowerment and agency, through which they have confronted diverse dimensions of power, within a patriarchal system, over the naturalization of the female body. On the other hand, it is also a matter of reproductive rights, when their use and notions of “to make the blood come down” provide a different perception of pregnancy loss, from which aborto/miscarriage is related to regulation of menstrual cycle whenever they induce menstruation.

Sterilization, which Kariri-Shoco younger women have often chosen through tubal ligation, involves a denaturalization of the female body and implies consequences for female embodiment, interfering with sexual desire and menstrual cycle. This option has also been a way in which Kariri-Shoco women exercise a power over their female naturalized reproductive body.

The gendered and female embodiment problematic is an implicit topic related to the representation realm, and has been a subject of a great attention, particularly in the last thirty years and mostly by feminists in the discussion on women's

powerlessness and empowerment (de Beauvoir 1973; Grosz 1994; Butler 1990; Castelnovo and Guthrie 1998, Ortner 1996; and many others). Sexuality has been, for at least four centuries, an object of reflection and control through knowledge and practices of different institutions (Foucault 1990a, 1990b, 1990c, 1988, 1986).

Csordas (1994a) mentions that “much of the feminist critique comes from disciplines such as literature and philosophy and operates in a poststructuralist semiotic paradigm that questions the content of specific representations while assuming the pragmatic and epistemological primacy of representation” (Csordas 1994a, 9). My essay about embodiment, gender, and sexuality (Martins 2000), exactly based in Csordas’s (1994a) analysis, criticized Butler’s (1990) concept of “heterosexual matrix.” I have used Parker’s (1987, 1991, 1999) phenomenological research about Brazilian sexual culture as an example of cross-cultural study on sexuality, which does not remain in the representational realm. Parker (1987, 159) investigates the social and cultural construction of sexual life in Brazil, which, according to him, has developed an “elaboration of sexual types, based principally on the active[/masculine]/passive[/feminine] distinction of popular culture” that are engaged in recreation of a “variable same-sex desires and practices” (Parker 1987, 162-163). The characteristic of these sexual types, as Parker (1987) observes, is “its flexibility and its fluidity” (Parker 1987, 163), which according to sexual practices (in examples he observed, but that he believes are present in Brazilian sexual ideology as a whole), the categories of sexual identities apparently fixed can always be transformed, and also “sexual classifications can be relativized and overcome in the reality of erotic practice” (Parker 1987, 163). I consider that Brazilian sexual

ideology and practices provide evidence of a sexual difference (and desire) that can be understood using Grosz's (1994) notion on sexual difference:

It is A mobile, indeed volatile, CONCEPT, able to insinuate itself into regions where it should have no place, to make itself, if not invisible, then at least unrecognisable in its influences and effects (Grosz's 1994, ix).

My arguments, when using Parker's (1987, 1991, 1999) findings on Brazilian sexual culture juxtaposed with Butler's (1990) concept, were based on my recognition that it is through phenomenological research that lived experiences, implicit in practices articulated to meanings and context, do not remain in signs and symbols or in representations. I also recognize that much of Butler's (1990) formulations are related to Western societies where discourses and coherence on sex and gendered bodies have been developed. Thus, from the Brazilian example, I started to consider that the problem with Butler's (1990, 1993) theory was not that it was culture-bound, only applicable to Western context, but that once she relies on the discursive and representational domain of the constitution of gendered bodies, it has a limitation in approaching actual possibilities of gendered bodies in lived experiences.

Ethnographic data registered during field research confirm Butler's (1990) formulation of "heterosexual matrix" (Butler 1990, 17) from which she explains that the intelligibility of gender identity follows biological sex (or biological sex or gender) "through the compulsory practice of heterosexuality" (Butler 1990, 151). In the Kariri-Shoco cultural context, gender identity (of being a woman or being a man) coheres by asymmetrical gender relationships through which the genders are understood and produced from biological sex and heterosexual practice of desires. From ethnographic data about sexual pleasure and practices there is among the Kariri-

Shoco a “heterosexualization of desire” (1990, 17) where heterosexual practice of desires follow biological sex.

It is in the context of female constraints that the ‘truth of sex’ coheres with asymmetrical gender relationships where a “heterosexual matrix” (Butler 1990, 151) naturalizes bodies, genders and desires. Kariri-Shoco shamanic specialists’ and women’s explanations about sexual pleasure (“the sensation”), illustrate how the naturalization of bodies (female and male bodily fluids), genders (woman and man), and desires (heterosexual practice of desires and of pleasure) are associated with the cultural domain of reproductive processes. The Kariri-Shoco shamanic specialists’ and women’s discourses reveal that the female “sensation” (sexual pleasure) during sexual intercourse relates to bodily fluids during sexual intercourse from reproductive female and male bodies.¹³⁰

It is after menopause that the female sexual desire and gendered body change among the Kariri-Shoco, because the female body becomes less often, or absent for heterosexual practice and desire. This happens through female embodiment, in which the lack of production of female bodily fluids in the menstrual cycle, provides maleness for the female body, since women become “closed” like men (not menstruating or able to become pregnant). In this way, the asymmetry between gender opposition changes, when women become equal to men. I observed, although I do not have sufficient ethnographic data to confirm this, that an inverse gendered

¹³⁰ I consider that when Kariri-Shoco women avoid during sexual intercourse feeling “the sensation” before the man, in order that they would not “catch a pregnancy,” evidences a way of resistance to the naturalization of their body to the prolific function and also as a resistance to sexual pleasure in the context of compulsory practice of heterosexuality, where they have to sexually “serve” their spouses. This is my particular view.

embodiment happens to men. It is perceived that as the male body becomes aged it becomes weaker.¹³¹ Thus, the way menopause is experienced among Kariri-Shoco women implies changes of gender and female embodiment. In a context of patriarchal conjugal relationships, even with the lack of sexual desire, Kariri-Shoco women continue to practice sexual intercourse in order to serve their husbands. This decision, which not only post-menopausal Kariri-Shoco women take towards sexual intercourse, relates to a naturalization of the female body. This naturalization is expressed through the perception that from female corporeality “women are always already ready” for sexual intercourse. On the other hand, the naturalization of male corporeality, in which man has to “get ready” or “to get prepared” (to have erection) for sexual intercourse, provides a perception that it is more difficult for the man to have sexual pleasure. These perceptions (“already ready” and “get ready”) express gendered embodiment for sexual practices. These perceptions also illustrate how bodies, genders and desires are naturalized in a context where a “heterosexual matrix” is produced.

In Chapter VII, I have discussed and demonstrated Kariri-Shoco knowledge of the body from which the ‘openness’ and ‘closedness’ of gendered bodies provide a basis for sexual difference. It is through this knowledge of the body that sexual differences between female/feminine and male/masculine bodies are culturally demarcated. Kariri-Shoco knowledge of the body relates to different characteristics of gendered bodies from which biological sex coheres within perceptions of male and

¹³¹ I describe an ethnographic interview in section 8.2, where Dona Maria Velha explained about male sexual problems that when a male aged body becomes disabled for sexual practices, the men is already “on weakness.”

female bodies. The corporeality of female/feminine and male/masculine bodies is intrinsically linked with gendered embodiment.

Kariri-Shoco ethnophysiological concepts related to male and female bodily fluids are situated within a cultural domain where a female emic organ called “Dona do corpo” and symptoms of “dor de mulher” provide evidence of female embodiment and also contribute to female embodied subjectivity. What is interesting about the “Dona do corpo” is that “she is like woman,” “she is made of blood” and “she doesn’t like man.” Thus, the “Dona do corpo” belongs to an essentially female/feminine gender domain. This female emic organ located inside Kariri-Shoco woman’s body, which provokes pain whenever “she” is displaced, attests to female and gender embodiment.

I understand that male and female bodily fluids demarcate marginality over sexual differences (Grosz 1994; Lock and Sheper-Hughes 1987). It is not the menstrual blood, the blood per se, but its quality as a female bodily fluid that opens the body when it transgresses its limits. Similarly, the female and male sexual bodily fluids’ encounter also characterize permeability over sexually different bodies during sexual intercourse, in which sexual pleasure related to female orgasm (“a sensação,” “gozo”) before the male’s provides the possibility for conception. In several explanations, the female bodily fluids from sexual intercourse and particularly female and male bodily fluids’ encounter during sexual intercourse and sexual pleasure provide conception and therefore pregnancy. The expression “to catch a pregnancy” relates to this perception, since it is with the female body (“Dona do corpo”), from

her ‘openness,’ that the woman “catches” (“*pega*”) a pregnancy during sexual intercourse when she “receives” (“*recebe*”) male bodily fluids.

In my research among the Kariri-Shoco I have found out that a truth of sex has been historically produced, and that was the main reason to use Butler’s (1990) concept of heterosexual matrix. It was Butler’s (1990) concept that provided the basis to explain and understand the radical change in which the Kariri-Shoco as an indigenous people were immersed historically under a patriarchal system. It was through this imposition that a displacement of women and female embodiment was produced. The tension between representation and lived experience in my research is marked by a thin boundary, since much of what I have described and analyzed is characterized by a mix between what is conceived by the Kariri-Shoco shamanic specialists (Chapter VII) and what is experienced by Kariri-Shoco women (Chapter VIII). My research is within the third group of feminists who focus upon sexual difference, but it also brings a new light to discussions on patriarchy and phallogocentrism, since I have recognized a historical process where the indigenous female body was immersed under a Western history of male oppression. Still, I have doubts if I have not overestimated representation and underestimated experience during my research.

Butler (1990) follows Foucault’s (1990a) ideas, who describes and proposes a methodological way of understanding how sexuality became arranged. Foucault (1990a; 1990b; 1990c) considers “sex as history, as signification and discourse” (1990a, 78). Foucault (1990a) calls attention to how historically “a norm of sexual development was defined and all the possible deviations were carefully described”

(Foucault 1990a, 36). In this way, children's sexuality, considered "unnatural", became stressed through education institutions (Foucault 1990a, 37), homosexuals became a "species" and the family a "more complicated network" (Foucault 1990a, 46). He explains that his aim is to move "toward an 'analytics' of power... toward a definition of the specific domain formed by relations of power... and toward a determination of the instruments that will make possible its analysis" (Foucault 1990a, 82). Then he analyses changes within techniques historically situated under Christianity to the advent of "medical technologies of sex" (Foucault 1990a, 119). As he explained: "we... are in a society of 'sex', or rather a society 'with a sexuality'" (Foucault 1990a, 147) and that is why:

...the mechanisms of power are addressed to the body, to life, to what causes it to proliferate, to what reinforces the species, its stamina, its ability to dominate, or its capacity for being used (Foucault 1990a, 147).

It is important to perceive that Foucault (1990a, 1990b, 1990c) analyses Western society, which has a sexuality and a specificity in its character, where the "discourse on sex has been multiplied rather than rarefied" (Foucault 1990a, 53). He distinguishes two emergent orders of knowledge, which are "biology of reproduction" and "medicine of sex" (Foucault 1990a, 54-55). He also makes a difference in "*ars erotica*" and "*scientia sexualis*" to mention how other societies (like Chinese, Japanese, Indian, Arabic-Muslim, from Rome) have practiced and accumulated experience from pleasure itself developing an "*ars erotica*" (Foucault 1990a, 57), while the Western societies have been the only ones to develop "the truth of sex" through the form of "knowledge-power" (Foucault 1990a, 58).

At a first sight I tend to perceive, based on Foucault's (1990a) analysis, that Brazilian sexual culture studied, described and analyzed by Parker (1987, 1991, 1999), is characterized by an "*ars erotica*," while what I have found among the Kariri-Shoco was a "*scientia sexualis*," where a truth of sex was historically produced, particularly under Catholic and governmental surveillances. To me this is a misinterpretation. Maybe the difference, which marks boundaries between those two Foucauldian concepts, is what is experience (*ars erotica*) and what is representation (*scientia sexualis*). Still, we live in a Western context where truths of sexes take place: my research findings and Parker's (1987, 1991, 1999) work provide ethnographic examples. We live in a Western world characterized by sexes, sexualities, genders, and desires where, as Foucault (1990a) argues, "mechanisms of power are addressed to the body" (Foucault 1990a, 147).

Maybe we should explore the idea that there is no "truth of sex" which sexed gendered bodies experience. Maybe we could conceive that the sexed gendered body lives/experiences pleasures through an "*ars erotica*" sense, and "*scientia sexualis*" is in the realm of representation within the "knowledge-power" domain, which has not been able to control lived experiences of (sexual) pleasures that human beings feel. I think my study is a good example to explore the idea that sexuality (Butler 1990; Foucault 1990a, 1990b, 1990c) can reflect a Western construct of desire, but it is the locus for a body that refuses to (sexually) hold still, paraphrasing Lock (1993).

APPENDIX A

STRUCTURED INTERVIEW SCHEDULE A CONDUCTED AMONG TWENTY-NINE KARIRI-SHOCO REPRODUCTIVE WOMEN:

Place/Setting/*Lugar*:

Interviewee/*Entrevistado*:

1. Age/*Idade*:

2. Conjugal Status//*Estado Civil*:

3. Do you have children/*Você tem filhos?* Yes/*Sim* () No/*Não* ()

If yes, how many children do you have/*Se sim, quantos filhos você tem?*

What are their ages?/ *Qual a idade deles?*

If not, do you plan to have children?/ *Se não, você planeja ter filhos?*

Yes/*Sim* () No/*Não* ()

4. Are you pregnant/*Você esta grávida?* / Yes/*Sim* () No/*Não* () Maybe/*Talvez* ()

5. How many times have you become pregnant?/ *Quantas vezes você já ficou grávida?*

6. Have you ever had any *aborto*/ *Você já teve algum aborto?*

Yes/*Sim* () No/*Não* ()

7. Do you use methods to avoid pregnancy?/ *Você usa métodos para evitar gravidez?*

Yes/*Sim* () No/*Não* ()

8. Has any son/daughter died:/ *Algum filho seu chegou a falecer?*

Yes/*Sim* () No/*Não* ()

If yes, could you tell how many, at what age, and why did it happen:/ *Se sim, poderia me contar quantos, qual idade, e porque isso aconteceu?*

9. Annotations from conversation /*Anotações sobre conversa*:

APPENDIX B

STRUCTURED INTERVIEW SCHEDULE CONDUCTED AMONG TWENTY-ONE *KARIRI-SHOCO* REPRODUCTIVE WOMEN:

Place/Setting/*Lugar*:

Interviewee/*Entrevistado*:

1. Age/*Idade*:

2. Conjugal Status/*Estado Civil*:

3. What was your experience when you got your first period?/ *Como foi a sua primeira menstruação?*

4. How many children do you have?/ *Quantos filhos você tem?*

5. Have you ever had an *aborto*?/ *Você já teve algum aborto: Como foi que aconteceu?*

6. Do you use contraceptive methods? *Você usa métodos contraceptivos?*

7. Have you had a tubal ligation?/ *Você fez ligação de trompas?*

If yes, have you noticed any difference? About what ?/ *Se sim, Notou alguma diferença em que? Em que?*

8. Have you already “tied up the big knife”?/ *Você já “amarrou o facão”?*

9. Have you ever experienced “woman’s pain”?/ *Você já sentiu a “dor de mulher”?*

10. Have you ever felt or heard about the “*dona do corpo*”?/ *Você já ouviu falar ou sentiu a “dona do corpo”?*

11. Annotations from conversation / *Anotações sobre conversa*:

APPENDIX C

ETHNOGRAPHIC INTERVIEW OUTLINE FOR RESEARCHING SHAMANIC SPECIALISTS AND THE MIDWIFE¹³²

1. Objectives:
 - 1.1. To develop rapport adapted to local patterns of interaction and obtain information on:
 - 1.1.1. Shamanism as a medical knowledge (which shapes gender differentiated health practitioners' specializations)
 - 1.1.2. Kariri-Shoco ethnophysiology: how Kariri-Shoco indigenous health practitioners perceive characteristics of the female body (ethnophysiology, gendered embodiment)
 - 1.1.3. How Kariri-Shoco indigenous health practitioners perceive and deal with the reproductive body (reproduction and reproductive health)
 - 1.2. To link interviews with cure-healing events investigating how Kariri-Shoco indigenous health practitioners perceive and have lived experiences related to cure-healing practices during events.
 - 1.3. To organize nine individual case studies of indigenous health practitioners for collective case study (see item 5)

2. Ethnographic Questions (both question and answer must be discovered from informants):
 - 2.1. Record questions indigenous health practitioners ask in daily life related to shamanism, ethnophysiology, gendered embodiment, and reproductive body (reproduction and reproductive health)

¹³² All framework was compiled from Spradley (1979) about ethnographic interviews and from Stake (1994) about case studies.

- 2.2. Inquire directly about how they formulate questions on issues related to shamanism, ethnophysiology, gendered embodiment, and reproductive body (reproduction and reproductive health)
 - 2.3. Ask to talk about the cultural scene: place and or setting of cure-healing practices related to shamanism, gender, reproduction, and reproductive health.
3. Descriptive Questions
- 3.1. The form of the questions depend on the indigenous practitioner's specialization and or the cultural scene selected, to investigate shaman, healer, and midwives' detailed knowledge and for individual case studies
 - 3.1.1. Grand Tour Questions: simulates an experience on cure-healing, ethnophysiology, gender, reproduction, and reproductive health: e.g. Can you tell me how do you treat... ?
 - 3.1.2. Mini Tour Questions: explore smaller aspects of experience with cure-healing, ethnophysiology, gender, reproduction and reproductive health: e.g. Could you describe a typical reproductive problem that you cure?
 - 3.1.3. Example questions: take an act or event identified by an informant or from my participant observation and ask for other examples: e.g. Can you give an example of another reproductive health problem?
 - 3.1.4. Experience Questions: ask about experiences they have had in cure-healing practices, related to ethnophysiology, gender, reproduction and reproductive health: e.g. Could you tell me about a cure-healing experience during the *Ouricuri* ritual?
 - 3.1.5. Native-Language Questions: ask indigenous health practitioner to use the terms or phrases most commonly used in the cultural scene (place and/or space of cure-healing practices related to shamanism, gender, reproduction and reproductive health):
 - 3.1.5.1. Direct-language questions: e.g. How would you refer to...

- 3.1.5.2. Hypothetical-Interaction Questions: e.g. If a woman comes with a [cover term for menstrual disorder], what do you first ask of to the woman?
- 3.1.5.3. Typical-Sentence Questions: e.g. What are other ways of saying “*mulher está desregrada*” [native language term for type of menstrual disorder]?
- 3.2. Select one setting for participant observation where informants conduct cure-healing routine practices.
4. Structural Questions:
- 4.1. The form of the questions adapted to each indigenous health practitioner to obtain explanations.
- 4.1.1. Verification Questions: ask indigenous health practitioners to confirm or contradict hypotheses about one domain (cure-healing practices, ethnophysiology, gender, reproduction and reproductive health): e.g. Does a post-menopausal woman have more strength to heal?
- 4.1.2. Cover Terms Questions: ask questions using a cover term: e.g. Are there different kinds of [cover term related to reproductive health problem]? Could you tell me how they differ?)
- 4.1.3. Included Term Questions: ask questions about included terms related to specific domain: e.g. Are [cover terms related to reproductive health problem] the same kind of health problem?)
5. Collective Case Study (individual case study undertaken jointly part of collective case study on indigenous health practitioners):
- 5.1. The general objective is to consider indigenous practitioners jointly in order to inquire into cure-healing practices, ethnophysiology, reproduction, and reproductive health.
- 5.2. The study of the particularity or individuality of the indigenous health practitioner:
- 5.2.1. His or her specialization

- 5.2.2. His or her historical background
 - 5.2.3. The physical setting for his or her cure-healing practices
 - 5.2.4. Other data contexts: economic, political, and aesthetic
 - 5.2.5. The relationship to other cases through which he or she is recognized
 - 5.2.6. His or her relationship with other informants through whom he or she is known
- 5.3. Explore, based on ethnographic interviews, the similarities, dissimilarities, redundancies, and varieties (each individual case study having voice) of indigenous health practitioners.

APPENDIX D

ETHNOGRAPHIC INTERVIEW OUTLINE FOR RESEARCHING WOMEN¹³³

1. Objectives:
 - 1.1. To develop rapport adapted to local patterns of interaction and to obtain information on:
 - 1.1.1. Perceptions, experiences and practices related to sexual difference issues
 - 1.1.2. Perceptions, experiences, and practices related the reproductive processes of pregnancy, childbirth, and the menstrual cycle
 - 1.1.3. Cure-healing processes which they have experienced through biomedical and indigenous medical systems
 - 1.2. To organize ten case studies of diverse women according to sex-gender identity and or reproductive experience for collective case study (see item 5)
2. Ethnographic Questions (both question and answer must be discovered from informants):
 - 2.1. Record questions women ask in daily life related to sex-gender identity, ethnophysiology, gendered embodiment, and reproductive body (reproduction and reproductive health)
 - 2.2. Inquire directly about how she formulates questions on issues related to sex-gender identity, gendered embodiment, and reproductive body (reproduction and reproductive health)
 - 2.3. Ask to talk about the cultural scene (setting and or social situation of women where shamanism, gender, physiological reproductive processes take place)

¹³³ All framework was compiled from Spradley (1979) about ethnographic interviews and from Stake (1994) about case studies.

3 Descriptive Questions

- 3.1. The form of the questions depend on the woman's sex-gender identity, reproductive experience, and or age
 - 3.1.1. Grand Tour Questions: simulates an experience on sex-gender identity, physiological reproductive processes, and reproductive health (cure-healing experiences with indigenous and or biomedical systems): e.g. Can you tell me how was your first pregnancy?
 - 3.1.2. Mini Tour Questions: explore smaller aspects of experience with sex-gender issues, physiological reproductive processes, and reproductive health (cure-healing experiences with indigenous and or biomedical systems): e.g. Could you describe how you experienced your first period?
 - 3.1.3. Example questions: take an act or event identified by informant or from my participant observation and ask for other examples: e.g. Can you give an example of a menstrual disorder?
 - 3.1.4. Experience Questions: ask about experiences they have had with cure-healing processes, related to gender, physiological reproductive processes, and reproductive health (cure-healing experiences with indigenous and or biomedical systems): e.g. Could you tell me about how you became healed [cover term for a reproductive health problem that she has had experienced] ?
 - 3.1.5. Native-Language Questions: ask to use terms/phrase most commonly used in the cultural scene (setting and/or social situation of women related to shamanism, gender, physiological reproductive processes, and reproductive health (cure-healing experiences with indigenous and or biomedical systems):
 - 3.1.5.1. Direct-language questions: e.g. How would you refer to ... ?
 - 3.1.5.2. Hypothetical-Interaction Questions: e.g. If your husband tells you that he wants another son or daughter, what do you say to him?

3.1.5.3. Typical-Sentence Questions: e.g. What are other ways of saying “*mulher está desregrada*” [native language term for type of menstrual disorder]?

3.3. Select one setting and or social situation for participant observation where informants conduct female daily activities

4. Structural Questions:

4.1. The form of the questions: adapted to each woman (according to sex-gender identity and or reproductive experience) and require explanation.

4.1.1. Verification Questions: ask to confirm or disconfirm hypotheses about one domain (gender, ethnophysiology, physiological reproductive processes, and reproductive health): e.g. Does menstrual blood make women weaker than men?

4.1.2. Cover Terms Questions: ask questions using a cover term e.g. Are there different kinds of [cover term related to reproductive health problem]? Could you tell me how they differ?

4.1.3. Included Term Questions: ask questions about included terms related to specific domain: e.g. Are [cover terms related to reproductive health problem] the same kind of health problem?

5. Collective Case Study (individual case study extended to the women’s collective case study):

5.1. The general objective is to consider women jointly in order to analyze sex-gender related issues, physiological reproductive processes, reproductive health (cure-healing experiences with indigenous and/or biomedical system)

5.2. The study of the particularity/individuality of women:

5.2.1 Her experience with sex-gender identity

5.2.2. Her experience with physiological reproductive processes

5.2.3. Her historical background

5.2.4. The physical setting for her daily activities

5.2.5. Other data contexts: economic, political, and aesthetic

5.2.6. The relationship of individual case studies related to physiological

reproductive processes

5.2.7. The relationship of individual case studies related to sex-gender identity issues

5.4. Explore, based on ethnographic interviews, the similarities, dissimilarities, redundancies, and varieties of perceptions and experiences of *Kariri-Shoco* women (each individual case having voice).

GLOSSARY

- ABORTO.** The experience that women have with pregnancy loss, whether from a miscarriage or from an induced abortion.
- ADIAANTADO.** To be advanced.
- ADIVINHO.** Foresighted. Guesser, the one who predict things or the future, who is also considered the one who communicates with spirits.
- AJUDANTES.** Helpers, those who helps.
- AGRESTE.** Intermediate area between the coast and arid region of Northeast Brazil.
- ALVARÁ.** Species of decree used by Portuguese Crown.
- AMARRAR O FACÃO.** To tie up the big knife, which for Kariri-Shoco women means to go through menopause.
- ANJICO.** Plant considered a sacred tree.
- APLICANDO PASSES.** It is an expression used in Afro-Brazilian religious practitioners which means to clean the person against bad fluids.
- APOIO.** To give support.
- AVÓ.** Grandmother. Kinship term used as a shamanistic status related to Ouricuri rituals.
- AVÓS.** Grandmothers. Kinship term used as a shamanistic status related to Ouricuri rituals.
- AVÔ.** Grandfather. Kinship term used as a shamanistic status related to Ouricuri rituals.
- AVÔS.** Grandfathers. Kinship term used as a shamanistic status related to Ouricuri rituals.
- BARSO.**
- BATATA-DE-CHEIRO.** Medicinal plant.
- CABEÇA-SECA.** Dry-head, expression used by Kariri-Shoco to refer to non-indigenous persons.
- CABOCLO.** According to Diégues Jr. (1975) are those Indians mixed with other Indians in Brazil. It is a term used with different meanings according to regions in Brazil.
- CACIQUE.** Political Indigenous leader.
- CACHACEIRO.** Term used to refer to those who drink lot of ‘*cachaça*,’ alcoholic beverage made from sugar cane.
- CADÊNCIA.** Vocation.
- CALORIA.** Hotness, hot flush, fever.
- CAPITANIAS.** Large parcels of land given to colonizers by the Portuguese Crown .
- CERA.** Beehive
- CIÊNCIA.** Knowledge, and also to be conscious, to know.
- COBRIR.** To cover.
- CONCENTRAÇÃO.** To be concentrated, focusing, often used with a sense of meditation, contemplation.

- CONTAMINAÇÃO. Contamination. Term often used to refer to disease contamination, something contagious.
- CORPO ABERTO. Opened body, when the body is vulnerable, not covered and not protected.
- CORPO FECHADO. Closed body, when the body is covered and protected.
- CORRENTE DE AR. Air chain, breeze, wind.
- CORRENTES . Chains, used to refer to winds, and also to spirits who are interconnected or associated.
- CRIADA. Term used for something that grows.
- CURA. The act of healing, the healing result, reza “prayer” ritual.
- CURADO. To be healed.
- CURANDEIRO. Healer shaman. According to Pajé Júlio they are “*mestres*” (masters), those who open table rituals. The one who heals, healer.
- CURANDEIROS. Healer shaman. According to Pajé Júlio they are “*mestres*” (masters), those who open table rituals. The one who heals, healer.
- CURIANDO. Looking with curiosity.
- DESPEDINDO. Saying goodbye.
- DIMINUÍDO. Diminished.
- DOENÇA. Disease, similar meanings of illness and sickness.
- DOENÇA DE BRANCO. White man’s disease. Those health problems that non-indigenous people catch.
- DOENÇA DE ÍNDIO. Indian’s disease. Those health problems that indigenous people catch usually associated to punishment, or evil spirits.
- DOM. Gift, vocation.
- DONA DO CORPO. Literally means the owner of the body, which is how Kariri-Shoco call an emic organ located inside the woman’s belly. It can also, considering “*dona*” as a noun that means Mrs. or Ma’m, be considered as the “woman” of the body.
- DOR DE MULHER. Woman’s pain. It is a gendered kind of pain which is only felt by women and is usually associated with the ‘Dona do corpo’. This pain is usually associated to menstruation, delivery, post-delivery, but it also can be felt on a woman’s head, legs, and stomach.
- DUCHA. Douche, treatment used by introducing medicinal liquid remedy inside the vagina.
- ENFEITIÇADO. To be bewitched.
- ENFRENTAR To face something.
- ESPIRITISMO. From the spirits.
- FAZER UMA MALDADE. To make something bad or evil.
- FECHAMENTO. The result of closing something.
- FEITIÇARIA. Witchcraft.
- FICHE. Strong, secure.
- FIGO. Colloquial way to refer to the liver.
- FOGOSA. Excited, ‘hot.’

FORÇA. Strength.

FORTALEZA. Strength.

FUMO. Tobacco.

GARRAFADA. Bottle remedy, made from medicinal plants and sold.

GASTURA. Nausea.

GOZAR. To have orgasm.

IDIOMA. Term used to refer to something related to indigenous language in a sense of something secret.

IMBURANA DE CHEIRO. Medicinal plant.

INCOMÔDO. Incommodate Something that hurts, disease, a health problem.

JUREMA. Medicinal plant with properties considered dangerous. There different species are identified by the Kariri-Shoco, used as remedy, for exorcism during mesa rituals.

MACUMBA Term that is used to refer to witchcraft.

MÃE. Mother. Kinship term used as a shamanistic status related to Ouricuri rituals.

MADRINHA. Term used in a 'fictive' kinship, used by the godchild to refer to a godmother.

MÃE DE SANTO. Mother of saint, Afro-Brazilian female religious practitioner who occupies an important position of conducting rituals and initiate neophytes.

MÃE DO CORPO. Body's mother. Emic female organ that woman workers in South of Brazil feel inside their belly before and after delivery.

MALFEITORES. Those who make evilness, witchcraft.

MALDADE. Badness, evilness.

MANDIOCA. Cassava.

MARIA PADILHA. Afro-Brazilian female spirit.

MASTRUZ. Medicinal plant, used also in "prayer" rituals.

MATADOURO. Place where cattle are killed

MATÉRIA. Matter, Substance of living things.

MÁ VONTADE. Bad will, usually associated to evil eye.

MEDICALIZADA . Medicalized, meaning under medical prescription.

MERECIMENTO. Something deserved.

MESA. Table ritual, when an altar is set and a healer and four other others perform in other to close the patient's body.

MESÁRIO(A) . Male or female Godmother or Godfather who participates in the mesa ritual.

MESINHA. Remedy (Jurema). Drank during mesa ritual

MESTIÇO. Person mixed from different racial origins.

MESTRE. Master, usually referred to the *curandeiro* shaman who performs mesa ritual. It also refers to enchanted, or Spiritual beings.

MOÇA. Young woman. Also referred to a virgin woman.

NAMORO. when boyfriend and girlfriend date.

NASCENÇA. From the time of the delivery.
NOVELO. Thread.

OBRIGAÇÕES. Obligations, usually referred to duties related to Ouricuri ritual.
OURICURI. The principal Kariri-Shoco and other indigenous people from northeast Brazil, when they move from their home to another village.

PACIFICADOS. Term used to indigenous people who were brought to missions in the beginning of colonization.

PADRINHO. Term used by the godchildren to godfather, as a fictive relative

PAI. Father. Kinship term used as a shamanistic status related to Ouricuri rituals.

PAJÉ. Indigenous Religious leader.

PAU-FERRO. Medicinal Plant.

PEGAR UMA DOENÇA. To catch a disease.

PINHÃO-ROXO. Medicinal plant.

POMBA-GIRA. Female Afro-Brazilian spirit.

POSSEIROS. Squatters.

QUEBRANTO. Evil eye, which makes you become broken, weak.

QUENTE . Hot.

QUENTURA. Hot flush.

QUILOMBOS. Africans refugee settlements formed during the seventeenth and eighteenth centuries.

RAIZEIROS. Those who deal with medicinal plants and make remedies.

RAMO. Bunch of leaves.

RAPARIGA(S). term used meaning prostitute.

REAL/REAIS. Brazilian money currency.

REBANHO. Herd.

REDUZIDOS. Term used during history to refer to Indians who were settled within missions

REGRA. Rule, menstruation.

REGRANDO . “Ruling,” which means monthly menstruating.

REMEDIO DE FARMÁCIA . “Pharmaceutical remedy”

REMÉDIO DO MATO . “Bush remedy,” made from medicinal plants.

REPUXO. What pulls somebody with move.

RESGUARDO. Confinement, Health care after delivery, or after taking a treatment with medicinal plants or surgery, etc.

RÉSTIA. Shadow.

REZA. “Prayer” ritual, words of prayers, prayers.

REZADEIRA. Female prayer shaman. Literally translating it means the one who prays on the pain.

REZADEIRAS. Female prayer shamans.

REZADOR. Male prayer shaman. Literally translating it means the one who prays on the pain.

REZADORES. Male prayer shamans. This is also the plural for male and female shamans in general.

RUA DOS CABOCLOS. Street where the Kariri-Shoco used to live before received parcels of land in the reservation.

SABEDORIA. Knowledge.

SECRETARIA DE SAÚDE Secretary of Health from state government.

SENSAÇÃO. Sensation, the sexual pleasure or orgasm.

SERENO. Dusk, early evening.

SERTÃO. Arid region in Northeast Brazil.

SIMPATIA. Light magic.

SINA. Fate, destiny.

SISTEMA DE COMPADRIO. Kind of fictive kinship very common in South American countries, which

SEM-TERRA. People dispossessed of land.

SORO. Medicine given through blood veins, intravenous.

SUSTO. Startle, fright.

TAMPAR. To close.

TOPAR. In a colloquial use it means to face something or someone.

TRONCO. Trunk.

TRÊS ABALOS. Three trembles.

TUTANO.

UM BOLO. A cake, something round.

UMA COISA REDONDA. Something with a round shape.

UMBANDA. Afro-Brazilian religion.

ÚTERO CRESCIDO. Grown womb.

VAZANTES. River banks.

VELANDINHO. Medicinal plant.

VASSOURINHA. Medicinal plant.

VIAGENS. Travels, trips. Usually referred to Ouricuri ritual when the Kariri-Shoco move to another village inside the reserve in the forest.

VIDÊNCIA. The quality of being able to predict and see things, to predict the future.

VENTRE CAÍDO. Fallen belly, a health problem related to something that has been displaced inside the belly, usually happens with babies.

VOCAÇÃO. Vocation, gift.

XANDUCA. Handcraft pipe made from sacred tree woods.

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