Birthing, corporality and care among the Guarani-Mbyá of southern Brazil

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Abstract

In this paper I draw attention to the happening of childbirth among the Guarani-Mbyá women. I highlight the centrality of a care language in the act of birth and of being born supported by the production of human bodies and kin. From Yva deliveries' stories I explore the connection between silences, bodies and human and non-human socialities by interweaving it with native modes of care and a critical analysis of the medicalization of birth derived from the relationship with the "*Juruá* ("white") system". I emphasize a non-reductive understanding of life and health in the translation of epistelomogies of care between indigenous and biomedical sociocosmologies. The data presented are results from a long-term ethnographic research carried out among guarani-mbyá collectives of the southern Brazil.

Keywords: Delivery and Birth, Guarani-Mbyá, Epistemologies of care, Medicalisation of Birth, Corporeality.

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Parto, corporalidade e cuidado entre as Guarani-Mbyá do Brasil meridional

Resumo

Neste artigo abordo o acontecimento de parto entre guarani-mbyá mulheres. Mostro a centralidade de um idioma do cuidado no ato de parir e fazer nascer, sustentado pela produção de corpos humanos e de parentes. A partir das histórias de parto de Yva, exploro as conexões entre silêncios, corpos e socialidades humanas e não humanas, entrelaçando-as com modos nativos de cuidar e uma problematização da medicalização do parto advinda da relação com o "sistema do *Juruá* ("Brancos")". Enfatizo, em particular, uma irredutibilidade dos entendimentos de vida e saúde na tradução de epistemologias de cuidado entre sociocosmologias indígenas e biomédicas. Os dados apresentados são fruto de um estudo de cunho etnográfico de longa duração entre coletivos guarani-mbyá do Brasil Meridional.
Palavras-chave: Parto e Nascimento, Guarani-Mbyá, Epistemologias de cuidado, Medicalização do Parto, Corporalidade.

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Birthing and being born are happenings that make explicit relations and affects. They are happenings in the sense given by Walter Benjamin (1940), understood not as a self-contained fact or a linear narrative of events, but as a flow of present moments in which questions surface like who gives birth, who is born, who is alongside, what is seen and what is not seen. For the woman, the epicentre of people's attentions and investments, sometimes technocratic, sometimes revelatory of the communication with invisible worlds, being the protagonist of the birth enables kinship actualizations and locates her in an interstitial space between what is happening at the moment and what will happen in the future of an ineluctable bodily experience. These are happenings since they also interweave memories and create and re-establish ties.

Among Mbyá women,[1] birthing alone or with the help of close relatives is still one of the most common modalities of childbirth. Although the medicalization of delivery and birth are also present, especially among younger women and those living in places not far from large urban centres, giving birth in the village and among kin remains an ideal. Among the Mbyá, childbirth is a silent, secluded happening. Few people participate and days go by before news circulates to more distant kin. If immediately announced, the news is transmitted in murmurs, protected from spreading too far. The dangers of the invisible world, or of what seems to be what it is not, are always lurking, waiting for a momentary lapse. Noises, smells and visual contact can be traps that lead the newborn to lose human vitality. The same applies to the woman who has just given birth: losing her Mbyá subjectivity is a constant risk, and the smell of blood that exhales from her body attracts beings imbued with intentionality.

To explore this intercourse between silences, bodies, and human and non-human socialities, or, in other words, birth as a happening among the Mbyá, I turn to the birthing histories of one woman, Yva, and their entanglements with reflections on modalities of care and processes of medicalization of childbirth stemming from the Mbyá people's relations with the '*Juruá* system.'[2] I show the centrality of an idiom of care in the act of giving birth, sustained by the production of human bodies and kin. A central argument in this process of translating their epistemologies of care is the irreducibility of the distinct indigenous and biomedical sociocosmological understandings of life and health. The article is structured in three parts. The first two are dedicated to childbirth and midwifery among the Mbyá, while in the third I extend the discussion on the limits and inflections of the 'differentiated healthcare' stipulated in Brazilian public policies.

1 Guarani-Mbyá collectives currently inhabit the national territories of Argentina, Brazil, Paraguay and Uruguay. In southern Brazil – and here I refer primarily to the region comprised by the state of Rio Grande do Sul – there exist approximately 3000 Guarani-Mbyá people. Demographic and linguistic data on this collective can be found on the website of the NGO Instituto Socioambiental (www.socioambiental.org).

2 Among the Guarani-Mbyá, the term *Juruá* is used for those they consider 'white' or non-indigenous in general.

1. Birthing alone, birthing as a midwife

The mother who birthed the World.
(Bigio, 2007)

Yva has given birth to eight children. Three of them alone. Not long ago, she described each of her births to me in detail, proud to have birthed without crying out, in silence. This was a great achievement. I consider Yva to be a long-term friend: I have known her for almost two decades, and, since we are using the verb give birth, I could add that Yva helped me to birth myself as an anthropologist. She knows this so well that, during our last encounter, she sat on a small stool in front of the fire and, in a professorial tone, said to me: "so is it today that you're going to film a video of me telling you everything about births and midwives?"[3] The day had just dawned and she was already clutching her mate and *petyngua* in her hands,[4] as usual. I had always wanted to film a video of her, especially on this topic, but I had never wanted her to feel obliged to do so. She may well have said no, had she not been inclined. Yet, even so, I felt embarrassed to want to capture her image and her narratives without the idea coming from Yva herself.

Yva has changed a lot since we first met back in 2003. At the time, she was one of the many Guarani-Mbyá women invisible to the eyes of *Juruá* ('white') interlocutors, the vast majority of them men looking for indigenous 'big men' who could reveal secrets from the shamanic world or from the terrain of clashes with the nation state. Yva was married to Chunu, who was the *cacique* (leader) of the *teko'a* (Guarani-Mbyá existential spaces) where they lived. He died many years ago and Yva subsequently, without any prior intention, transformed into one of the most active voices of the Mbyá collectives of southern Brazil. With the vacuum of representation and a dispute between the younger men to assume the place previously occupied by Chunu, Yva gradually became an internal advisor to her collective. While in 2003 she spoke little Portuguese, and had little or no contact with the world outside her *teko'a*, after her husband's death she became a *liderança*, a 'leader.'[5]

Female leaders are rare among the Mbyá of southern Brazil. I know just two such women who are called *cacicas* (the female of *caciques*) by their own communities, both of whom emerged in recent years.[6] One of them is Yva. The interlocution with the *Juruá*, with the world outside the Mbyá collective, is the terrain of men par excellence. There are a number of reasons for this, including the fact that most women do not speak, or do not like to speak, Portuguese. A deliberate avoidance of contact with the white world. Today, Yva speaks Portuguese fluently and has been accepting an ever increasing stream of invitations to take part in public events. This movement involves a degree of oscillation on her part, ranging between an openness to the *Juruá* demand for representation to a wish for the distance needed to deepen her shamanic knowledge as a *kunhã karaí* (female shaman) currently in training.[7] These positions are virtually irreconcilable insofar as they demand communications and performances with very different outside worlds.

3 Over the course of the text, I use quote marks when citing phrases, words and expressions used in Portuguese by Guarani-Mbyá interlocutors, translated here into English.

4 Mate: a hot drink made from yerba mate (*ilex paraguariensis*). Drinkers use a gourd and a *bomba* (a metal straw). It is also known as chimarrão. Drinking mate is a practice common to the peoples of the geographic and cultural region of the Pampas, who descend from Guarani indigenous collectives. A *petynguá* is a recipient made from clay used to hold tobacco (*pety*). It is a significant object for the Mbyá, since it acts as a potent means of communication with the deities. The smoke produced by burning tobacco (*tatachy*) relates to the creation of the first Mbyá world and is conceived to have the power to cure and restore humanity.

5 In quotation marks because this Portuguese term is a broad and relatively recent category, also employed emically. It can be taken as a consequence of the relations with the white world and the search for indigenous territorial rights or their guarantee. On many occasions, *liderança* signifies sporadic representation in meetings with state and non-state agencies. At other times, it refers to a continual representation, legitimized by the support of these agencies. The figure of the *cacique* (a Taino-derived word used throughout much of Latin America for indigenous chiefs or leaders) is still the most frequently used to refer to political representation of the *teko'a*, without this excluding the coexistence of *lideranças*.

6 Rebelo (2015) reflects on this subject in the masters dissertation entitled "*Kunhangue Mba'e Kua*: as trajetórias das mulheres cacicas Guarani-Mbyá de Santa Catarina".

7 The article by Colpron (2006) deepens the discussion on shamanism and women through an ethnography carried out among the Shipibo-Conibo people.

Transforming into a *kunhã karaí* requires an investment that involves reclusion and protection from the dangerous and voracious world of the whites. Menstrual blood and the care necessary to ensure children grow up strong are some of the obstacles to becoming a *kunhã karaí* while still young. As a process that requires the apprentice's dedication, women put their knowledge into action when they already belong to the category of elder. No longer with small children or menstrual blood, which places the women and their kin in a vulnerable situation at 'each turn of the moon,' as the Mbyá say, the path is clear for her to consolidate herself as a *kunhã karaí*.[8]

1.1 Making a body for birthing

Just like turning into a *kunhã karaí*, making a body that knows how to birth requires action. And time. Unlike a naturalist conception of the body, whose capacity for reproduction occurs with the biological maturation of the female or male reproductive organs, among the Mbyá nothing is set in advance. A Mbyá body needs to be made, and a body that knows how to give birth forms part of this premise. The now classic texts of Viveiros de Castro (1979) and Seeger, da Matta and Viveiros de Castro (1987) highlighted the centrality of the body in the indigenous socialities of the South American lowlands. The sociocosmology of the Guarani-Mbyá collectives of southern Brazil is contemplated within this theoretical framework.

Looking from a comparative perspective, Euro-American societies today do not experience seeing or participating in the birthing of their kin. Women belonging to these societies have, for decades, grown up without seeing or witnessing other women giving birth. Indeed, in some countries like Brazil and Mexico, for example, parturition is actually on the decline given that a large portion of births take place through caesarean sections. Even in countries like England, where the midwife profession is highly regarded and home birthing recommended,[9] most deliveries occur in maternity hospitals, far from the family environment. Without entering more deeply into discussions about the management of pregnant bodies in technocratic societies (Davis-Floyd, 1992), the point I wish to emphasize is the distancing achieved from the corporality inherent to the act of birthing. Teaching how to birth is an incomplete act in itself, likewise teaching how to help or care for a woman who is in the process of birthing. Both forms of knowledge are located in the body: effectively, one learns by birthing and by caring for women who are giving birth.

Touching the viscosity of the uterus, smelling the liquids, and allowing oneself to be moved by affective states in the expectation of an outcome, are all part of the sensible world, interwoven with a disruptive temporality: the birth as a happening. Studies of the interface between science, technology and obstetric education have shown the challenges – already longstanding – of reproducing the pregnant body and the birthing process in educational materials (Nott & Harris, 2020). Simulators that try to translate the viscosity, friction and adherence of the uterus and placenta, for example, have only partial, incomplete results, unable to fulfil the function of replacing the actual experience of watching or taking part in a birth. Beyond the physical dimension, incomplete in its sensorial effectiveness, this 'educating' involves a purification of the happening of birth that excludes odours, affects and substances. Among Amerindian collectives, but elsewhere too, women recognized as wise in the art of caring for other women during childbirth are women who have already birthed themselves. They are women who already contain in their own bodies the experience of pain, aromas,

8 Among Amerindian collectives, blood potentializes dangers by accentuating communication with the invisible world. Menstrual blood in particular is a vehicle connecting celestial beings, like the moon, animality and the corporality of women (Belaunde, 2005). Aline Regitano, an anthropologist who works with the Mehinako collective, told me in a personal communication that one of her interlocutors, Iamony, also became a shaman after a certain age. However, she was still menstruating.

9 British National Health Service (NHS) website: https://www.nhs.uk/conditions/pregnancy-and-baby/where-can-i-give-birth/ Consulted 20 April 2020.

times, and affects. This contrasts with the institutionalization of the obstetrics and obstetricians as a profession in modern societies, insofar as what legitimizes the knowledge of these professionals is an academic training relatively independent of embodied experience.

A purification of birth as a happening, its transformation into a biomedical event, allocated to a sphere controlled by measuring risks and deploying techniques for rending the woman's body docile, has run in parallel with the same historical distancing from death (Elias, 2001). Over the twentieth century, the place for birth and death became crystallized in hospital institutions. If birthing appears to be a purely physiological act, the consequence of a biological action of expelling a baby through the vaginal canal, a comparison with other sociocosmologies reveals the existence of multiple intersections between the relational, generational, power and gender dimensions involved in the act of birthing.

Mbyá women prepare and learn to birth. As well as an entire corporality that shapes the body from a young age, such as squatting while cooking, sitting by a fire, or washing clothes in the stream or at taps, all of which substantially help mould a musculature capable of supporting the act of birthing, young girls also have their bodies made from qualities extrinsic to Mbyá humanity. Long before their first menstruation, during the transitional period between *mitã* and *iengué*,[10] a process begins to differentiate the bodies of Mbyá women from those of Mbyá men. At this moment a more direct investment is made in making a body to give birth. An example is the use of the grease from a *mbykuré* (common opossum, *Didelphis marsupialis*), which is commonly rubbed on the lumbar region of girls. The fat between the animal's flesh and skin is removed and stored in a hollow length of bamboo. This 'grease,' as Yva calls it, is set aside to be used on various girls (*kunha'i*) on recurrent occasions. This is the most frequent and direct method of action on bodies, since the Mbyá attribute *mbykuré* with the capacity to birth without difficulty. By having the animal's fat rubbed on their lower back and consequently absorbed, the bodies of Mbyá girls also acquire the quality of being able to birth without complications. The making of a body is literally under way: the making of a body of a woman, a body with the capacity to birth. Our tendency is to focus on the physical and material when thinking about indigenous epistemologies of care. Referring to the grease of *mbykuré* facilitates the visualization of a fabricated body. At some level, after all, the materiality of the grease can be compared to a pharmaceutical drug. A body able to birth, however, is not made from so-called physical substances alone.

Before making a body that births, it is important to focus attention on a Mbyá body-person. It is first necessary *to be* a Mbyá before then differentiating oneself as a man or woman. And it is these bodily and relational actions that configure the differentiation between the sexes. I emphasize this point because although the focus here is on birth, Mbyá bodies are subject to successive investments from birth onwards. These are not aimed at an intra-human differentiation alone, that is, the difference between Mbyá men and women, but also between humans and non-humans[11]. The vaginal canal, for example, is also opened up. Sexual stimulation is needed for menstruation to become possible. Among the Mbyá, as among many other Amerindian collectives, menstrual blood is the result of an intimate relationship with the moon, a celestial and divine agent. The 'moon boy,' as Mbyá women tell, failed to observe a distancing rule by having sexual relations with his mother's sister.

10 The word *mitã* can be translated as child and *iengué* as a girl with breasts. I consider it inappropriate to employ biomedical categories like infancy and adolescence for indigenous collectives, which is why I maintain the native terminology. *Nimbé*, for its part, is the name given to girls who have had their first menstruation.

11 I discuss the body and person among the Mbyá in more depth in a recently published book (Prates, 2019). The articles by Vilaça (2005) and Surrallés (2004) are also key references to think about bodies among Amerindian collectives as unstable entities, also made with and through affects.

Menstrual blood is the outcome of this incestuous act, an intentionally provoked action that disrespected the rules of marriage among the Mbyá. The vaginal canal was literally opened by the penis of the moon boy[12] and, as a consequence, Mbyá women menstruate every four turns of the moon.

The Amerindian world is inhabited by a multiplicity of beings, both visible and invisible, and the body is a site of differentiation between these beings. It is necessary to make a Mbyá body not only to birth but also, and above all, to be a Mbyá person. In the case in question, the differentiation between Mbyá women and men relies on the participation of a non-human agency, *jachy* (moon). It is an incestuous relationship that provokes bleeding, opens the vaginal canal and thus instigates the dangers related to menstruation and birth, outcomes of an extra-human agency.

1.2 *Aata ambo jau*: tricking the unseen

Beginning the narrative about her eight births, Yva said to me: "A Guarani likes arriving in the middle of the night, very slowly, while everyone is asleep." The idea is evoked of quietness and silence as a welcoming environment for a new being. It is the child itself, if we take into account where the subject is in the phrase, who wants to be born in the night-time. By announcing that a new Mbyá being is about to arrive in this world, the person who heads off to encounter the woman giving birth, in order to help her, customarily says *aata ambo jau*, which I translate as *I'm going to give a bath*. This tricks what is unseen and may threaten Mbyá humanity by making use of a language dissuasive of attacks. *Ambo'a*, for its part, may mean give birth, drop and bathe.[13] And this applies to both someone who provides care and someone who gives birth: *aata ambo jau* (I'm going to give a bath) and *ambo'a che memby* (I birthed/bathed my child). It announces that a birth is approaching and sets the emphasis on the meaning *to bathe*. Bathing is the first invested action. To bathe the small newborn child is to transform him or her into part of the collective. It is not the physiological act of birthing that gives birth to a Mbyá child, it is the action of cradling and bathing the child that confirms that a new member has arrived.

In the first pages of his book *Chronicle of the Guayaki Indians*, Pierre Clastres (1995, p.11) provides a precious description of childbirth and the cosmological meanings of this happening among the Guayaki. Many correlations exist between the latter people, also speakers of a Guarani dialect, and the Guarani-Mbyá. Clastres interprets the passage to human existence through an exploration of the meaning of the verb to fall, *waa*, which he translates as *being birthed* and the verb to rise, *upi*, signifying the *act of suspending* – in this case, the child. For Clastres, bathing the newborn entails re-establishing a cosmic order. It is a reallocation of Guayaki relations in light of the origin myth of their humanity (1995, p. 14). Just as among the Mbyá, an interstitial space exists between birthing and being born: it is necessary to recognize this recently birthed being as one of their own and bathe the child to give it a social birth.[14]

A thin and extremely sharp blade of bamboo is used to separate the placenta from the recently birthed child among the Mbyá. The woman births in squatting position and, when accompanied, is supported from behind. The baby falls on the ground, generally onto earth, and before he or she begins to cry is held either in the arms of the women who birthed or those of her birthing companion. The child is immediately bathed with water already waiting in a container. Under no circumstances can the baby be washed in running water, whether from the tap or in the river. Running water, as well as noises and visual contacts, is a vehicle for non-human beings to take advantage of the moment of vulnerability of Mbyá humanity. As I said earlier, everything

12 During my fieldwork, long time ago, Yva and her sister Jachuká introduced to me the mbyá knowledge regarding menstruation and bodily transformations. It was then that I heard for the first time, in Portuguese, the designation of "menino lua" (moon boy). In the Guarani language, he is called Jachy, a celestial agent and the divinity who plays an important role in the guarani mythology.

13 According to field data, supported by the Montoya dictionary (2002).

14 It is an interstice between actions that defines making live or not letting live.

unfolds in silence, the spatiotemporal ruler of this happening. Both the woman who birthed and the person who cared for her during the birth need to bathe too. Not in running water but in the same way as the newborn is bathed: with still water, taken from a container. Here the problem with running water is the aroma. It is not a question of what comes with it, but what comes after it. Running water is a vehicle for spreading the smell of blood, and this in turn arouses the interest of predators – that is, other intentionalities.

As I mentioned earlier, Yva birthed three times on her own. One birth was in the swidden (*kokué*), another was in the bamboo grove, and another was while she was walking along a dirt track. She said that as soon as she had birthed, she 'bundled up' the child, still attached to the placenta, in the skirt she was wearing and ran home. Only once within the walls of her house did she finally cut the umbilical cord and bathe the newly birthed baby. In none of these situations had it been her intention to birth alone. She said that she had felt a lot of pain during her first childbirth only, which explained why she did not realize she was about to birth in the subsequent pregnancies. In the Guarani language, the pain of childbirth is called *imemby achy*, meaning something like 'child pain.' To announce that she is birthing, the woman usually says, guardedly, *xeera achy ma* ('I am making myself ill' or 'I am making myself feel pain'). Births frequently occur in the *opy* (the house of prayers and ceremonies). Yva calls it the *casinha*, 'little house,' in Portuguese. Depending on how long the labour takes, a *kunha karaí* or *karaí* (female shaman or male shaman) may be called to help care for the mother. Care involves communication with invisible beings, including here the deities, with the aim of facilitating the path of arrival of the child's *ñe'e*[15] (divine vitality) in the actual terrestrial world.

2. *Mitã jary'i*: women who know how to care for other women birthing

Our grandmothers will tell the beautiful path
Let's all walk together
With our grandmothers
(Guarani-Mbyá song)[16]

Among the Mbyá, as among many other human collectives,[17] there is no institutionalized figure of a midwife. Caring for other women giving birth is above all a relation between proximity (through kinship) and embodied experience. Some women become renowned as wise and experienced in the art of caring for other women: they have already birthed, have already cared for other women giving birth and are close relatives – whether affinal or consanguineal – of the latter. Only rarely will a distant woman, unrelated to the woman birthing, be mobilized to take care of her. And even if it is not prioritised that men attend the birth scene, in some way they are often required. It is not rare for birth to be attended by men-husbands. It is a delicate moment of risk and vulnerability and any contact with strangers is avoided.

Mitã jaryi can be translated literally as the child's grandmother (*mitã*/ child, *jaryi*/ grandmother or elder woman). The woman who is due to give birth is usually cared for by her mother's mother. Yva's first birth was assisted by her maternal grandmother. In two other births, it was her companion Chunu who assumed this role. Narratives about men who care for their wives during childbirth were actually fairly commonplace in my fieldwork. The spacetime of childbirth as a happening is mostly, yet not exclusively, feminine.

15 *Ñe'*e, translated as soul-word by scholars of Guarani collectives (Cadogan, 1997), designates both vitality of divine origin and language. The word or act of speaking are related to the communication between humans and deities. This intrinsic relationship between speaking and existing as a human is a key aspect of Mbyá sociocosmology.

16 *Ñande jary'i tomobeú tape porã*/Jaguatakatu *joupive'i*/*Ñande jary'i roupive'i*. An excerpt from the Guarani-Mbyá song *Nãnde jary'i mbaraété'a* (The strength of our first grandmothers) by the *Ñamandu Ñemõpu'a* choir. A similar version can found in the book *Yvy Poty, Yva'á* (Lucas & Stein, 2009).

17 The institutionalized 'midwife' can be conceived as an exception among most human collectives, past and present. For more examples of the social arrangement between kinship, proximity and care during childbirth, see the texts by Gutschow (2011) and Belaunde (2000).

Men may care for women giving birth. Undoubtedly certain circumstances may favour a man's participation as birth carers instead of women, such as when, at the moment of birth, the pregnant woman is not in the same place where her mother or grandmother live. What I emphasize, though, is that the ethnographic data shows that birthings 'cared' for by men are not rare. Births that occur in the depths of night, without significant complications, tend to happen silently inside the houses. The reclusion of the newborn's father and mother effectively announces to the community of kin that a new member arrived. In the days following the birth, food proscriptions and prescriptions are followed. Physical exertion is avoided and likewise affective states deemed hot (*aku*), such as anger and jealousy.[18]

2.1 Connecting worlds, making persons: what is 'care'?

The umbilical cord (*puru'a*) connects Mbyá humanity to deities, produces kin and affects. By cutting it, the connection between humanity and the deities is separated, in part, while the relations between Mbyá persons is strengthened. *Puru'a* connects visible and invisible worlds, and operates as a vehicle enabling a Mbyá humanity. The umbilical cords of children born in the *teko'a* are cut longer than those usually performed in hospital births. Indeed, this is one of the points of divergence between Mbyá and biomedical modalities of care. For the Mbyá, the umbilical cord needs to be cut some distance from the child's navel in order to ensure that when it dries and falls off, a necklace can be made from it.[19] This practice is thus compositive, rather than decorative, in intent: its aim is to enable the absorption of the divine qualities of the umbilical cord and thus guarantee the child's health and Mbyá humanity. From a biomedical viewpoint, the umbilical cord needs to be cut short to ensure it dries and falls off quickly. The placenta (*he'e ndague*),[20] translated by Yva as the baby's 'cocoon,' can be understood as a double of the child. The placenta is buried, still warm, as soon as it is birthed after the baby. When placed underground, the placenta must still be at the same body temperature it was when birthed. Just like the lengthy cut on the umbilical cord that allows the necklace to be made, burial of the placenta ensures the strengthening of the child's body and, consequently, good health.[21]

Both the umbilical cord and the placenta are connections between the Mbyá person, who is being invested with care so that the child becomes fully human, his or her kin and the deities. When the birth takes place in hospital, both the umbilical cord and the placenta are discarded. The cord is cut off as close as possible to the newborn's navel and the rest, along with the placenta, become hospital waste. After my description of the modes of making and caring for people among the Mbyá, could the reader imagine anything more dissonant with the indigenous notions of body, life and health than transforming these elements into garbage?

18 Postpartum reclusion is referred to as *couvade* in ethnological studies. Rival (1998) discusses the theme in an article dedicated to the couvade among Huaorani peoples.

19 The necklace is made from cotton, or another flexible and comfortable material, and a kind of rectangular pendant. A type of cocoon, as Yva translates placenta from Guarani to Portuguese, which will protect the remains of the umbilical cord, already dried and shrivelled in size. This object will be used until worn out, a moment taken as the completion of the body's absorption of the qualities that motivated its confection.

20 I was unable to find the word placenta in the Montoya dictionary (2002) and transcribe it here in accordance with my fieldnotes.

21 Aline Regitano, in personal communication, told me that among the Mehinako of the Xingu region, the placenta is buried to avoid its use for predatory purposes. In other words, there is an apparent difference between Mbyá and Mehinako women about the reasons for its burial. However, given Regitano's explanation for the burial of placentas among Mehinako women, I think that both motives may be present among Mbyá women: burial of the placenta ensures that the child grows up strong and that the placenta's putrefaction does not occur before it is buried, which likewise averts predation. Among the Mbyá, the body's blood and flesh are related to *angué* (telluric vitality) and it is important to invest in human-divine Mbyá vitality (*ñe'e*), which, in turn, is related to bones, smoke, fine words, maize and affective states of contentment. *Angué*/*ñe'e* are intrinsic aspects of the Mbyá person and ambivalence is a constant feature in the course of the life-cycle. Since the placenta is basically composed of flesh and blood, therefore, it also makes sense that it is best to avoid any predatory agency. In this article, though, I stress the placenta as a resource to ensure the 'strong' growth of Mbyá children since this was the emphasis given by the interlocutors.

In 2008, the State of São Paulo, via its health department, launched the "Project for Recovery of the Traditional Medicines of the Indigenous Population," thus assuring respect for Guarani food prescriptions and proscriptions in the hospitals, as well as the handing over of the placenta to the mother, in a styrofoam container packed with ice, for burial in her *teko'a*.[22] The motive for creating the project was given as the high rate of births taking place outside the hospital environment, which, according to its proponents, was directly associated with child mortality. I do not know the details behind this equation between birth in the *teko'a* and infant deaths. At the time, I talked with Mbyá women living in a *teko'a* in southern Brazil about this initiative. For all these interlocutors, once in hospital, the rules of the *Juruá* had to be followed. They added that it was no use bringing a 'contaminated' placenta – even if frozen, I would add to complete the phrase.

All the practices and techniques for making a Mbyá body-person, to ensure the production of kin and of affective states like joy (*vy'a*), can be read through an idiom of care.[23] Such care is collective, invested with cooperation and exchange in every detail of quotidian life. Silence during birth, the burial of the placenta, reclusion during the menstrual cycle, can all be read as modes of care. Care of the self, the person's care for kin, and kin who provide care for someone in a vulnerable situation. Making kin involves eating together, paying attention to what one says, maintaining a proximity that allows for care. Care means being attentive to what transpires between the Mbyá world and the invisible world. Caring for a woman during childbirth, for example, requires that a woman providing care is not menstruating, or a man doing the same has had no contact with animal game on the day of the birth or those just before. A hot state, like the menstrual or postpartum period, is a motive for reclusion (*jekoaku*). Like the relationship between blood and female shamanism, providing care during childbirth requires an absence of blood in the body, an absence of a hot state. Knowing how to care also means knowing how to care for oneself. Knowing when and how to enter reclusion.

The first time that Yva cared for another woman during childbirth was by chance. The woman's male companion came to summon her at home. It was one of her aunts, her mother's sister. Yva said that there were no other women more experienced than herself in the *teko'a* at that time, and initially she was afraid. However, she was encouraged by the memory of her grandmother Pará's teachings and how she had birthed her first two children. The birth happened without complications and thereafter Yva began to feel emboldened (*mbaraete*) to care for other women. Sometimes, the male partners of the women due to give birth do not feel comfortable caring for them. Yva even told me that Chunu, if he could, would 'run off' to avoid having to care for her during childbirth.

I note the form with which Yva verbally mobilizes her birth experiences, both as a protagonist and as a carer. These are the configurations of kinship, corporality and territoriality that seem to sustain the almost unexpected happening of giving birth alone and caring for a birthing woman for the first time. She birthed alone without intending to do so, and cared for a woman who birthed because someone else asked her because she considered her wise in the art of birthing. Both experiences – which ended up with her becoming recognized as a *mitã jaryi* among kin – are events engendered by an artisanally fabricated and invested corporality. She made and they helped her make a body capable of birthing, thus embodying an experience that ended up making her capable of caring for other birthing women too. Collective life revolves around these micro-productive traits of persons, relations, kin and, in relation to the spacetime of these happenings, territorialities.

22 Further information on the project can be found on São Paulo Government website at: https://www.saopaulo.sp.gov.br/ultimas-noticias/hospitais-estaduais-farao-parto-indigena-1/

23 *(O)nhengarekó* can be translated as care – at least to some extent and taking into account a number of caveats in relation to the heavy semantic connotations of the word in English. I employ the word 'care' because I think it can be problematized in light of contemporary discussions of the theme (Mol, 2008; Platt, 2013) and, principally, because this is the translation given by the Mbyá interlocutors for the term *(o)nhengarekó*.

At the intersection between care, kin and territoriality, for example, it is necessary to register the difficulty today of constructing an *opy* (house of prayers and ceremonies): there is a lack of suitable clay, bamboo and grass. Yva recently moved *teko'a* and, though happy to have found a new and beautiful place to live with her kin, she has faced a series of problems in completing construction of the *opy*. The bamboo can be found in other *teko'a*, but the clay and grass are in what are now natural reserves, impossible to access for the purposes of gathering material. Something relatively simple from the 'physical' viewpoint,[24] but highly significant for the existence of a collective, ends up obliterated by the territorial restrictions imposed upon it. Refusal to recognize indigenous territories, combined with denial of any possibility of a Mbyá existence in accordance with their own modalities of making kin and caring, perpetuates an epistemicide and, ultimately, extinguishes lives.

Were indigenous collectives able to access what we call the physical realm that helps sustain their modes of life, like plants, animals, forests, clean bodies of water, the relationship with whites would be based on exchange and help rather than dependence. But what can be observed, instead, is a relentless annihilation of the indigenous way of life through forms of government that make these peoples dependent on epistemologies of care mostly incompatible with what keeps them alive as such. Any attempt to strengthen these knowhows and 'cultures' that does not involve consideration of an indigenous territoriality erases, or at least erodes, a range of different modes of existence indispensable to life as a collective. Indispensable, ultimately, to what 'care' means in Amerindian terms.

2.2 Attempted capture: should traditional indigenous midwifery be institutionalized?

In recent years, public policies focused on maternal and infant health have attempted to introduce midwife training courses (Ferreira, 2013). Yva has participated on some of these. She has identified as a midwife at public events, a recent fact that, as I see it, has conferred her a significant place in the interlocution with the *Juruá*. A place with two dimensions: a political positionality, which ends up competing directly with that of Mbyá men; and the role of a wise woman experienced in the art of caring for other women. The latter is to some extent considered more prestigious by her and Yva seems to feel more at ease in it.

I recall the narrative on the first midwife course on which Yva participated. This was many years ago, perhaps ten or more. On returning from the city of São Paulo where the course had been held, we met in the centre of Porto Alegre to have lunch. Yva was quite upset by the fact that the speakers had told her to use gloves to hold the newborn baby. She did not understand, she said, why babies are considered dirty by the *Juruá*. "Whites," she continued, "do lots of filthy things, like placing their mouth on the partner's genital organ [a reference to oral sex] and yet they put on gloves to hold a baby!"[25] Listening to her, I understood that what was in question for her were not just conceptions of filthy and clean, or sexual modalities alien to Mbyá practices, but also a knowhow announced as technical that nonetheless appeared senseless to her. Touch, the body that feels another body, the fluids, aromas and intensity of a birth, cannot be apprehended through training courses or explanatory pamphlets. Much less still were her hands to be covered by gloves, thus impeding the tactile. Furthermore, not having her knowledge recognized in its own terms left her suspicious that they wanted to transform her into a '*Juruá* nurse.'

Other invitations to take part in workshops on midwives, not necessarily with the aim of providing training, have come her way over the last few years. Whenever these invitations make it clear that they recognize her as a 'traditional midwife,' Yva expresses an interest in taking part. It is an opportunity to travel, meet other people, indigenous men and women, and return with a bag full of new relations. Moving about is a means

24 Based on modern Western sociocosmology, whose nature/culture bipartition delineates the boundaries with the invisible world (Descola, 2005).

25 In this case, I have not transcribed the word used by Yva literally.

to be happy, as shown in the ethnography of Pissolato (2007). Swapping knowledge about childbirth and mother-child care among indigenous women is a new phenomenon. I refer to this within the framework of a broader understanding of indigenous 'women' – this generic and universal category of woman, which eclipses other forms of producing difference and alterity in Amerindian sociocosmologies. Moreover, the emphasis on this period of life is something in some ways quite distinct from what happens in intracommunity relations. It says a lot about Euro-American societies, rooted in biomedical logic and attention to 'life' and 'reproductive health,' but little about how indigenous collectives situate the topic in a native idiom.

On one hand, this stress on maternal-infant health, isolating it from the life-cycle as a whole, can certainly be considered one more sign of the medicalization and control of indigenous bodies. On the other hand, though, it comprises a sticking point if we think that, in some situations, indigenous women may be treated by white biomedicine and as a result not suffer complications in childbirth and the postpartum period. This means that while it constitutes another form of making them dependent on the white world, it also becomes an inevitable means, in a certain sense, for these collectives to continue to exist as 'biological bodies,' to paraphrase Rose (2006).

Because childbirths are not assisted by a 'midwife,' in the sense of an institutionalized figure for this office existing among the collective, a degree of invisibility protects the happening of childbirth from a more incisive form of medicalization. How can a 'midwife' be identified if such women do not exist among the Mbyá in the expected form? How do we identify a midwife if all Mbyá persons are potential midwives? They do not exist and simultaneously exist in high numbers everywhere.

3. Aligning knowhows, weaving temporalities

It would be so nice to wrap that thing around my wrist and follow the sun, even at night.
(Kopenawa & Albert, 2015)

The temporality of childbirth is a node essential for us to emphasize on the disjunctive interface between Mbyá modes of care and the biomedical understanding of care. In Euro-American societies, the control of time, via the clock, configured a revolution in the way in which lived temporality is experienced. Measuring, controlling, verifying, timing: actions that fractionate and that mostly aim to maximize corporal production.[26] In the book *Childbirth, Midwifery and Concepts of Time*, McCourt (2009) explores the relation between time and childbirth. The author discusses the industrial revolution and the development of the capitalist system as key moments for the beginning of a timing of birth. Bodies acquire a time span for delivering products in the form of babies. Childbirths go through stages, which also become timed so that a time for 'delivery' can be normalized; stages become fractioned too with the aim of achieving a more accurate prediction of the moment of the baby's vaginal expulsion. McCourt shows how too pride is obtained in births that happen quickly without too much physical strain either for the woman giving birth or – and above all – for the medical team assisting her. Birthing – but no longer just birthing, but also being submitted to caesarean section, for example – turns women into docilized bodies at the mercy of a biomedical intervention that demote them to the place of supporting actor in the birth scene (Davis-Floyd, 1992). Adapting bodies to a time predetermined as normal becomes a major objective for biomedical rationality, while this adaptation will be reflected a feat worthy of validation and being publicized. Outmanoeuvring time with intervention techniques and risk management becomes a synonym of modernity.

26 In *Discipline and Punish* (1987), Michel Foucault proposes a genealogy of disciplinary institutions, the hospital among them.

As remarked earlier, the coexistence of knowledge and epistemologies of care, including biomedical and indigenous, has some limitations. The irreducibility of certain notions like body, health and time, for example, can be highlighted as one such point of divergence. This is not necessarily an obstacle to their coexistence. Field studies in the anthropology of health (Langdon, 2004; Garnelo, 2014, among others) show that any closure to the joint treatment of diseases and therapeutic indications is on the part of biomedical professionals. Indigenous people from a wide variety of collectives tend to transit between different modes of cure in the attempt to re-establish their physical and social well-being. In this sense, the irreducibility occurs through the failure of health professionals to recognize that biomedical knowledge also derives from a historical and sociocultural base of knowledge production. A supposed transcendence of the truth regime of biomedical rationality impedes recognition of other forms of knowledge just as legitimate as biomedicine. While the efficacy of biomedicine's modes of cure, based on the use of drugs and surgical interventions, is, in some cases, understood to be effective by indigenous collectives, it does not account completely for what 'health' means and, less still, for what 'care' means for these collectives, as we saw earlier. Indigenous epistemologies of care, as well as signifying health in terms other than our own, including not being limited to a biological functioning of the body, are open to new modalities and alliances, so long as what is in play is the combination of actions intended to assist the recuperation of the person feeling unwell. From the point of view of indigenous sociocosmologies, there is no competition over a leading role since different modalities of care may be used in conjunction. What comes from the white world, when considered pertinent and appropriated, can be seen as part of the indigenous world, even if in other terms, since these sociocosmologies are accustomed to being open to difference and alterity.

The idea that being a midwife derives from technical training, in the biomedical acceptation of the term, and training acquired by repeatedly attending patients, does not seem to be the point for acting as a *mitã jaryi*. Without a sociocosmological background, which allows the anticipation of relations of kinship and proximity, the midwife function tells us little or nothing about insertion within a community. Many Mbyá people could be trained as so-called traditional midwives, for example, but pregnant Mbyá women might nonetheless make increasing use of hospital births. What is the difference between a midwife, who shares the same precepts as *Juruá* nurses and doctors, and the health professionals working in a hospital setting? Kinship is a strong component in this equation and the advantage of going to hospital is that at least there the risk of attacks from Mbyá shamans – and invisible beings – is less likely to occur. Ultimately, the traditional midwife – as we might circumstantially call the *mitã jaryi* – is not a professional making use of intervention techniques, wearing a wristwatch to time the different phases: she is an elder recognized for her wisdom and her proximity to the birthing mother, who also knows how to intervene through care techniques. Her interventions occur in the body of the parturient woman through massages, infusions of medicinal herbs, curing tobacco smoke, and advice in words that connect humanity to the deities. All these techniques are Mbyá forms of knowledge, meaningful because they are inserted and expressed through a singular mode of existing – and of birthing.

Institutionalizing the place of the midwife without reflecting globally on this place dedicated to them in the Guarani-Mbyá configuration of the cosmos and the porosity towards public health policies exacerbates the difficulties faced by indigenous existences. Unlike the situation among other peoples, like the Paumari (Bonilla, 2016) and the Mehinako (Regitano, 2020), or even their territorial coinhabitants, the Kaingang, among whom hospital births are more frequent or even predominant, the Guarani-Mbyá collectives of southern Brazil still see the act of birthing in their *teko'a* as a way of protecting themselves from the white world – and also nurturing networks of kinship and affect.

3.1 Dissonant temporalities: between the hospital and the *teko'a*

During my periods of fieldwork and, more recently, in my research specifically focused on hospital birth among Guarani-Mbyá women,[27] many narratives appeared about births in the *teko'a* that had occurred without intervention from the multidisciplinary indigenous health teams (EMSIs),[28] even when these births took place at the same time as these teams happened to be on location. Interviewed nurses and public health managers reported that the advice given to Mbyá collectives is to mobilize the appropriate EMSI or the SAMU emergency healthcare service only if they wish the birth to take place in hospital or, obviously, if they observe that labour is developing atypically.

One of these narratives was told to me a short time ago and concerned a birth that occurred in the *teko'a Nhuundy* (Guaíba river basin) last year. A young Mbyá woman gave birth to her baby in the silence of her own home, helped by her mother, early in the morning at the same time as the EMSI was providing care at the local health post. The health professionals learnt the following week that the child had been born. I have had an image of Mbyá resistance as the act of birthing, as not following the biomedical model, in my thoughts ever since. One more image of the many, many micro-resistances in everyday life, a Mbyá speciality to eschew the ravenous world of the *Juruá*. They avoid direct conflicts but do not relinquish their own *ñande rekó* ('way of being'). Another way of successfully avoiding misunderstandings when hospital birth has been indicated contrary to a Mbyá woman's wishes, while still following medical guidance, is to communicate with the EMSI or to mobilize SAMU only when the woman is on the verge of giving birth. This means that the birth will transpire in the *teko'a*, with the woman cared for by her kin, but the collective cannot be rebuked for failing to enter into contact with the EMSI or SAMU, as advised previously.

Most of the healthcare professionals who work in the EMSIs and those responsible for providing care to Guarani-Mbyá collectives in southern Brazil, especially in the Guaíba river basin, have good relations with the *teko'a* and are welcomed. Indeed, some of these EMSI teams are sympathetic and respectful of the decisions taken by the collective. They tend not to interfere in a birth if they are not summoned. According to the accounts of Mbyá women, they are 'partners' and allies. It would be rash to generalize, obviously, especially since some localities have a high turnover of healthcare professionals in the EMSIs. Teams that maintain continuity over time in providing care and developing good relations with the Mbyá tend to acquire and share mutual trust. The result is then considered satisfactory for both parties. It is worth emphasizing that a significant difference exists between being treated by an EMSI professional when the person is already familiarized with the Mbyá universe, and being treated by a professional who works in a hospital. The Mbyá tend to avoid going to hospital and more than a few times I witnessed nursing staff from the EMSIs accompany Mbyá people going for exams in hospital institutions. This is not a function officially performed by these professionals. If they do perform it, however, this is because they sympathize or feel affected – thinking with Pereira (2012) – about the possible difficulties experienced by Mbyá women and men if they are not accompanied by a *Juruá* man or woman whom they trust. Mbyá women, above all, do not usually speak Portuguese and this not only hinders their care provision, it provokes a certain reluctance on their part to follow-up on the medical indication for those exams only conducted in hospitals.

27 Between 2014 and 2018, I coordinated the research study "From cosmological tensions to the reversibility of meanings," financed by CNPq. Fieldwork was conducted in two public hospitals within the metropolitan region of Porto Alegre (RS) and the research interlocutors were health professionals from both SESAI and the two hospitals covered by the study. Data from this research and the respective analysis are presented in an article currently in press (Prates, 2020).

28 The *equipes multidisciplinares de saúde indígena* (EMSI) run by the Special Office of Indigenous Health (SESAI: *Secretaria Especial de Saúde Indígena*) provide care at primary health posts, located in indigenous territories, when these exist, and also through weekly visits by the so-called flying healthcare teams. Hence, not all indigenous communities possess a specific locale for healthcare provision by the EMSI, the so-called *pólo-base*, but all are served by these teams since the latter are accustomed to providing weekly care in each of the communities covered by them and form part of the same health district.

The ethnographic data from the master's dissertation of Rita Lewkowicz (2016) allows us to complement this point. In a rich ethnography undertaken in the Guarani-Mbyá *teko'a* of *Koenju*, situated in the state of Rio Grande do Sul, on the border with Argentina, descriptions of childbirth care and consultations in the local health post are recorded in detail. Setting out from a Foucauldian perspective, the central argument of Lewkowicz's work (2016) is the emergence of a category of 'indigenous population' as a governable collective. What specifically interests us here, though, is the understanding of a 'right time' to be born, which appears in remarks made by Ara, one of the anthropologist's interlocutors, in the final chapter of her dissertation.

Explaining the low survival rate of chicks born in the winter, Ará told Lewkowicz that there exists a 'right time' to be born and that birth before this time leads to future health problems. Sensitively and backed by her ethnographic research, the anthropologist connects the understanding of a 'right time' with the birth of a child in *Koenju* through caesarean surgery. This event seemed to move the entire community, Lewkowicz writes. "She went without feeling any pain and returned with a baby," a Mbyá interlocutor tells her (Lewkowicz, 2016: 111). The child's birth had occurred unannounced, without any bodily expression that might allow a birthing to be anticipated. Without, as Mbyá women say, *imemby achy* (child pain).[29]

How can a woman return with a baby in her arms if she was sent to hospital without any sign that she was about to give birth? While for the health professionals who received her in hospital, caesarean surgery was necessary because the birth was already 'overdue,' for the Mbyá the concern was that the child had been born 'before the right time.' And being born too soon, as tends to happen with chicks, means failing to meet the minimum requirements for the avoidance of suffering ill health in the near future.

3.2 Birthing in hospital: care networks and 'differentiated healthcare'

Taking into consideration the dense entanglement between solemnity and wisdom that characterizes birth as a happening among Mbyá women, why do some of them go to hospital to give birth? In the first lines of this article, I asserted that the younger the Mbyá woman and the closer to an urban centre she lives, the more chance there is that she will birth in hospital. The current hospitalcentrism of birthing and dying applies to the Mbyá too, so long as access to medicalization of these events does not encounter obstacles such as distance and a lack of transportation. Hence, if Mbyá women do not feel supported by a network of care in their *teko'a* and if the local EMSI recommends a hospital birth, even without a justified medical indication, they are likely to give birth in a hospital. Women who give birth for the first time in hospital will not necessarily do the same again the second time, however. "It's bad there because you're on your own" Pará told me when I asked her about the birth of her first daughter, which had been in a hospital. Depending on the relation established between the community and the EMSI, though, births can occur without any *Juruá* intervention in the *teko'a* itself, as we have seen.

Revisiting the notes made in my field diaries years ago, I remembered the Mbyá men, when it came to the topic of childbirth, were emphatic that Mbyá women should give birth in the *teko'a* as a means to maintain the 'culture.' My female interlocutors, though always demonstrating a preference for birthing among kin, were less vehement about the need to give birth in the *teko'a* to maintain what their male peers called 'culture.' One of the points stressed most was that the pregnant woman should birth wherever she did not feel 'fear.'

"She said that she was afraid," "the doctor said that she had high blood pressure," "they took her and she has already come back with a baby" litter my field diaries as reasons given why some pregnant Mbyá women give birth in hospital. The reason, I emphasize, from the perspective of Mbyá women.

29 Gestations that end 'before their time,' as Mbyá women say, have been studied from the biomedical viewpoint and appear to corroborate the Mbyá understanding that the anticipation childbirth through caesarean surgery has implications for the child's health (Diniz et al., 2016).

This 'fear' particularly attracted my attention: fear of what? Two factors seem to intersect here. First, the kind of birth imagined and depicted in soap operas and movies as a painful event, covered in blood and outcomes, typically showing a woman being saved from the dangerous act of giving birth by a kindly and heroic doctor, does indeed seem to startle the women and provoke such a fear. Young Mbyá women are not immune to this understanding of birth as a dangerous event, present in the technocratic cosmologies dominant in contemporary Brazil. Moreover, if a pregnant Mbyá woman says that she wants to go to hospital to give birth, she is unlikely to be dissuaded from doing so by her kin network. Another issue is that women experienced in the art of caring for other women birthing do not feel confident about advising and insisting that a woman stays to give birth in the *teko'a*. There is an implicit and tacit fear that if something occurs during the birth, the 'midwife' responsible will be penalized by the law of the *Juruá*. And finally there is the motive that seems strongest – namely, that of respecting the 'wish' of the pregnant woman.[30]

Based on her ethnographic research, Lewkowicz (2016: 119-120) claims that giving birth in the hospital or in the *teko'a* arises from multiple traversals, among them "the relations interwoven with healthcare professionals, with kin, with divinities, with exams, with pain, with the baby's movement, with the winds" and I would add here dreams as part of the traversals that the anthropologist denominates a 'village birth effect.' Agreeing with Lewkowicz, it seems to me, in sum, that a confluence between the presence of women experienced in caring for other women in childbirth (*mitã jaryi*) in the *teko'a* where the pregnant Mbyá woman finds herself, on one hand, and a less invasive stance from the local EMSI, on the other, is a factor that ends up strongly influencing the place where she gives birth.

I was unable to access the quantitative data on births in Mbyá territories, nor on births in the hospital environment, which is why I cannot provide the percentage and proportion of each of them in relation to the total Mbyá population.[31] However, the ethnographically collected data does indicate that less than half of the Mbyá women gave birth in hospitals in the state of Rio Grande do Sul (RS). This means that most Mbyá children continue to be born in the silence of their *teko'a*, in the 'depths of night' and among their kin. One of the nurses who works in the EMSI for the Guaíba river region told me that during twenty years of work in the team, she could recall just one birth undertaken through caesarean surgery. In her assessment, just one in three pregnant Mbyá women gives birth in hospital. This same proportion has been verified by other healthcare professionals who work in the EMSIs and also by Mbyá interlocutors. Observations derived from long-term fieldwork, recorded in field diaries, tend to confirm that most Mbyá births continue to occur in the *teko'a*.

Since the beginning of the 1990s, indigenous collectives living in Brazil have had the right to healthcare that takes into account their modes of existence. The First National Conference for the Protection of Indigenous Health, held in 1986, more than three decades ago, therefore, is considered a landmark in the configuration of a new field of reflections and public policies on the issue. Following the new Brazilian constitution, promulgated in 1988, and the new democratic atmosphere, the National Policy for Promoting the Health of Indigenous Peoples (PNASPI) was designed and implemented as a subsystem of the National Health System (*Sistema Único de Saúde*: SUS) in the following years. This process gave birth to the National Health Foundation (FUNASA) and the current Special Office of Indigenous Health (SESAI), both of which, along with the continuous national conferences on indigenous health, resulted from the sedimentation of rights achieved with the active participation of social movements. While the EMSIs work directly in indigenous territories, resulting in a closer relation based on trust, hospital care, as stated previously, is set apart from this logic.

30 I use 'wish' here as a counterpoint to 'choice,' which relates to an entire neoliberal moral economy inapplicable to the Mbyá understanding of agency or movement towards one path or another.

31 Although this data can, in theory, be accessed by any interested person (Federal Law n. 12.527/2011, also known as the Freedom of Information Law), I did not receive any reply from SESAI over four years of requests. The details of these attempts are contained in a forthcoming article (Prates, 2020). The Porto Alegre Municipal Health Office did, however, make available the partial data under its responsibility.

What happens in the health posts, called *polo-bases* and situated in indigenous communities, the mobile healthcare of the EMSIs, the indigenous health itineraries in dialogue or divergence with the biomedical system, the implementation of public policies, among other themes relating to the 'indigenous health' category, has been studied closely by anthropologists over the last decades.[32] Ethnographies and qualitative studies have enriched a field of discussion that extends beyond anthropology to include public health, epidemiology and nursing, among other fields of knowledge. However, there are still few studies focused on what happens and how in the interaction between indigenous people and hospitals, and on the care that they receive there. Though the right to 'differentiated healthcare' remains valid outside indigenous territorial spaces, there appears to exist an erasure of identity markers. This means that indigenous people still use the National health System (SUS) but are no longer supported by the health subsystem that protects them by respecting their ethnic singularity (Indigenous Healthcare Subsystem – SasiSUS). Once they are hospitalized, the diacritic traits that ensure they receive 'differentiated healthcare' fade away. My purpose in this article is not to discuss and deepen an exploration of this issue: I simply wish to emphasize the absence of similarity between the care provided by the EMSI and the care provided to indigenous people in hospital, even though both locations share the same public health policy – which makes studies within and about this latter care context even more pertinent.

The work of Pereira (2012) comprises an exception in the field I previously denominated 'indigenous health,' since it explores the processes involved in translating conceptions and relational transformations from the perspective of the health professionals who work with indigenous collectives. Seeking to examine the consequences and possibilities for understanding situated in the interstitial space of a biomedical practice that requires interventions and responses and an indigenous alterity in which body, health and disease are conceptions anchored in cosmologies not limited to a physiological corporality, the author explores the idea that the processes of translation inherent to the relation between the different do not occur solely at the conceptual level. Inspired by Deleuze, the author refers to the dimensions of affect and percept as compositions of the translational process in which the irreducibility of difference may sometimes be revealed in an agent capable of transforming relations – and the possibilities of understanding. The analysis by Pereira (2012) inspired me to think about the data collected in ethnographic research conducted in two public hospitals located in the south of Brazil, dedicated to hospital births involving Mbyá women, which I have discussed in another article (Prates, 2020). The relation between health professionals and indigenous people ends up generating a microsphere of transformative (mis)understandings of this relation.

Final remarks

In writing this article, I have sought to give meaning to Yva's narratives on parturition and birth, supported by long-term ethnographic research among Mbyá collectives and by recent research conducted in two public hospitals on the occurrence of hospital births among Mbyá women. The data from the latter research has not been analysed here, but it has indirectly contributed to my reflections. Paying attention to the happening of birth allows us to interconnect an indigenous world open to transformation and the divergences inherent to every relation – in this case, with the '*Juruá* system.' It also allows us to enter a world teeming with the visible and the invisible. I have sought to describe what happens among indigenous Guarani-Mbyá collectives, based on a description sensitive to emic notions and meanings relating to birth and care in order to provoke reflections to be completed by the reader concerning widely used categories like 'life' and 'health,' in dialogue with public

32 Examples include the works of Conklin (2004); Langdon (2004, 2014); Gil (2007); Langdon & Garnelo (2017); Diehl, Langdon & Dias-Scopel (2012); Ferreira (2013); Garnelo (2014); Pontes, Garnelo & Rego (2015).]

policies aimed towards a 'differentiated healthcare.' This I have attempted to do without exalting frontiers like traditional versus modern, or any other opposition that ends up conferring a quality of exoticism to indigenous sociocosmologies. Likewise, although not one of my focal points per se, I have aimed to show how biomedical knowhow is far from a monolithic block closed off to the relational implications of working in an indigenous context. There are porosities, affects, dissonances and social dramas involved in every situation, both from the viewpoint of the Guarani-Mbyá and the EMSIs.

The verb 'to birth'[33] has been widely employed for a specific reason. It seems to me to reflect more precisely the idea of an acting body, a bodily act protagonized by the woman without the use of euphemisms like *dar à luz* (Portuguese), *deliver* (English) or *accoucher* (French). *Ambo'a*, which can be understood as to bathe, birth and/or drop in Guarani-Mbyá, fully evokes this sense of bodily action undertaken by the woman. To birth is not something that happens alone. It is an action that requires a subject. And this subject is the woman.

In recent years, the works of Belaunde (2000, 2015), McCallum (2001), Els Lagrou (2007), and Lea (2020) have contributed to an ethnological discussion of sexuality and gender among Amerindian collectives. The first two anthropologists have written texts dedicated to childbirth and care. Also specifically discussing birth and care among Amerindian collectives, the doctoral thesis of Scopel (2014) and the master's dissertations of Lewkowicz (2016) and Regitano (2019) stand out as works dedicating special attention to the theme, not absorbing childbirth and care as tangential topics within broader ethnographic descriptions. Generally speaking, though, anthropological studies of these themes, whether or not embedded in discussions of gender, have been timid. Furthermore, hovering in the background are diverging theoretical lines on the potential yield of the categories of gender or care as a window for apprehending Amerindian relationalities.[34] Although I have not invoked gender as an analytic category here, it is present tangentially. I hope to have contributed some reflections to this growing field of studies – focused on birth, indigenous women and care – with the expectation of deepening them in future works.

As for Yva and her stories, whether they result from interlocution for ethnographic ends or from a *-kypy'y* (sisterhood) relation, they will continue with me while and whenever I write. The video that I shot of her about birth and midwives will perhaps be shared publicly one day, but for now I emphasize that Yva told me about her births and her care as a midwife as, in some ways, a gift to me: what she really wanted, in that cold dawn, was to tell me about the latest happenings involving death and *-djepotá* (the transformation into a non-human). Her eyes shone when, in the silence we shared next to the fire, she told me, wavering between hesitancy and ecstasy, about the apparition of these dead former kin. But that is for another time.

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33 Translator's Note: parir: parturiate (Latin *parere*, to bring forth). The Portuguese verb translated here as 'birth' is *parir*. This derives from the Latin *parere*, 'to bring forth', and provides the root for the relatively common English nouns 'parturition' and 'parturient.' However, unlike its Portuguese equivalent, the cognate English verb, 'parturiate,' is extremely rare, now classified as obsolete. As a solution, the translation uses ' to birth' as a transitive verb, which connects with the substantive 'birthing,' with its connotation of 'natural' childbirth with minimal medical intervention or hospitalization ('home birthing' and 'free birthing'). Unlike the Portuguese term, the verb 'to birth' also carries a residual (now mostly obsolete) sense of 'to be born', which, however, also subliminally connects with the idea of birth as a process primarily involving a double subject, mother and child.

34 The book *Gender in Amazonia and Melanesia* (Gregor & Tuzin, 2001) provides an overview of this theoretical debate.

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