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Pregnancy and childbirth during the pandemic

by Maria Paula Prates, Aline Regitano, Gicele Sucupira, Araci da Silva, Arthemiza Puruborá, Iamony Mehinako
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Research Note

The first research note published at PARI-c regarded childbirth and indigenous women as protagonists in combating COVID-19. The present note follows the considerations on some of the issues raised in the first note and presents new research data which will be used to develop the case study entitled "Childbirth and care during COVID-19", to be published on the second semester of 2021. We wrote this note in *co-llaboration* [*co-laborativamente,* in Portuguese, as for *working together*] from different contexts and modes of producing knowledge. Araci, a Mbya indigenous woman, has worked with Maria Paula, Aline has worked with Iamony Mehinako and Gicele with Arthemiza Puruborá.

Odete's childbirth and the children who remain

Gicele and Arthemiza

For slightly less than ten years, hospital births have become a possibility for indigenous women assisted by the Reference Centre for Indigenous Health in Guajará-Mirim, a city located in Northern Rondônia, because SESAI began to provide transportation to the city. Currently, the Reference Centre assists nearly six thousand indigenous people, nearly 52% are women from over 20 different ethnic groups who live in 53 villages, amongst which 32 can only be accessed through water, which hinders assistance in the case of medical emergencies. In the past years, due to the distance as well as the number of boats and fuel available, pregnant women have been taken to the city long before the 40th week of pregnancy. Some of them stay at Casa de Apoio à Saúde Indígena (CASAI) [Indigenous Health Care Facility – CASAI] for over two months, especially if they are diagnosed with anaemia, infections or other diseases.

Having to stay at CASAI, away from family, is a problem which has worsened during the pandemic, when the number of hospital companions has been more restricted than before. A new building for the local CASAI was inaugurated in April 2021. It substituted the previous one, an old rented hotel which was used for admissions. It was in one of the narrow rooms of the old CASAI headquarters that Odete Arikapú Jabuti and another pregnant woman were infected with COVID-19 in July 2020, when the nurse on duty placed a patient with COVID-19 symptoms in their same room.

When Odete, who had completed her 40th week of pregnancy, developed respiratory difficulties and decreased saturation, she was sent to Porto Velho for a surgical birth in order to save the child and improve her respiratory condition. In the city of Guajará-Mirim, hospitals did not admit Odete for treatment nor for childbirth. "Our town is not prepared to treat pregnant women with COVID-19", lamented the indigenous health professional.

Due to complications in her kidneys and lungs caused by COVID-19, Odete passed away at age 38 on August 25, 2020, three weeks after giving birth to her 9th son, at the Reference Hospital in Porto Velho. The baby, her first male, who had been long awaited by Odete, remained at the hospital for one more week in order to gain weight until his paternal

aunt took him back to Sotério village, located in Pacaás-Novas Indigenous Land, where Odete lived with her husband from the Oro Nao ethnicity and their eight children. Odete did not have the chance to return to her home-village, and her body was buried in a village from Linha 8, the closest one to the Indigenous Land.

In order to carry the body from Porto Velho to Guajará-Mirim, and ascertain the cause of her COVID-19 contamination, indigenous leaderships and relatives called for assistance to Conselho Distrital de Saúde Indígena (CONDISI) [District Council for Indigenous Health – CONDISI] and Ministério Público Federal (MPF) [Federal Prosecution Service], because they understand that Odete's death was caused by a "white person's mistake" and "did not accept" that a young woman as Odete, who was healthy when she left her village with the health professionals that took her to the city in order to undergo pre-natal exams, would not have survived.

Odete's death caused a great amount of pain, indignation and the fear of going to the city and not returning to the village. After the episode, when someone becomes ill, indigenous people treat them at the village, not allowing them to be taken to the city. According to an indigenous health professional, *narima,* woman/women in the Txapakura language spoken in the villages of the area, have opted for signing a term of refusal for hospital assistance so they give birth to their children in the villages, something which had not occurred before. Mothers have also advised their daughters not to become pregnant during pandemic times because "they are running high risks".

In the village where Odete lived, relatives recalled the death of another mother with grief: one who passed away from cancer right after giving birth. Her son, who was born prematurely at eight months, was nursed by his aunt, who treated him as her own son. A similar situation to the one of Odete's oldest daughter who has, at 16 years old, become a "sister-mother". COVID-19, as cancer, has been considered an illness brought by non-indigenous people in order to wipe out indigenous people. Deaths by COVID-19, uncertainty regarding the conduct of health professionals and the fact that the Brazilian president fosters distrust regarding the vaccine, leading to more uncertainty, have led indigenous communities within the area of Guajará-Mirim to refuse vaccines. In the end of April, vaccination had barely reached 50% of the population who was 18 or older within local villages. That was only possible after many talks and campaigns supported by indigenous leaders.

The many risks of being pregnant amongst Mehinako indigenous women

Aline e Iamony

Mehinako women have quit giving birth at their homes for almost two decades. Several events were responsible for turning hospital birth into common ground for women in Xingu, such as the proximity to the "white people's world" and due to this an appreciation for biomedicine, their speeches, procedures and structure. As a rule, nurses and physicians who work within the Mehinako indigenous area recommend hospital birth for biomedical reasons which involve "risk" management. Amongst such reasons is the possibility that a woman may have a complication during home birth and, thus, there would not be enough time to move her to a hospital for an emergency Caesarean section. Women over forty years old, regardless of being healthy and having given birth to several children throughout their lives, are automatically classified as "at risk" when pregnant. The same happens for first-time mothers, who are considered "too young". In short, pregnancy and childbirth have been considered a pathology by biomedical health teams, and it affects Mehinako women as well. In addition, it is relevant to highlight that the understandings of "risk", even when supported by statistical

and epidemiological data, are only estimates, and native understandings are usually disregarded.

Daily follow-ups provided by Indigenous Health Agents (AISs) who live in the villages and share reports regarding the community every morning, guide recommendations for displacing patients to the city, which includes pregnant women. “Indigenous health”, as used in Mehinako language, is responsible for the departure and the return of patients, a movement which may include a water, ground or air travel. During the pandemic, once it is known that hospitals are sources of contamination with the new coronavirus, the idea of “safety” towards imminent childbirth “risk” becomes paradoxical, to say the least. Determining that women living in indigenous villages should travel to the city, following the same risk management guidebook previous to the pandemic, is incompatible with social distancing measures and closed indigenous villages which have proven most effective in avoiding COVID-19.

Even though, in contrast with the indigenous women from Baixo Xingu [Lower Xingu], where a movement of reclaiming traditional knowledge and practices has flourished, including the ones regarding home birth, Mehinako women continue giving birth at hospitals despite the dangers of traveling to cities during this period.

In the cities around TIX [Xingu Indigenous Territory], such as Canarana (MT) and Gaúcha do Norte (MT), CASAI has been divided in two units as a preventive measure in order to avoid contamination, and one of these units is destined to people who have been infected by the new coronavirus. In hospitals, however, a structure which guarantees isolation of infected patients or infected and non-infected pregnant women does not seem to exist.

All childbirth events which have occurred between February 2020 and April 2021 have taken place at the hospital. Several reasons have been reported and they follow the discourse of pathologizing pregnancy and childbirth, which is very popular within the biomedical area in Brazil and envisions women’s bodies as defective or incompetent for childbirth. In one of the cases, a woman who was pregnant with her third son, with a history of caesarean sections explained due to having “hips that were too narrow”, was directed to the hospital for childbirth. In another case, a woman tried to give birth to her baby in her village, but labour would have ceased its rhythm of development, and because of that she had to be transferred to a hospital by plane in order to undergo a caesarean section. The fact that there is a timespan considered “normal” in scientific literature, and it is based on studies which set an average time for childbirth length, is one of the main tipping points between indigenous and biomedical knowledge.

In a third event, a pregnant woman who went to the city for treatment which was not related to COVID-19 was banned from returning to her village due to fear regarding a possible coronavirus contamination amongst health professionals. And, because of that, she spent the remainders of her pregnancy until childbirth in the city. Instead of testing her and supporting her return to her village, she was kept in the city, away from relatives and running a real risk of COVID-19 contamination. How are “risks” measured within a context of consolidated pathologization regarding the pregnancy-childbirth-puerperium cycle and COVID-19 infection? COVID-19, within Mehinako indigenous women, is an additional “risk” amidst many other potential illnesses, many times partaken amongst indigenous and non-indigenous health professionals, associated to pregnancy and childbirth.

Caring for women, empowering midwives amongst Mbya indigenous women

Maria Paula e Araci

Before the pandemic, giving birth at the hospital came forward as a clearly defined horizon for many Guarani Mbya women. Elements such as living close to urban centres, authoritative guidelines by Multidisciplinary Teams of Indigenous Health and not being able to rely on a woman who is experienced at the art of caring for other women during childbirth within their communities are some of the reasons which have led to hospital birth instead of birth amongst relatives.

What seems to take place during the pandemic, in turn, is an opposite movement: the increase of childbirth amongst relatives. And, in general terms, a greater unwillingness in "calling the ambulance" as to give birth at the hospital. COVID-19, amongst Mbya Guarani women, seems to cause concern but it is not the main reason for not giving birth at the hospital. We have followed the reasoning of research note 01, in which we understood the pandemic as a possibility, an almost-possibility, in avoiding hospital births amongst some indigenous collectives. This movement is enhanced when the woman who is pregnant can rely on a *mitã jaryi* ("midwife").

Over the past weeks, Araci has talked to a few women from her kinship network in person, and Maria Paula has exchanged audio messages with Araci and Yva. Besides the pandemic itself, other issues have emerged, such as "empowering traditional midwives", "the cut" (episiotomy) and hospital birth as "inhuman". Quotation marks refer to words said both by indigenous investigators and research interlocutors in Portuguese.

Recently, Kerexu gave birth at Tekoa Pará Roke and her mother, Yva, took care of her. This has been the third child Kerexu gave birth to, but the first one born amongst relatives. The first two were born at the hospital. As contractions intensified and the possibility of "having to call the ambulance" was envisioned, Yva asked Kerexu directly: "don't you trust me?" Yva was sure that the time and the rhythm of the labour process was following a course considered "normal", and that there was no need to rely on help which was external to the knowledge and techniques she disposed. Kerexu "trusted" her mother Yva, a longstanding and experienced midwife, and gave birth to her child under her care.

Yva and her new born grandson under her care, at Tekoa Pará

Yva has "empowered herself" as to care for pregnant women before, during and after birth. Such strength comes through prayers and chants at the *opy* (House of Prayer), the *petyngua* (tobacco smoking pipe) and the use of medicinal herbs. She has also been "empowered" by the women who trust her words and knowledge. Frequently, during our research conversations, we have heard from Mbya Guarani men and women that it is necessary to "empower midwives" (*nhamombaraete mitã jaryi kuery*). This effort is not exclusively related to a position of political dispute towards *juruá* (non-indigenous) knowledge. It is a two-way empowerment, regarding knowledge, techniques, but also regarding the making of bodies which are intertwined with affection and relationships with deities. These connections culminate in healthy children during childbirth, as well as fathers and mothers who are also empowered as to invest on their children's healthy growth. Empowering and being empowered reverberates on the health and well-being of the whole collective of relatives.

Soon after Kerexu gave birth, we asked ourselves which micro-occurrences and relations would have changed the configuration of a history of hospital births to a birth amongst relatives. The presence of Yva during the first signs of labour and a Multidisciplinary Team of Indigenous Health that was less invasive and directive during prenatal care amongst Guarani Mbya women seem to have contributed to the outcome. Currently, two Guarani Mbya women from the same community where Yva and Kerexu live are pregnant, Pará and Ará, and they do not to wish to go to the hospital. Both wish to give birth under the care of Yva, amongst relatives. We will follow them throughout the coming weeks, talking to both and to Yva.

In one of the conversations between Maria Paula and Araci, the first birth of Yva Mirim, Yva's other daughter, was the theme of the conversation. Yva Mirim says she would have

liked to give birth to her first daughter under her mother's care, but due to a recommendation given by Yva herself, she had to opt for a hospital birth. As Yva noticed that Yva Mirim was "weak", with low energy as to have the baby amongst relatives, Yva evaluated that *juruá* knowledge and techniques would have to be employed as to complement what had been invested on her as care. Yva Mirim's first baby was then born at the hospital. It all went well, but there seems to be a consensus amongst Guarani Mbya women regarding hospital birth as being "inhuman". Yva herself says she did not want to go into the hospital delivery room for closer assistance to Yva Mirim. She preferred to stay in the waiting room. She avoided witnessing interventions and technologies of care performed by *juruá* practitioners and nurses. Even though the mother was aware they needed to rely on knowledge and techniques which were foreign to the knowledge she had in order to safeguard her daughter's health, it was painful to see what was happening.

Even though the birth of Yva Mirim's first daughter took place years ago, when COVID-19 was still unknown, the memories and scars left on the body due to a hospital birth are reignited when the subject is pregnancy and care. Yva Mirim recalls the "cut" (episiotomy) she was subjected to and how much pain, suffering and difficulty to return to daily activities it brought her. According to Yva, the manner childbirth takes place in hospital delivery rooms is "inhuman". Both Kerexu and Yva Mirim agree with Yva's statement.

Final remarks

The three research contexts presented throughout this note differ greatly from one another. They concern indigenous collectives with different languages, histories and modes of relation with non-indigenous people, and which have responded do COVID-19 from plural understandings and locations. As we could see, relationship policies and the orchestration of care vary, but the manner biomedical assistance takes place in prenatal care and childbirth definitely implies on how it is possible to give birth and bring to life, either in a COVID-19 scenario or not. What we have noticed is that whilst *caring means intervening* in biomedical terms, for many indigenous midwives *caring means carefully observing.*

Translated by Karen Villanova
For Iamony, one of the authors of this note, who passed away on May 25, 2021 due to complications from COVID-19

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