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Into an interference zone: childbirth and care among Mehinako people

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Introduction

In this article, I analyse a recent transformation that has been taking place among the Mehinako people of the Upper Xingu: the displacement of birthing from village to hospital, as seen from the perspective of Mehinako women. There is great pressure from the medical teams working in the villages on women to give birth in hospital, but other motivations, such as women's fear, also contribute to producing the current configuration. Going to the hospital involves women leaving their home/village and staying in an institution similar to a hostel provided by the health service called *Casa de Saúde Indígena*—CASAI (Indigenous Health House) to await labour. These medical institutions constitute what I name *interference zones*, where a composition of worlds may be produced out of ontological differences. I draw on ethnographic material gathered during five months of fieldwork conducted in the Utawana and Uaypiuku villages and in the cities of Canarana (MT) and Gaúcha do Norte (MT) between 2017 and 2018, along with some more recent fieldwork in Utawana village in August and November 2022 and May 2023.¹

Mehinako is an Aruak language currently spoken by around 200 people divided into four communities (Utawana, Uyapiuku, Aturua, and Kaupüna) on the banks of the Curisevo, Mirasol, and Tuatuari rivers in the Indigenous Land of Xingu (TIX). This region, known as “the Upper Xingu”, is a pluriethnic and multilingual community situated in the southern part of the Indigenous Land between the Brazilian *cerrado* and the Amazon forest in the state of Mato Grosso, and is home to fourteen different Amazonian peoples. The Mehinako people live alongside and share many different experiences with the other nine existing groups, while making interethnic alliances and circulating people and goods—a complex of relationships that has been described in the anthropological literature on the region for a long time (cf. Gregor, 1977).

Mehinako ontogenesis² demands a person's preparedness to care for others in specific and diverse ways. As is well known in the Amazonian context, the making of a person is an investment that is made through the body, which is not (taken as) a given, but is the object of continuous production (Seeger et al., 1979). The same applies to Mehinako people, who value dedicating their time to producing their and their children's bodies according to Upper Xingu aesthetics. By preference, they work hard in the fields, men and women together carefully maintaining their cassava swiddens to produce the cassava flour that will be used to make *beiju* porridge, which constitutes their diet's main source of carbohydrates. Men and women, but especially men, must also engage in fishing and, on some occasions, hunting, which provides people's main source of protein: fish, turtle, stingray, monkey, and some species of birds. Bodies and their shapes are moulded by this joint work of men and women.

Mehinako women control the outcome of sexual activity with the use of native contraceptive methods. A single woman may maintain multiple sexual partners, whom she visits or is visited by, usually in the dark of the night. While according to Gregor (1977), Mehinako people see pregnancy as the result of multiple and continued sexual relations, I didn't find my interlocutors' reports to add up to a consensus that would sustain a Mehinako theory of

1. In this text, I bring in elements from my master's dissertation (“*Cuida direitinho*”: *cuidado e corporalidade entre o povo mehinako*), and I also draw reflections from my PhD research in progress at the University of Sao Paulo entitled *Tsukuyalu Iaiacapiri (papo de grávida): corporalidade e relações de gênero a partir do parto Mehinako*.

2. Speaking in the terms Toren (2012) formulates with respect to ontogenesis as a social process, we humans need the care of others to grow and nurture our autonomy throughout life, and in doing so, we accommodate meanings from the meanings that we access. Producing a dynamic transformation of the past, each person embodies their own history, living and manifesting it in all aspects of their being.

conception. However, by and large, it is said that one single sexual relation is enough. There are even spells that may provoke a woman's pregnancy with no sexual intercourse involved. The restrictions during pregnancy and the postpartum period among the Mehinako correspond to what is acknowledged in the anthropological literature as *couvade* (see Colpron, 2006; Menget, 1979; Métraux, 1949; Rival, 1998; Rivière, 1974; Viveiros de Castro, 1977). As I see it, for the Mehinako, it is necessary to maintain distance from any powerful owner/spirit, and anything that may "transfer" its bad quality to the child or the action of childbirth must be avoided. On the other hand, there are practices and substances that are prescribed to aid pregnancy and labour.

Amazonian pregnancy, childbirth, and childcare are processes well described from the perspective of body fabrication, and are subject to local knowledge, norms, and practices of women in the Upper Xingu region. Childbirth is understood in different ethnographic contexts as a collective event (though often with restrictions placed on participation in it), which may involve mostly female relatives, as well as the assistance of specialists such as midwives and shamans (Scopel, 2014; Cayón, 2010; Franchetto, 1996; Prates, 2021). Even if the birthing woman is alone, her strength may be collectively nurtured earlier through the teachings of her mother and other relatives (Belaunde, 2000). Among Mehinako women, this is no different: gestating, giving birth, and nurturing are all collective events that are lived preferably among close female relatives. However, as I will make clear in this text, this changes when women no longer give birth at home.

Indigenous people in Brazil are, at least in theory, supported by the *Subsistema de Atenção à Saúde Indígena* (SASI-SUS) (Indigenous Peoples' Healthcare Subsystem) created in 1999 and granted *full and differentiated health access*. As Pontes et al. (2015) report, this differentiated attention is the fundamental guideline of the *Política Nacional de Atenção à Saúde dos Povos – Pnasp* (National Policy for Peoples' Healthcare), which, while still lacking a clear definition, revolves around the idea of integrating diverse medical rationalities. However, as the authors argue, since the time the SASI-SUS subsystem was implemented, there has been no evidence that different forms of healthcare have in fact been articulated. Rather, the evidence points to a biomedical hegemony expressed not only as formal discourse, but also structurally, built into practice. However, our analysis is complexified by the fact that health professionals and patients may always find gaps to produce a particular way of handling health. This is the analytical path I will follow in this text.

As Xinguan people, Mehinako people also rely on healthcare inside their Indigenous Territory. The three main therapeutic itineraries of Mehinako people are to the Municipal Hospitals of Gaucha do Norte, Canarana, and Água Boa in Mato Grosso state. These three towns are located at the centre of the country and surrounded by soybean plantations. When a hospital visit is required, the SASI-SUS will provide transportation to and from the village, and if an overnight stay is requested, villagers can stay at the Indigenous Health House. As mentioned previously, visits to these medical institutions may be read as interference zone scenarios. I posit this notion as an allusion to radio waves, in which frequencies do not cancel each other out, but rather compete—with one sometimes being more clearly heard than the other—cross over, and make noise. It finds parallel with the concept of a *zona de contato* proposed by Pratt (1992) and developed by Follér (2004): as a setting of colonial (frontier) encounters between Indigenous people and health professionals, in which biomedical and Indigenous knowledges interact. These zones are marked by a radical asymmetry in the relations between colonised and colonisers, where the latter are dominant.

However, instead of putting the emphasis on the idea of contact and the long-term consequences of the colonial endeavour for Indigenous people's lives, in this article I adjust my lens to focus on the flexible and mutable interferences produced, in order to open our view to the

historical emergences of childbirth events, and to encompass Indigenous people's creativity and their responses to microhistorical contingency. In the city, Indigenous women's bodies are indeed susceptible to a series of interventions with which they may or may not agree. The women are not, however, alienated from their own hospital childbirth experiences, as they also produce interferences and resonate their own voices. What we find in most cases is similar to what Prates (2021) finds among Guarani-Mbya people: that the woman is not rendered passive but is an active protagonist of the process of giving birth, not only in the village but also at the hospital, where there are interlacements of the Indigenous and non-Indigenous worlds.

In the practical unfolding of a childbirth event, one may find harmonies among the cacophony of frequencies, despite all the mismatches and conflictual happenings. Moreover, selfcare³ (Menéndez, 2018) may be at the centre of this process. I am looking at two aspects: a pre-existing set of rules, procedures, and behaviours, where power relations are established mostly through the hierarchical principles that operate in medical institutions; and the emergence of the childbirth event in practice, as a historically situated, unique, and unfolding process. With this in mind, the question I am asking is: how do the interference zones affect Indigenous women's birth experiences?

Childbirth and affection

Because in the city, it's very different from us... It's different because here, in the village, when giving birth, everyone, the mother, the midwife, takes good care of us. They hold our legs... Then the mother holds us here [under the breasts] ... But in the city, it is very different. ... The doctor leaves us alone in the room, then we get scared.⁴ (Y. Mehinako, Utawana village, 2019)

When Mehinako childbirth used to happen in the village, it was in the hammock, at home, in the dark, with ideally at least two female relatives taking care of the parturient woman—one of them being her mother, who would take the lead in caring for the parturient and the newborn baby. The hammock was positioned vertically, so the woman stayed almost standing up. Usually, one person would be holding her legs (to keep them open), touching her knees, and another supporting her back from behind the hammock (pressing her belly right under her breasts in the expulsion phase of the birth). If the woman holding the parturient's legs was able to pray a childbirth prayer, she would do so while blowing air rhythmically towards the vagina. Childbirth may last hours or even days, and as a fifty-year-old midwife told me, midwifery requires dedication and full-time care, where one has to abdicate sleep and food to be present, literally holding up the birthing woman.

After the baby is born, there is still the feared birth of the placenta⁵ to come, and after that, careful blood management. The bloody hammock must be buried with the placenta in the backyard, and the formerly pregnant woman offered the right dose of *epenhêin* or another emetic made from specific roots, given as a tea to make the blood flow out. Women are supposed to fast for up to one week after the birth, not eating or drinking anything and thereby provoking a "cleansing" of the body, and be in seclusion⁶ with the baby and her or his father for around six months. Mehinako women are indeed connoisseurs of prayers, of birth techniques, and of forest medicines. If the pregnant woman does not happen to have a local midwife,⁷ a roots specialist, or a shaman as a close relative, she can request the assistance of a more distant one (when this happens, it is usually the women's leadership who will mediate the interaction between the birthing woman and the specialist).

Thus, there is a role for local knowledge in the form of childbirth techniques and technologies that have been supporting homebirth for centuries, and which are still extant and available in the village, including knowledge not only related to childbirth, but also to pregnancy and the postpartum condition. There are certain foods and specific activities that are

3. I define selfcare in line with Menéndez's definition of *auto atención* as referring to knowledge, representations, and social practices that a person or a micro-group autonomously use to diagnose, support, heal, or prevent events that may affect their health, without medical intervention.

4. This and other excerpts of interviews presented in this text were translated into English from Brazilian Portuguese.

5. The expulsion of the placenta is considered one of the most critical moments of Mehinako childbirth, as it is particularly dangerous. Its birth may well finalise the process of giving birth to a child. For various reasons, including the use of spells, the placenta can become stuck and cause the woman in labour to die. One recurring argument advocating for hospital births in the birth stories collected is that it is necessary because it offers a range of technologies not available at the village that can save a woman's life in case of her placenta getting stuck. Paradoxically, in the hospital, women do not have easy access to Mehinako techniques and technologies, such as those performed by shamans and prayers who can treat certain conditions that doctors cannot (e.g. those provoked by spirits).

6. According to Mehinako people, the first child's seclusion is followed with particular rigour. From the second child onwards, seclusion is more flexible, due to the circumstance of already having the first child to nurture and care for.

7. Even though in the past, every woman should have been able to help her relatives to give birth by holding their back or their legs, among Mehinako people, there have always been *tawanakutxupalu* (or *parteira*, in Brazilian Portuguese), who are women recognised as specialists

to be avoided so as not to transmit any negative qualities to the child or provoke the rage of a spirit (e.g. hunting, or eating a turtle with a missing digit). This guidance is usually taught by parents to their children. Roots and herbs found in the forest⁸ and prepared at home are offered as tea to the pregnant woman to drink in order to prepare her body for childbirth, as this will cause the moistening of the vaginal canal for the baby to slip through. After birth, these local medicines are important for controlling the blood flow to avoid any retention, which is considered dangerous and even deadly.

Although the mentioned ideal configuration of assistance during birth is not always present (for example, because there are women who live far away from their mothers), it is rare for the parturient to give birth alone. As in the words of my interlocutor (here named Y.) quoted at the beginning of this section, birth in the village is characterised by the care offered by female relatives and specialists, in contrast to birth in hospital, where women give birth alone. Tófoli (2020) refers to a comparable opposition between relatedness when giving birth in the village and loneliness when giving birth in hospitals among Tapeba and Tremembe people.⁹ This association of loneliness with hospital birth has been described in diverse contexts, an experience that many—Indigenous and non-Indigenous—women share, which is informative about how hospital births are conducted in Brazil.¹⁰ Y. has had ten children, eight of whom were born by vaginal birth in the village, where she received care from her relatives, with no complications and no need for outside intervention. We will see in the next section that something more than fear moved her towards the hospital to give birth to her two younger children, and how each of these cases transpired.

First, however, let us walk through the care and kinship arena, which will be valuable for a better comprehension of how kinship and alterity are entangled through the event of childbirth, and what changes emerged with the displacement of birth to the hospital. Overing (1999) finds that trust is the hallmark of the generative cultures of the Amazon. People live because of what they do (Overing, 1999: 86), and what they do is to hunt, plant, cook, and generate and raise children in a “community of similars.” It is in the sphere of intimacy that a person, but also social life, is created daily through care and affection among its members. Gow (1991) verifies that among the peoples of the Bajo Urubamba there are two kinship languages: the first is based on physical connection and substance sharing (the importance of which is emphasised during postpartum restrictions and breastfeeding); and the second is the language of care and reciprocity in the use of kinship terms (with a focus on the care offered to the child and the way in which the child appropriates kinship terms). Among the Mehinako, caring forms the focal language of relationships between relatives and defines the category of legitimate family. I propose that care shapes bodies, relationships, and materialities. Especially concerning childbirth, this care, when displaced to another context, is withdrawn from the previously intricate core part of kinship, as it is no longer practised among relatives as it used to happen in the village, but in the company of strangers (nurses and doctors), or even with no company at all (when women experience birth alone).

In my master’s dissertation (Regitano, 2019), I explored a variety of materials from lullabies to birth prayers and children’s drawings to evince what care means in Mehinako terms. I do not follow the approach taken in a study of these same people by Gregor (1977), whose kinship¹¹ model coincides with the biological one and presupposes a continuum of possible relationships between relatives and nonrelatives. The problem with this model is that Western conceptions of life rely on biological knowledge as universal data. This equation would not be able to properly accommodate relationships that produce bodies, but which are not the result of reproduction, as, for example, those between mothers/fathers and their adopted children.

Guerreiro’s proposal (2015: 161) of analysing affiliation as a vector of identification among Kalapalo people is relevant to this study, as it offers two important elements of this

on assisting others during childbirth.

8. In the circular Mehinako villages, the house’s back door leads to the backyard, where some fruit trees and other plants are grown. From each family’s backyard, crossing the *pequizar* (*pequi* orchard), it is possible to follow paths that lead to the food gardens and the fields (whose vegetation is *cerrado*, the Brazilian savanna), as well as to the Amazonian forest.

9. Tófoli (2020) verifies for the Tapeba and Tremembe context that the implementation of differentiated healthcare in the villages paradoxically brought with it the disruption of local birth systems.

10. As an example, McCallum and Reis (2006) describe the struggles of (mostly black and working-class) adolescent women giving birth at a public maternity hospital in Salvador, Bahia, to overcome pain and loneliness in order to re-signify their birth experiences.

11. According to Gregor (1977), as soon as someone is born, (s)he will begin a relationship with those by whom she or he was made (*utamapai*).

relationship, conception and creation, the latter being a path of “similarity” between parents and children: to create someone is to make them alike, regardless of conception. What we see in the case of the adopted children is that the care taken when creating them generates a process of consanguinisation and, therefore, an insertion on equal terms into the networks of relationships of those who adopted them. At the moment they are received into a house with their own hammock, they are positioned in a network of kinship, considered as someone’s son or daughter, and, by extension, as someone’s grandchild/cousin/sister or brother-in-law.

In a broader sense, taking proper care has everything to do with affection between relatives, as expressed through daily actions such as nurturing, talking, teaching, painting, and bathing. It is the result of a collective construction that implies focusing purposefully on the fabrication of the bodies of those cared for and acquires multiple interfaces throughout life. And that is because kinship as a whole belongs to the order of things that need to be produced and created, against a background of otherness that can always “capture people” (see Viveiros de Castro, 2002). Xingu is not as peaceful as it may look at first sight, since witchcraft is a constant threat and may be practised by people close to one, as Vanzolini (2015) shows. And witchcraft also plays a role in childbirth, as it is an event during which women and their babies are most vulnerable and exposed (to all sorts of hazards), which makes them susceptible to attacks by sorcerers. Furthermore, caring between siblings, and especially between women, holds major importance for Mehinako sociality and a person’s production. Mehinako women usually want to be cared for by their mothers or other close female relatives while giving birth because of their experience, but also because this support is given by mothers to daughters over many generations: it is how they know, or at least how they used to know, the experience of childbirth. There is still no space in hospitals for this aspect of care, as will be shown below.

Loneliness at the hospital: the challenges of feeling fear

When that [amniotic] fluid was born, I felt a lot of pain. The doctor put me on the bed, opened my legs. They put my legs on the legs’ support... Then I got scared, because I was alone. Nobody took care of me, right? When the doctor placed my legs, she told me to hold it here [the head of the bed], and she left. “Will I be able to give birth?” I thought. Alone... Then it came out [the baby]... I felt a lot of pain. Fear. But I had the courage, right? Then I thought: “Oh, okay, everyone left, right?” I was left alone. When I felt a lot of pain, I breathed heavily, then he was born. I was all alone... I was holding on very tightly [to the bed], then she [the nurse] told me: “When you’re in a lot of pain, then we’re going to put you here, on the small bed [stretcher]...” I got up, because she told me: “You can’t get up?” “Okay, okay.” I wanted to get up. I went to the bathroom, I tried again... There was a lot of pain. I saw the liquid, it came out a lot, you know... I held it for a long time, then when she [the nurse] arrived, she said to me “Are you in a lot of pain?” “Yes, it didn’t cease.” “Ah, okay, I’ll come later,” she said to me and went away again. That’s when I held it well, I understood, how do you say it...? I saw his head being born, his little head, then I held it [the bed], and he was born, he was born alone. (Y. Mehinako, Utawana village, 2019)

Before reflecting on the second excerpt of Y.’s birth story, it is necessary to highlight the attributes of public health access for Mehinako people in the villages and the towns to reflect on the hospitalisation of childbirth. Utawana village is about forty kilometres away from Gaúcha do Norte, where there is a primary care hospital, a transfer that can take from forty minutes to two hours in the dry season. Uyaipiuku village, on the other hand, is three hours distant from Gaúcha do Norte, its closest town. From Gaúcha do Norte to Canarana, the journey adds up to around 155 kilometres. From Gaúcha do Norte to the reference hospital, the Municipal Hospital of Água Boa, it is roughly ninety-one kilometres, but the time it takes to get there varies according to the climate and the condition of the road. The municipal hospitals of these three cities are the destinations of the most frequent itineraries made by Mehinako women (although in exceptional cases, they also give birth in hospitals in Cuiabá/MT, Brasília/DF, and Goiânia/GO), a decision made by the nurses and doctors who work at the village that depends on the hospitals’ availability and also on the patients’ condition. The

usual recommendation of the medical team is to refer pregnant women towards the hospitals due to the “precariousness of the internal context” (i.e. the medical structure and resources in the Xingu Indigenous Territory), with problems ranging from the most complex to the least complex, such as: the lack of a night flight system; the absence of a referral centre for secondary and tertiary care; low staff numbers and lack of basic materials such as serums, reaction strips, oxygen cylinders, etc.

When Mehinako people are in town for treatment, patients have transport guaranteed by the health team to leave from and return to the village, but the conditions of the Indigenous Health Houses are precarious. In the town of Gaúcha do Norte, by the time of my fieldwork in 2018, the Indigenous Health House, Casai,¹² had moved to a new address and had recently been renovated, but depending on the flow of people, its structure was still insufficient to serve all patients arriving from the communities. In addition, there were rooms that were not in good condition, with issues such as poor ventilation. When they move from the Indigenous Health Houses to the hospitals, women giving birth face another set of difficulties. The two municipal hospitals of Canarana and Gaúcha do Norte have the municipal hospital of Água Boa as their first reference but try to meet the demands they face locally. The Canarana hospital is relatively well-equipped and has regularly available staff, with three doctors taking shifts, one of whom is the obstetrician on duty. The Municipal Hospital of Gaúcha do Norte does not have a paediatric area, a neonatal intensive care unit, nor even a heated cradle, a situation that is in line with the hospital’s classification as a “primary care centre”, but in practice is inconsistent with its non-primary daily demands.

The displacement of childbirth to the hospitals¹³ has transformed many aspects of the process, but the convention of vaginal childbirth remains, roughly speaking, a constant. A nurse once told me in an informal conversation that Indigenous women “save” the vaginal birth census. It is worth noting that in Brazil, overall and repeated caesarean section rates were 55.1% and 85.3%, respectively (Dias et al., 2022). Among the reports of Mehinako people from Utawana village, the cases of caesarean section are exceptional, usually involving women considered by the medical team to have risky pregnancies. But even though the majority of births are vaginal, these are events full of interventions in their “natural” development, such as the routine offering of serum and intravenous labour-inducing hormones such as oxytocin.

Mehinako women no longer give birth at home in the village, and the factors that led to the hospitalisation of Mehinako childbirth are many. As noted above, fear is one key factor. Mehinako cosmologies present the event of childbirth as one surrounded by dangers, because it involves both menstrual blood, which is dangerous in itself, and extremely vulnerable bodies, that is, those of the birthing woman and her baby. As the scholars of Amazonian haematology show, menstrual blood has the potential to cause nonhuman responses and alter the cosmological order of the events (see Belaunde, 2015). Among Mehinako people, it is especially dangerous for secluded boys, ill people, and fighters of Huka-Huka, the traditional Upper Xingu martial art, who are especially vulnerable—not least to attack by sorcerers. So giving birth in hospital may be a good way to get away from any “sorcerers”, or bad, undesirable relatives.

Even though women think of themselves as “made” for this event,¹⁴ they cannot help but fear it, and their fear is underpinned by the placental agentivity¹⁵ and past birthing outcomes. Pain may provoke fear in those who experience childbirth for the first time, but it is the fear of dying that remains despite the passage of time. Women say it is truly a life-and-death battle, and some of them still carry memories of and grief for those who have died while giving birth (not necessarily in the village). It is not, however, a battle fought alone. Women have always been there, supporting each other in overcoming fear and pain and eventually succeeding. Mehinako midwives learn from older midwives and from their experiences to help other women navigate the dangers of childbirth.

12. Coordinated by the Secretaria Especial de Saúde Indígena - SESAI (Special Secretariat for Indigenous Health), Casai offers shelter for Indigenous people in medical treatment in the city. Macedo et al. (2017), looking at Casai São Paulo, verify that it is a space constituted by differences on multiple relational scales where patients and professionals are engaged in cosmopolitics.

13. The last register of a homebirth at Utawana village is from 2015.

14. Through the activities women engage in and their ways of doing things (e.g. the corporeal posture adopted during daily tasks such as the production of cassava flour), their bodies are made as bodies able to give birth.

15. In my master’s dissertation, I discuss a Mehinako *apapayey* (spirit) called Malahialo, who is considered to be the newborn’s invisible grandmother. Not all of my interlocutors knew Malahialo, and there was no consensus on her attachment to the placenta. Gregor (1985) talks about the *atsikumã*, the grandmother spirit who lives in the pregnant woman’s uterus, and who is responsible for making the child and for deciding his or her sex. Guerreiro finds a spirit who inhabits the placenta from conception until childbirth, and who is a “*idealizadora da fecundação*” (“idealiser of fertilisation”) (Guerreiro, 2015: 163), among the Kalapalo. I found that among Mehinako people, despite this supposed direct relation between the placenta and the Malahialo, the placenta in itself was considered dangerous and moreover involved menstrual blood, which is also a dangerous substance. It therefore had to be managed with attention and care in order to not cause harm to the baby.

There is also the kind of fear that seems to be motivated by biomedical discourses, such as the arguments that the village is not a safe or adequate place for a woman to give birth, that it is dangerous because it lacks options for interventions when needed, and that it does not have acceptable hygiene conditions. This provokes women to trust the hospitals' technologies and apparatus to offer safe and good care in order to alleviate their own fears. But ironically, even though hospital childbirth offers to Indigenous women expectations of security, it also leads to a brand-new range of fears they did not experience before. These include the fear of being cut (i.e. subjected to an episiotomy or a caesarean section),¹⁶ the fear of being alone during birth, or the fear of becoming "pot-bellied"¹⁷ because of blood retention.

In addition, the move from village to hospital is full of ambiguous desires and aspirations. The hospital may be chosen out of curiosity, as happened with Y.: she chose to benefit from the medical care that was afforded her as a legal right. She "wanted to see how it was", as she told me. From the beginning, her husband, the only available companion to take her to the town, was prohibited from entering the delivery room. Luckily, she could speak the basics of Brazilian Portuguese and understood nurses saying things such as, "Call me when it's time" (referring to the final phase of labour). The nurse subsequently went away, leaving her entirely unassisted, even on being told: "It is about time." In the end, Y. experienced bringing a son into the world all by herself—completely alone for the first time—finding the strength that allowed her to engage in self-care in her own corporeal experiences of previously successful births (births she saw and supported, and her own birth experiences) and in her mother's teachings. This course of events was repeated with her most recent child, also born in hospital, where she was all alone again.

Peter Gow (2000) offers an idea that can be fruitful for a better comprehension of this loneliness Mehinako women talk about in what he describes among Piro people as being "helpless", the state of suffering of someone who lacks kinspeople. The author verifies that Piro people's daily routines revolve around acting on behalf of those who experience a "helpless" condition, such as newborn babies (who are extremely dependent on their caretakers for surviving) and mourning people (who depend on others to overcome the loss of a relation), those who are feeling alone and in urgent need of being related to somebody. The author (Gow, 2000: 47) states that "the interplay between the states of 'being helpless' and 'being compassionate towards others' are the affective preconditions of Piro humanity and its intrinsic sociability." As helplessness and compassion are affective preconditions of sociability among Piro people, so, too, looking after each other and showing compassion to people in need are at the basis of Mehinako relations. Again, we are talking about people who do almost everything accompanied: eating, working, bathing, and even defecating. Life is lived mostly collectively, and that's why giving birth alone is so particularly hard for these women. The loneliness resulting from the lack of relatedness experienced by them during hospital childbirth could easily be transformed if their companions' presence was allowed and made possible. Ultimately, all that a Mehinako woman usually expects for her childbirth is to be related, to be well cared for, if possible by a female relative.

Thus, there are things about hospital childbirth that Mehinako women do appreciate, but there are many other things that they emphatically do not. They may find themselves reacting against how care is handled and by whom, while the promised "differentiated care" remains a mere token. The differences from the village context that the women experience include the layout of the space where they give birth, with its white and overly bright lighting. Moreover, gender relations are mixed up in the hospital context, which presupposes the presence of men (as doctors, nurses, and companions) at an event that used to be exclusively female. Thus, they face new confrontations with themselves—new kinds of fear and shame to deal with and to overcome—and with others, with whom they will need to communicate and negotiate. As we saw, a mother's care is key for a Mehinako woman in labour, and yet, this is a form

16. Each of these procedures carries its own risks, which means that, even by Western standards, this fear is not irrational.

17. One of Mehinako people's biggest concerns related to childbirth and the postpartum period is precisely to do with blood retention. After accumulating over nine months, this blood must flow if the health and safety of the woman in postpartum condition are to be guaranteed. While in hospital, women are frequently kept from fasting and drinking emetics, which are their own techniques to manage the blood associated with birth. Instead, they receive an injection (oxytocin) that, according to my interlocutors, stops the bleeding. The birth blood that doesn't flow out of the woman will make her belly swell up, and she will enter a condition of being pot-bellied, which, ultimately, may lead to her death.

of assistance neglected, if not prevented, in the hospital context. Although the presence of the parturient's companion is guaranteed by law, conflicts generated by the medical team's prohibition were mentioned in my interlocutors' childbirth narratives.

In their stories, we see a trend towards mechanised and segmented ways of dealing with birthing bodies. In this way, the technocratic model of childbirth, as formulated by Robbie Davis-Floyd (1993), and before her by Emily Martin (1987), is relevant here because it offers us two important elements to reflect on. First, the technocratic model, which operates with the metaphor of the body as a machine and brings childbirth to the hospital as a way of dispensing with the "rituals of homebirth", in fact produces a re-ritualisation of childbirth. With the male body as the prototype of the machine and the female body as the defective machine that can be segmented and reassembled, childbirth is understood as a mechanical process. Second, the technocratic model of childbirth reflects broader notions—above all those that sustain the patriarchy, the Cartesian division of mind and body, and the logic of capitalist production of goods and commodities—that offer women the means to integrate into this wider culture. It replaced an earlier paradigm that used to put women and birth into the confinement of the home. The author's two arguments are valid for the Mehinako hospital birth case. The reproduction of obstetric rituals is eminent in a mechanised appraisal of the body. And for many of my interlocutors, an interest in feeling a sense of belonging to a broader "culture" beyond the domestic context (including an interest in the cities, the white people's world and its institutions) was a factor in their opting for hospital births.

Jordan's (1997) concept of authoritative knowledge is also relevant for this analysis because it shows how, in disputes between different systems of medical knowledge, the one that tends to carry more weight than others due to its presumed "superior basis" is the biomedical one. While its claim to superiority may be based on its being scientific, commonly it is ideologically rooted and aligned with power structures. As a result, it becomes a core of knowledge that suppresses and delegitimises other information and practices in such a way that people become willing to submit themselves to the medical authority and engage with its propositions, even in cases where its practices or knowledge are not in line with scientific evidence. Speaking of Indigenous women in Brazil, a country that has a history of discrimination and negligence of Indigenous peoples, it is not surprising to notice this vertical power relation becoming apparent in the quarrels between Xinguan people and the health teams. But we are far away from suggesting a unitary definition of "biomedicine", which, as Mol (2003) showed in masterful fashion, is complex and multifaceted.

Interfering in one another: negotiations and perspectives

I didn't want to go to the city, I was afraid. But I ended up going. The nurse soon referred me to Casai [Indigenous Health House]. I said to her: "I don't want to, it will be born right here." ... She wrote the document, sending me straight to the city. I still didn't want to. Then I said, "Okay." I called my mother, told her, and she kept quiet. Then I went to the city, waited at Casai. It took almost one month. ... At 4am, the pain started. By 9am, I couldn't take it anymore, and I told the nurse. Then they sent me... First, they sent me to the hospital in Canarana. Then they sent me to Água Boa... She [my daughter] was born around 1am, at night... I got there, and the nurse took care of me. When the pain was coming, they took me to another room. There were three nurses there. They didn't like my mother coming in. Then my mother said: "No, I'm going in with her!" She spoke very harshly. Then one of the nurses said: "Let her in." Then my mother was taking care of me in the hospital. My mother squeezed me, and the nurse didn't like it: "Oh, you can't squeeze," and my mother said, "I'm going to squeeze her myself. That's how we are. That's how it is in the village." ... my mother was holding me. The nurse was just pushing her hands out of me. I didn't like it... Then he was being born, right, and then they [the nurse] touched the baby. To us, it can't be done, otherwise it's dangerous. You can only touch it when it is completely born. The nurse... put her hand on the baby's head... My mother was just screaming, saying she couldn't do this. That's not how it works in the village, in the village they take care properly. (M. Aweti, Utawana village, 2019)

M. is from the Aweti people, and she lives with her Mehinako husband. A mother of two, she had her first child at her mother's house. It was a difficult birth, with a successful outcome despite the complications in its progress. Nevertheless, she wanted to have her second child at home. She says that as soon as she shared with the village nurse the fact that her first childbirth had been difficult, she was formally forwarded for a hospital birth. There tends to be strong pressure from Indigenous health professionals for women to give birth in the city. Through participant observation and informal conversations, I found that the motivations of professionals for referring women for a hospital birth vary. Many reproduce the biomedical arguments that the current configuration of the villages does not offer minimum safe conditions for homebirth. Others assume that they will be held responsible if any complications occur with the parturient and her baby. Negotiations around childbirth, therefore, begin long before the event of the birth with the first prenatal consultations, where the medical itinerary is defined and the date of birth is anticipated.

After waiting for about one month at the Indigenous Health House, M. endured long hours of labour in pain and silence until finally notifying the nurses that it was happening. This is a recurring strategy in the reports of my interlocutors as a way to circumvent the temporality imposed by medical dynamics and to spend less time in hospital. Concepts of normality and time in hospitals are such that the time "allowed" to people to give birth is restricted, with the development of labour frequently being measured objectively, with eyes on the monitoring devices, as McCourt (2014) has pointed out.¹⁸ It is a dualistic arrangement that separates the physiological aspects of a woman from her subjective aspects (ibid.). M.'s mother left the village and went to meet her at the hospital, but was initially prevented from accompanying her daughter to the delivery room. She had to stand up and "*falar duro*"¹⁹ until one of the three nurses present asked the others to let her in. In the expulsive phase of labour, M.'s mother squeezed her belly, as is customary in the village, which the nurses disapproved of. A further conflict occurred between the patient's family and the professionals when one of the nurses touched the baby's head while it was being born, a practice the Mehinako see as dangerous because it can cause the baby to get stuck.

These mismatches happen because notions of care and corporeality that are foreign to biomedical paradigms are usually not welcomed in hospital. Even when healthcare is marked by a discourse of "interculturality", health professionals use these encounters to send messages about health to the communities in an attempt to keep biomedical control over health and illness processes (see Ferreira, 2010). The idea of interculturality may lead to a production of caricatures of Indigenous people and Indigenous health that will ultimately generate internal contradictions and produce new problems for Indigenous communities (ibid.).

Before continuing to explore the ways in which Mehinako women and healthcare workers in hospital affect each other, a brief aside about how the notion of care is used in the official materials produced and published by the Brazilian Ministry of Health. This literature seeks a dialogue with health professionals. Launched in 2004, the *Manual de atenção à saúde da criança indígena brasileira* (*Handbook of healthcare for Brazilian Indigenous children*), for example, offers general guidelines for health professionals who work with the Indigenous population, disseminating a humanisation approach.²⁰ Professionals who provide home care to Indigenous people are advised that, whenever possible, the patient should be assisted in the presence of relatives and village specialists. The manual states that there is no incompatibility between Indigenous and Western medicine, but my interlocutors contradicted this. The theory of humanised care as it is promoted in policy is merely layered on top of existing concepts—such as the separation between mind and body, ideas about faulty bodies, and a very mechanical rather than ecological and complex model of birth physiology—so that the underlying thinking is not shifted at all. As a result, the policy is not implemented effectively in practice. Also, despite the goodwill of those who are thinking about it with seriousness,

18. In the context McCourt (2014) is looking at (maternities in England), female knowledge is not given any validity, and with the increasing domination of technologies, it becomes less expressive. The author's analysis nevertheless presents us with a dose of optimism, as it shows that voices of resistance (such as those of midwives), which, throughout history, have sought to challenge the prevailing order, have promoted effective changes in government policies.

19. "*Falar duro*", which we may translate as "to speak tuff", means speaking sharply and forcefully.

20. In the year 2000, the Ministry of Health of Brazil established "O Programa de Humanização no Pré-natal e Nascimento" (The Prenatal and Birth Humanisation Programme) through Ordinance MS/GM nº 569/2000, whose primary objective is "to ensure improved access, coverage, and quality of prenatal care, childbirth, and postpartum care for pregnant women and newborns, from the perspective of citizenship rights" (Ministério da Saúde, 2002: 5; my translation from Portuguese).

there is an “original sin” here: although they recognise the “cultural” plurality, there is still the assumption that it is possible to work with one singular notion of care—the one promoted in the health guides—that is held by one singular society inhabiting one world in which we all, different as we are, live. That is definitely not the case, as the Indigenous peoples are patiently trying to show us.²¹

Trying to add humanisation onto a system that is modelled on a different conception of what humanity is produces conflicts. A brief example illustrates how conflicting these divergences can be: Kamü, the sun, is a special character of Upper Xingu mythology; he’s envious, powerful, and not entirely reliable—and for all those reasons, he is deeply respected. He may be dangerous, so the most vulnerable people, like women in postpartum seclusion and newborn babies, are strongly advised to avoid him. That’s the main reason why a Mehinako newborn must stay secluded within a dark house, by her or his mother’s side, for at least six months in order to grow up and get stronger until he or she is able to be exposed to the outside. Biomedical notions, on the other hand, consider the newborn’s exposure to sunlight not only beneficial, but also necessary for her or his health. Exposure to the sun is even one of the elements to consider when calculating the degree of risk a child is at, with children who are in some way deprived of the sun being considered more at risk due to possible vitamin D deficiency (see Yamamoto ed., 2004). Nowadays, it is usual to see women in postpartum condition outside their houses, taking their babies to be vaccinated in the village’s health post during vaccination campaigns, but covering themselves and their children with towels or cloths as a way of minimising damage.

Health promotion and risk management measures for care in the baby’s first thirty days of life are detailed in the already mentioned *Handbook of healthcare for Brazilian Indigenous children*. Among other practices, this book suggests that shortly after birth, the baby’s temperature must be stabilised; the umbilical cord must be secured with a clamp or umbilical tape sanitised with 70% alcohol; the eyes should receive drops of silver nitrate at 1%; the baby should receive 1mg of vitamin K1 oxide administered intramuscularly; weight, height, head circumference, thoracic, abdominal, and detailed physical condition should be evaluated. The nurse checks the newborn’s entire body for possible abnormalities, evaluates his or her skin, scalp, eyes, mouth, neck, abdomen, genitalia, anus and rectum, extremities, Moro reflexes, as well as the respiratory and heart rate. Traditionally, among the Mehinako, care for the newborn in the postpartum period is carried out by the maternal grandmother, possibly with the paternal grandmother’s help. The maternal grandmother cuts the umbilical cord as soon as it stops pulsating, she gives the first bath to remove the blood and other childbirth fluids, and analyses the baby as a whole, looking for any abnormalities such as spots or missing fingers. She checks eyes, head, mouth, abdomen, genitals, and extremities, massages the body vigorously, shaping the granddaughter/grandson with her hands to make the child strong and beautiful, and then takes her or him to the mother to be breastfed for the first time.

The *National Policy for Comprehensive Child Healthcare* has the objective of promoting and protecting infant health and breastfeeding (Ministério da Saúde et al., 2018) through planned integral and integrated care, which is strategically divided into distinct lines. In the list of *Healthcare for Indigenous Children*, the manual provides the *National Policy for Care for Indigenous Peoples*, whose project is to offer comprehensive healthcare, covering social, historical, and political diversities, and guaranteeing Indigenous peoples the right to their culture. Respect for cultural diversity, practices, and knowledge in pregnancy and childbirth includes efforts to bring to the hospital care environment the presence of “traditional” specialists such as midwives to assist with the care for parturient women, as well as to provide training on postpartum care and childcare (based on accepted biomedical notions) for people in the communities. What I find most interesting about this policy is its plan to foster the autonomy of care and the co-responsibility of the family. I question, however, whether this

autonomy in fact exists in practice, so that the primary care for the newborn is of the kind that involves kinship as carried out by the maternal grandmother, or whether mechanised procedures conducted by nurses are prioritised. In the daily practices of health professionals, will there be a space for patients and their families to take care of themselves, or will health professionals in fact—albeit perhaps unknowingly—claim for themselves a monopoly on legitimate care?

As long as the notion of care is not defined with consideration for the historical character of people (that is, taking each being's unique and historically determined difference, as well as their different perceptions of the world, as a starting point), we will have a problem: the elaboration of a universal notion of care, whose content has been refined over the years, but which lacks the capacity to take into account the plurality of distinct meanings attributed to care. As refined as this theoretical approach with its recognition of people's ethnic and "cultural" differences may be, it still aims to universalise one single notion of care that has its roots not in Indigenous understandings and practices, but in biomedical ones. This can be seen in the birth stories presented, where the events frequently include conflictual interactions and divergences on how care should be handled, as in the following example:

Now, they [medical staff] accept a companion. But not in the past. When my daughters get pregnant and go to town to have a baby, I go with them. At H.'s birth, I was with a small child, they didn't let us in. When my last daughter was giving birth, I was able to follow. I was the one who supported her during birth. When the child was born, I ran to the doctor. I called the doctor. I called the nurse. Nothing... Good thing the child was born soon. Now, the placenta took a long time to be born. Then the doctor came, and I said: "It's already born, what about my daughter? You didn't even take care of her." I didn't accept that, I didn't like it. In Canarana, the doctor treated her well, beautiful. Then I liked it. I don't want my daughter to die in front of me in the hospital, Aline. Because I took her to the doctor's hands to help her. I took her from the village, took her to the city, for the doctor to take care of her... Then I get very sad, you know. I always remember that. (C. Mehinako, Utawana village, 2019)

C. is a mother and a grandmother. Unlike M., after experiencing a difficult birth (her daughter's), she believed that hospital birth was the best choice from the start and did not require persuading. She trusted the doctors as specialists able to take good care of her daughter, but they did not fulfil her expectations when they were absent from her daughter's childbirth. C. was there to take care of her daughter herself, but she was not able, in an unfamiliar environment, to lead the event. Thus, while she desired the hospital birth for her daughter and her grandchild, she didn't feel acknowledged in the way it was carried out. Mehinako childbirth (which consists in constant physical contact with women literally holding each other) makes the solitary waiting required by the strategy of the medical caregivers appear as negligence, which is one of the most-noticed irreconcilable divergences between Mehinako practices and the technocratic view of birth. That said, as the hospital is not only made of walls and equipment but also of people, the different approaches adopted by each nurse, technician, or doctor mean that there are varying degrees of interventionism and receptivity of divergent practices in these interactions.

We can affirm that, in the ontological and epistemological disputes around hospital birth, biomedical assumptions and routines usually echo louder than Mehinako ones. However, it is also the case, as we can see from the stories told here, that women are willing to enter into these disputes, make themselves heard, and even produce noise, strongly resisting and fighting for their rights. On a local level, their strategies of resistance include arranging care networks among Mehinako women and their relatives, pulling little "tricks"²² to maintain their practices, and so establishing female "networks of tricks." For instance, while visiting a sister after giving birth at the hospital, a woman may eat her food so the nurse thinks the food was eaten by the postpartum woman when she is, in fact, fasting. Or a woman might take her sister an emetic herbal tea in a plastic bottle hidden in a bag, which she can drink while hiding in the hospital's toilet. In this way, women try to make the experience more Xingu-like, with its own sounds

22. "Trapaças", in Brazilian Portuguese, is a term mobilised by my interlocutors while proudly telling histories of how they found ways of circumventing hospital rules, and, in resisting in that way, re-signifying events to produce something new.

and colours, occupying all available spaces and affecting those who interact with them, such as their relatives and the healthcare professionals. They do so by being present and speaking their languages, by refusing to eat food after the childbirth, by drinking root and herb teas, by holding or being held by a relative on the hospital bed. Furthermore, women engage in local politics through formal and informal daily reunions concerning women's health, attend annual regional women's meetings in other Xinguan villages as well as events held outside the state of Mato Grosso, and participate in the national political debates.²³ On a broader scale, Indigenous women in Brazil also assume charge in organisations and become activists in national movements²⁴ and events.²⁵

Final considerations

Looking at Mehinako birth stories, it is possible to identify much of what women experience in hospitals as obstetric violence in the sense presented by Dána-Ain Davis (2019: 561): “a form of gender-based violence experienced by people giving birth who are subjected to acts of violence that result in their being subordinated because they are obstetric patients.” The idea of obstetric racism developed by the same author is also valid in this context dealing with non-white women. Davis argues that obstetric racism lies at the intersection of obstetric violence and medical racism, emerging from reproductive care and putting black women in danger. The author shows that premature birth rates are 49% higher among black women in America than among white women. In addition, black women frequently face discrimination and are neglected by the medical team while giving birth at the hospital, which is also the case for many of my interlocutors. Reflecting on obstetric violence and obstetric racism in relation to the Mehinako case is something to explore in depth in future work.

For now, we may assert that in this arena of ontological disputes, Mehinako women face the hospital's precariousness and its technocratic and interventionist practices from a disadvantaged position, given the verticality of the relations between patients and the medical team—they are not on their own territory, nor under their own rules. They are, however, engaged not only in the event of childbirth itself, but also in all the arrangements and negotiations surrounding pregnancy, childbirth, and the postpartum period in the village, at the hospitals, Indigenous Health Houses, and beyond. They are at once producers and products of the events they experience. As Kelly and Matos (2019) show us, when talking about Amerindian peoples, we should avoid analysis with binary terms such as activity/passivity because action is distributed rather than inherent in one person or another, and its effectiveness is always in dispute: it may or may not be measured. Regarding the Yanomami from the Upper Orinoco, Kelly and Matos argue that they are compelling people to act, constantly updating relations, and seeking to appropriate the effects of established relations (in the same way they do with nonhuman entities). The authors characterise the forms of action and organisation of Indigenous collectives in the lowlands of South America as a “politics of consideration”, in which people are visible to and regard one another in such a way that one is at the same time a moral agent, object of the consideration of others, and also a subject who considers others and may endure or provoke actions.

Moreover, it is worth considering care in Mol's (2008) terms as intervention, that is, an interactive, open-ended process that is invented and shaped in practice. The author suggests that articulating the logic of care is hard to achieve in current hospital contexts due to the resilience of long-established practices that were not set up to deal with unpredictable reactions to interventions. She presents a fascinating proposition of articulating the logics of care collaboratively, with patients and the medical team building together what good care means, instead of the logics of choice, where it is all about the patient's choices and improving them. As a way of improving healthcare—and, by extension, patients' daily lives—and also as a

23. For example, Sonia Guajajara and Joenia Wapichana, who are both federal governors.

24. ATIX – Xingu Indigenous Land Association is an example of one of these movements.

25. For example, the ATL – Free Land Camp gathers thousands of Indigenous people from all over Brazil right in the capital of the country, in front of the National Congress, every year.

working tool for producing differentiation (complexifying understandings of people and their diseases) and specification, this logic is promising and well fits contexts such as the interference zones mentioned here, where encounters between diverse worlds and perspectives take place. It is crucial to analyse different practices and how they interfere with each other based on the assumption that they are flexible and divergent, rather than operating with dichotomous categories such as traditional medicine vs modern medicine, or empirical medicine vs scientific medicine. As Kroeger and Barbira-Freedman (1992) argue, none of these practices are static, so what is referred to as traditional medicine may be modernised, and what is named modern medicine may include traditional practices. In the same way, practices followed in hospitals in some cases are not based on scientific evidence, but on the empirical knowledge of doctors and nurses (ibid.).

Furthermore, it is imperative to consider that these ontologies and epistemologies that are sometimes in dispute with one another are not fixed or generic understandings either, as they are constantly built and inscribed on a microhistorical context. As Cecilia McCallum (2014) verifies while looking at the Huni Kuin people and their entanglement with biomedicine, it is possible for Amazonian people to conceive new meanings out of encounters with outsiders without decoupling from their own ontological regimes. She discusses this in relation with Christina Toren's phenomenological theory of mind (Toren, 1999), in which meaning is always emergent and historical, and which sees the ontogenesis of knowledge of the body as a processual occurrence arising from the meeting of different ontogenetic approaches (rather than the dispute of two knowledge domains). Knowledge is "*progressively embodied through experience*" (McCallum, 2014: 513; my italics), in constant reorganisation while in exchange. Likewise, among Mehinako people, many of the outsiders' ideas and practices they encountered were received and mixed with their own, but this did not lead to a devaluation of local conceptions. As we can see, these people are creative and resilient.

Finally, we can assert that, as Mehinako childbirth and postpartum practices are displaced from the villages to the medical context of the towns, and as, consequently, women cease to follow some practices such as birth in the hammock, in the dark, with female relatives managing the development of childbirth, their relations to others also change. There are specific bodies of knowledge that are not as easily accessed in the hospital as they are in the village (e.g. midwifery and shamanic treatments). Gender and kinship arrangements have changed as relatives' participation is limited and no longer restricted to women. Mehinako women were affected by these interference zones in many ways, their bodies becoming objects of intervention, their babies under the care of others (strangers), their voices having to be vocalised in ways that they didn't have to be in the village. Experiencing city childbirth has changed them. Even if there were huge improvements in the medical care offered in the villages, so that health professionals would be able to advise and support homebirths, it is likely that women would still want to give birth in town. They have found new ways of performing childbirth that are rather different from their grandmothers', and which are also different from white women's experiences. Hospital birth has broadened the margins of their world, and they want to be part of it. They desire that "differentiated healthcare", which is Indigenous people's right in Brazil, be enacted in practice. Since these women have faced this situation for some time now (almost a decade), they have learned how to deal with it, how to position themselves towards it, to negotiate, to produce effects in Strathern's (2006) and Kelly's (2011) terms—that is, they are visible and they are agents who act with other people in mind as they engage in relations resulting from social interactions where cause and agent are separated. In short, they make the most of the care they actually receive, facing their daily challenges with much affection and strength, making each other's bodies and babies' bodies through care, and also preparing the terrain (their community, their houses, and their fields) to receive those who won't cease to arrive: the little Mehinako persons to be born.

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