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Mbyá Grandmothers, Mothers and Granddaughters.

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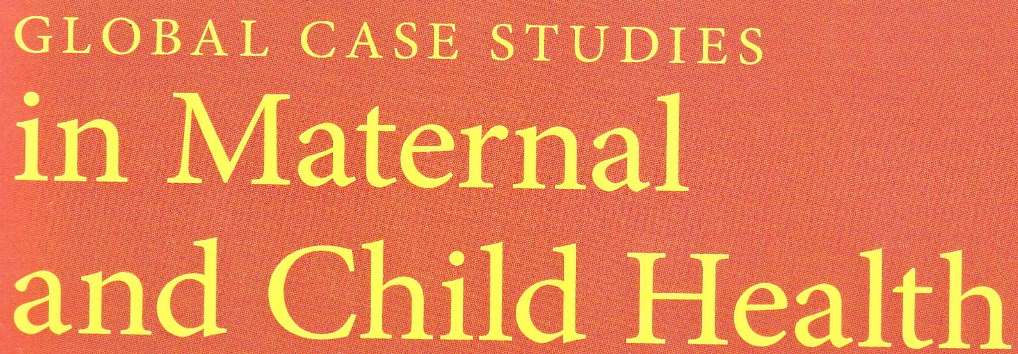

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GLOBAL CASE STUDIES

in Maternal and Child Health

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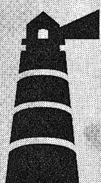

JONES & BARTLETT LEARNING

CHAPTER 13

Mbyá Grandmothers, Mothers, and Granddaughters

Motherhood and Upbringing throughout Generations

Carolina Remorini, PhD

Location: National University of La Plata (UNLP), Argentina, South America

Name of Project: Culture, environment, and health. Ethnographic and cross-cultural study about child rearing and healthcare practices in rural and aboriginal populations.

Sponsoring Organization: National Council for Scientific and Technical Research (CONICET)

Target Population: Children aged 3 years and younger and their caregivers in Mbyá Guaraní communities (Misiones Province, Argentina) and Molinos population (Salta Province, Argentina)

Project Goal: The ethnographic research explores representations and daily child rearing practices in two rural populations of two contrasting ecological contexts in Argentina—Mbyá Guaraní indigenous communities located in the northeast rainforest (Misiones Province) and creole communities from Molinos (Salta Province)—in the highlands and semiarid areas of the Argentinean northwest

Project Objectives:

1. Identify and characterize ecocultural factors that influence child development and health–illnesses processes in various populations in Argentinian territory
2. Make a comparative analysis of the impact of ecocultural factors on child development and health–illnesses processes
3. Develop and contrast hypotheses about the differential value of these factors with regard to their impact on the populations studied

INTRODUCTION

The information in this chapter is the result of research[1] carried out between 2001 and 2005 in Mbyá Guaraní communities in the province of Misiones, Argentina, that focused on the study of health–illness processes in the first stages of the life cycle (Remorini, 2008). Based on that, the aim of this chapter is to analyze both the discourse and practices of women of different ages about experiences such as pregnancy, delivery, the postpartum period, and child rearing. In order to do so, our study is based on the results of combined and complemented applications of different qualitative techniques, including daily observation (Lewis, 1985), genealogies, and semistructured interviews. The use of observation and discourse allowed information triangulation and enabled us to contrast the hypotheses that emerged throughout the research.

Working with women belonging to different generations allowed us to gain access to the way they speak about changes in their knowledge and practices related to pregnancy and delivery, as well as health–illness processes during these stages of their life cycle, within the context of transformations in the Mbyá way of life.

In this chapter, we consider three cases, based on the information obtained from interviewing three women of different ages and the observation of their everyday activities. By means of this selection we attempted to show the diversity of life courses inside the Mbyá society, where the different perspectives, customs, projects, and decision-making criteria can be seen. This allows us to transcend the homogeneous and static way of seeing Mbyá women that appeared in classical

literature about this ethnic group so we could perform analyses focused on these women's everyday life, taking into account their numerous present contexts. We will particularly focus on their health conditions, their opportunities to access health services, and their views of those services.

This chapter aims to contribute a different outlook on everyday life and expectations of these indigenous women about both their children's and their own health care within a context of deep ecological, economic, political, and cultural changes.

MBYÁ CHILDREN AND WOMEN: HEALTH CONDITIONS AND THEIR ACCESS TO SANITARY SERVICES AND PROGRAMS

At present, there are some communities, scattered throughout Argentina, Brazil, and Paraguay, that belong to the Mbyá people. The total population is about 19,200 individuals (Assis & Garlet, 2004). In our country, according to the Complementary Survey of Indigenous Peoples (ECPI) in 2005, there are about 3,975 people who recognize themselves as belonging to the Mbyá Guaraní people in Misiones Province. The Mbyá language is spoken within these communities, and most adults and schoolchildren also speak Spanish and, less frequently, Yopara (Paraguayan Guaraní) and Portuguese. The Mbyá communities where we developed our research settled on land that is considered a private reservation, Valle del Arroyo Kuña-Pirú, which belongs to UNLP, in Misiones Province between Cainguas and Libertador General San Martín departments. Provincial Route Number 7, which connects these settlements with neighboring localities and other Mbyá communities on the basin of Cuña Piru I and II streams, goes through the northern part of the reservation. According to a census we made in May 2003, both communities constitute a total of 280 people. These figures may have changed due to the constant movement of individuals and families among the different settlements as part of their life strategies. From a demographic point of view, it is a young population, with most individuals between 0 and 14 years of age (54%).

The present subsistence strategies combine traditional activities—horticulture, hunting, fishing, and gathering in the *monte* (forest)—with new ones that have emerged from their relationship with several sectors of national society. At present, craft selling and temporary paid jobs in *colonias* (rural settlements devoted to the production of yerba mate, tea, tobacco, and tung) contribute to

the subsistence of most households. Some individuals receive allowances, and others get a salary for being teaching assistants or sanitary agents. The money obtained from either activity allows them to obtain supplies (flour, sugar, pasta, rice, beans, cold cuts, soda, and candy, etc.), which has resulted in a lesser degree of commitment to traditional food-gathering activities and important dietary changes (Remorini, 2008). Consequently, according to our research, the most frequent illnesses in indigenous populations are respiratory, gastrointestinal, and nutritional (Navone, Gamboa, Oyhenart, & Orden, 2006; Remorini, 2008; Sy, 2008). The relationship among infection by geohelminths, malnutrition, and anemia has been shown in numerous research papers (Navone et al., 2006; Sy, 2008; Sy & Remorini, 2009).

In Ka'aguy Poty community there was a sanitary station until 2000. It had two permanent staff members: a nurse and a sanitary agent (aborigine). A doctor who provided primary health attention (PHA) paid a weekly visit. At present, a doctor from the Dirección de Asuntos Guaraníes visits the communities to deliver PHA, but not on a permanent basis. This is done with the help of the local sanitary agent. The doctor generally has medicine (antibiotics, antifever, antiparasite, pain killers) to solve the most common problems. The sanitary agent is a member of the community and is appointed by the Health Ministry of Misiones Province, within the framework of the Program for the National Support of Humanitarian Actions for Indigenous Populations (ANAHI). His job involves distributing medicine (under a doctor's supervision) and recording and distributing powdered milk granted by the provincial government to pregnant women and children younger than age 2 years, whose weight and health state are checked. Work in the Sanitary Unit was extended to nearby communities, such as Yvy Pytã and Ka'a-Kupe.

The Mbyá population in this area goes to urban centers to solve health problems that cannot be solved within the community by local specialists.[2] One of the most frequently attended health centers is Unidad Sanitaria Aristóbulo del Valle, which has doctors, odontologists, and biochemists on its staff. This unit is about 14 kilometers from both communities. Less frequently, the population also goes to the Hospital de Jardín América (30 kilometers), which has more advanced services. Other alternatives are the hospitals in Oberá and Posadas, which are situated farther away from the communities (58 and 147 kilometers, respectively). The latter, although it is farther away, has the advantage of being near the government organization (Dirección de Asuntos Guaraníes) that offers accommodation to members of aborigine communities (Sy & Remorini, 2008).

Sanitary programs in indigenous communities were recently established (within the past 10 years), and their development and results have been influenced by the discontinuities that are characteristic of public policies in Argentina. In spite of the state's interest to reach the indigenous population with programs (e.g., ANAHI of the National Health Ministry 2000–2005; the Community Team for Originary Peoples; Plan Nacer; and Techaî Mbyá—Indigenous Health—Province Health Ministry), there are serious barriers to accessing health assistance.

Experts on the subject agree that the main obstacle to improving the health situation in indigenous communities is the lack of specific information about epidemiology within the Guaraní population in the province. This makes it difficult for us to accurately analyze the distribution of health indicators among the Mbyá Guaraní. Even though a higher appeal to biomedical health services has been recorded, aborigines face a lot of difficulties related to their interaction with the staff. Among these barriers is the homogenization of the target population, the lack of culturally acceptable strategies, the poor training of sanitary staff to work with indigenous populations, the difficulties to mutual communication and understanding, the aboriginal expectations about medical diagnosis and treatment, and the distant locations of health services (Foro de Investigación en Salud de Argentina, 2008; Sy & Remorini, 2008).

BACKGROUND OF MOTHERS AND WIVES: MBYÁ WOMEN IN THE ETHNOGRAPHIC LITERATURE

The Guaraní are one of the ethnic groups in South America that have been most written about; descriptions of their beliefs and customs can be found in the early records of naturalists and missionaries in the 17th and 18th centuries. Beginning in the 20th century, anthropologists have also shown interest in Guaraní linguistic differences and lifestyles, due not only to their wide mobility and geographic dispersion, but also because of their contact with other societies throughout time (Clastres, 1993; Metraux, 1927, 1948a, 1948b; Müller, 1989; Schaden, 1991; Susnik, 1983). Moreover, some ethnographers have accounted for the common aspects, beliefs, and practices that make the Guaraní a cultural unit beyond regional variations (Schaden, 1991).

With regard to the Mbyá in particular, Cadogan's extensive work is the most obvious starting point to approach any subject related to the Mbyá from Paraguay. Cadogan examines in various papers, through their myths and accounts, the Mbyá's beliefs and practices related to health care in different stages of the life

cycle, mainly during gestation and childhood (1948, 1949, 1950, 1971, 1997). His main text (1997) contains some very significant passages about the human being's constitutional process and the events that may cause illnesses and death in different stages of the life cycle. Cadogan stresses the importance ascribed to pre- and postbirth care (mainly in terms of respecting taboos and performing traditional rituals) for the newborn's health and the individual and collective consequences of that care.

We also found in other papers some references to child rearing and health care associated to life cycle characterization, where beliefs about conception, the soul, birth, and puberty rituals are described and compared in Guaraní ethnic groups (Metraux, 1948b; Susnik, 1983). Many of these authors devote only a few paragraphs to childhood. The way they treat childhood is limited to describing games and puberty initiation ceremonies (Metraux, 1948b; Müller, 1989).

Not much is mentioned about motherhood. There is very little reference to the mother's health, which is sometimes limited to describing delivery and listing a few taboos during gestation and the postpartum period (Cadogan, 1950, 1997; Susnik, 1983). Occasionally these appear as only superstitions or magical beliefs without an in-depth study of their meaning and their relationship to other aspects of the culture. Conversely, a lot has been written about the Guaraní women and their traditional roles of wife and mother. Susnik states that since historical times, "a Guaraní woman's ideal has always been her role as hai, mother-breeder, the guarantee of community continuity (teyy)" (1983, p. 16). In every ethnographic paper, the importance the Mbyá ascribe to maternity is reinforced, as is a child's birth because it enables the society's continuity. The Mbyá's desire to have a lot of children is attributed to this, as is the social undervaluation of an infertile woman (Cadogan, 1950, 1997) and the fact that an individual achieves Karai or Kuña Karai status, as an adult, only after his or her first child is born (Cadogan, 1997). Therefore, parenthood is an event that marks an important transition in any individual's life cycle.

Likewise, the literature reinforces women's relationship with the domestic realm, which is linked to child care, food preparation, and looking after the fire. Therefore, according to Cadogan, "The Guaraní woman's duty within her culture may be defined as 'being next to the fire'" (1971, p. 113). It is in this sense that women are considered to be oriented to the inside (home, the community), and men are oriented to the outside, that is, they go into different spaces that are, supposedly, exclusively male (the monte, or rainforest), and they go out to other communities and cities to work or participate in political meetings.

This characterization of traditional roles and activities seems to hide other roles that women perform, but at the same time they offer a static and stereotyped image of themselves. In fact, the long-time, exclusive use of male informants (in part due to linguistic issues) and the predominance of spoken sources over observational records of everyday activities has led to Mbyá women becoming invisible. It is only in the past years that an interest has arisen to describe the women's actions in different contexts than the domestic one, as shown in the documentary and bibliographic revision work by Dos Santos Landa (1995). Ciccarone, in turn, published a thesis (2001) focused on the character of a Kuña Karai (shaman woman) in a Brazilian village and analyzed her performance in different spheres of the village everyday life and her leadership while moving to different places in search for better life conditions. This work turns out to be particularly interesting because there are scant references to women's performance within the domain of religion and therapeutics. In that respect, Martínez, Crivos, and the author of the present chapter have extensively dealt with the old roles of women, their everyday activities, and their contribution to the domestic group's subsistence, as well as child rearing and health care and welfare of all community members due to their therapeutic and religious knowledge (Martinez, Crivos, & Remoini, 2002; Remorini, 2005, 2006).

We have recently found a paper by Enriz and García Palacios (2008) that focuses on describing the process by which a girl becomes a woman, that is, Kuña, Karai and points out the changes that take place in roles and social relationships among women, and among women and men, from the moment of a woman's first menstruation.

In short, we do not have any systematic ethnographic studies on Mbyá women in Argentina, except for the ones quoted. The studies on child rearing and health care are also scarce, and it is difficult to find official data on Mbyá children and women's health in our country. The research developed by the author (as described in the Introduction) contributes by making these subjects visible, along with the problems affecting their development possibilities.

DIFFERENT STORIES, THE SAME CULTURE: INTRACULTURAL VARIABILITY AND GENERATIONAL CHANGES

As we said at the beginning, using three cases (Kerechu, Jachuka, and Para) will allow us to develop different aspects of women's everyday life, as well as their

knowledge, expectations, and practices related to their own and their children's health care. It is necessary to clarify that these cases were not chosen for being representative of statistics, but because they offer the possibility of exploring convergences and differences about the aspects we pointed out. Through them, we can account for generational perceptions of beliefs and practices in health care during pregnancy, delivery, and the postpartum period.

Kerechu: "I Am Guaymi, That's It, We Are from the Past"

Kerechu is the Mbyá name of AC (50). She was born in Garuhape Mini village (El Alcazar locality), and she lived in Leoni, Yvy Pytã and then in Ka'aguy Poty, where we interviewed her. She is married (*acompañada*) to Adolfo, 51, and they have two children: Francisco and Santa. Kerechu had her first child at the age of 18 years. Three of her daughters died very young.

> (How many children do you have?) three alive and . . . let's see . . . three dead ones . . . one died of, of measles, one of diarrhea . . . the other died of . . . I don't know what it was . . . (How old was she?) one died when she was one year old, the one with diarrhea, the one with measles died when she was 7 months old . . . the other also died when she was 7 months old . . . (Where did they die?) They died . . . the first one, in El Dorado . . . and the other one, the one with diarrhea, died near . . . Intercontinental, that is near Brazil (Did they die at the hospital or at home?) No, at home because I was never at the hospital, you see, I never had my children at the hospital, they were all born at home, all of them. My mum help me and some other woman, a midwife.

Francisco is married (acompañado) and has a 3-month-old daughter. Another daughter had previously died 15 days after birth from respiratory infection. Francisco and his wife live with his grandmother in 1º de Mayo, a faraway village. Santa, who is also married, has two children (a 2-year-old daughter and an 11-month-old son). She lives with her family in Concepción, close to the southern border with Corrientes Province. Both Santa's and Francisco's children were born in state hospitals. Their children's and their granddaughter's deaths were caused by the health problems we previously described, that is, infectious-contagious and gastrointestinal diseases that have a greater impact on children's morbidity and mortality.

Kerechu defines herself as *guaymi*, an elderly lady from the past—that is, she leads the same kind of life her ancestors led. Her speech focuses on traditional patterns and practices in relation to women's health care from their first menstruation,

during pregnancy and delivery, and caring for the newborn child. She emphasizes that she never gave birth at the hospital, and she usually assists other women in her community, as other woman assisted her in her own youth. This is how she explains the midwife's task during delivery and the mother's care afterwards:

> You have to rub the belly and movements for the baby to go down; she must be sitting . . . and the woman who helps her has to know where the baby's head is, and if you have found the head, then you must make it go down . . . then we give her a herb tea so that it doesn't hurt. She must go on taking the tea for three days, for the belly not to hurt.

The massage they perform to place the child in the right position for birth; the administration of "remedies" favoring delivery and relieving postdelivery pain; the provision of smoking tobacco (*sahumados*) to scare away evil spirits (*mbogua*) who may harm both the mother and the child; and the advice these women usually give to the laboring woman (rest, proper food, etc.) cause them to be highly valued specialists within the community.

According to the information obtained from two sets of fieldwork, in both communities 90% of babies were born in hospitals, and most of their mothers were born within the community environment, which accounts for a generational difference in terms of their use of healthcare services. Although most of them choose hospital delivery, some women still choose to have their babies within the community because they feel safer and calmer in the company of the midwife and other women in their family. That is, they prioritize emotional support over arguments about the higher risk they will be exposed to in the community (see the following discussions of Jachuka and Para).

Although most elderly women, like Kerechu, favor delivery in the community, some of them find it beneficial to have assistance at the hospital. No adult or elderly men expressed being in favor of that practice. Younger men (between ages 20 and 30 years), on the other hand, believe it is up to the woman to decide where she would like to get help. In general, those who choose the hospital have been trained as sanitary agents or nurses. Those who prefer delivery in the community give preference to two factors: (1) more emotional support and more attentive care to the woman when she is surrounded by her relatives, and (2) the ability to have women of different ages watch during the delivery, which favors intergenerational transmission of traditional practices.

Going back to Kerechu's account, she highly values the fact that she almost never went to the hospital. This is quite ordinary among elderly people. They

usually say, "I never got ill and I never went to hospital." That is, the absence of illness is associated with the fact that they never go to the hospital. This does not imply that they never got ill, but this argument is used to enhance a generational difference in relation to health conditions ("there was less illness in the past") and to young people's decisions ("now they all go to hospital"). In speaking about her own health, Kerechu says that she was ill a few times. Nevertheless, she remembers suffering from great depression when her first son died and had to be admitted to the hospital:

> When I was 18 I was admitted I don't know what about, and I had a relapse, you see, after that . . . never again, because when I had the first one who died, I got bad, I got sad, I went in hospital, I was admitted. . . . for a long time, yes . . . a month, I got saline solution, injections, pills, but I don't remember the name (And after that you never had any illness?) no, never, a few times . . . I had a headache or flu, or a fever, but not bad, I cured very soon, with *yuyo* (medicinal herbs) . . . well, there are illnesses, you see, but when you take care you don't get ill very often, if you believe in God you don't get ill and nothing happens to you. God looks after you.

From her perspective, though she has suffered from some illnesses, she does not believe them to have been serious. She was able to solve them within the community, using medicinal plants.

Finally, and in relation to little children's health care, Kerechu advocates the need to respect food prohibitions, consume food that is "light" (not heavy) or "ours" (of Mbyá culture), and avoid sexual intercourse for some time.

> *Mbaipy* or some *locro*[3] we prepare, with a mortar take all the kernel corns, take the kernels off the cob and we put them in the mortar . . . sometimes some kind of bean is put, and when some tatú meat can be found, that is put, too, because that is our own food, also some coatí or some deer from the forest. [Otherwise] you can catch some illness, some relapse or headache, dizziness, then you look after her, she doesn't get up for some days, you look after her, give her something to eat, but she mustn't get up.

Apart from food restrictions, the prohibition of sexual intercourse between spouses is indicated to avoid another pregnancy. Among the reasons for the prohibition are the woman's need to devote herself exclusively to feed and nourish the child. It would be difficult for her to look after more than one breastfeeding baby at a time. The baby's vulnerable condition during this time justifies the need to guarantee a long breastfeeding period as a way to avoid illnesses. It is worth mentioning than some of the elderly women's main criticisms about young

mothers is that they do not breastfeed their children for as long as "the ones from before" did, and they sometimes choose to give bottled milk, which, from their point of view, does not feed or protect the infants in the same way. Kerechu says that she breastfed her children until they were 1 year old and supplemented their diet with a milk bottle and bee honey. Changes in child rearing patterns and their consequences on health are considered, by the women in Kerechu's generation, the result of a break in intergenerational transmission of Mbyá knowledge and practices:

> The old ones are the ones who know the most, how the Mbyá live before, and now everybody, almost nobody knew nothing else, history, children know almost nothing, Mbyá history . . . before, the mother gave them advice, to the girls, how they had to live, when they had the menstruation, they talked to the mothers, the aunts "you are my daughter, you're going to be a woman, you are no child any more, go around like a lady, do your lady things . . . work as a lady does and then, when you find someone you are interest in . . . marry."

Jachuka: Keeping Tradition and Participating in Changes

Jachuka (29) has seven children and lives with them, her husband, and her mother-in-law in Ka'aguy Poty, where her parents live, as well as her uncles, aunts, grandmothers, and eight siblings. Jachuka's husband was trained in educational and sanitary institutions and was a sanitary agent for a few years. Her two grandmothers are prestigious old ladies because of their knowledge as traditional therapists and midwives. Jachuka's house is somewhat apart from her family's, but there is permanent traffic of mainly women and children. Her everyday activities basically consist of performing domestic chores—with her mother-in-law and children's help—and making crafts for sale.

In several ways, Jachuka's everyday life and accounts reflect the continuity of traditional patterns for rearing children and for mother and child health care. When it comes to little children's nourishment, for example, she tells us about the food that is allowed and forbidden at a certain age:

> I always breastfeed them until one year and five months, so, because if they have teeth it hurts already, well, to some I gave until two years (And if they have teeth they may start with something solid?) yes, when they were six months old they already had a little soup, rice, corn meal, beans too, but in soup, AnD already eats, now she likes eating everything, meat too, chicken, always chicken, boiled, beef is also eaten (and pork?) no, not pig because it is bad for children, they say, I don't

> know why, that's why we, Mbyá, don't give pig for one year and five months (Why is it bad for babies?) well, because it gives diarrhea, some babies have diarrhea because some are fed at 5, 6 months things they can't eat and they get ill, they catch parasites, the older people say (And before they are one year old, what do you give them?) only milk (And who gives you advice on these things?) my granmother, old ladies are the ones who always advise moms.

The pregnancy period (*mitã yrui*) and the 2 months after birth (*mitã*[4] *pyta*) are considered extremely vulnerable for both the mother and the baby, and there are a lot of restrictions in terms of diet, everyday activities, and the spaces they should stay in and go about, which also affect other members of the domestic group. It becomes obvious from Jachuka's accounts that breaking the rules may cause illnesses in the child that will require traditional specialists' intervention or consulting health services, depending on the kind of illness:

> (How should mitã yrui be looked after?) well, you don't have to do any heavy job . . . you may go to the stream but not bring soaked clothes . . . that is heavy, I always go with somebody else, you can clean, but slowly, go and fetch water, you can, cook too . . . some of them go, it depends on the person, I went to the stream and I almost fell and I was hit, the baby was somewhat bad, that's why I had to be admitted and stay at the hospital in Obera for two days . . . it hurt and I could barely walk . . . I had an ultrasound (at the hospital) everything to see if it was all right (And is there any other thing that is forbidden?) well, you shouldn't take any yuyo (herbs) medicine when you're pregnant, there are some that are very strong (And who advises on which remedies can be taken?) well, sometimes my mum, but sometimes my husband says, because my husband knows everything, too, because he attends courses on all that (And does he explain to you why they can't be taken?) yes, well, that it is for the baby to be born healthy and for me too.

It is interesting to note that when they are asked about what should or should not be done during that period, informants (between 20 and 30 years old) refer to a set of restrictions that have been respected since "the old people's times" (*el tiempo de los antiguos*) to avoid damaging the child's health or to avoid complications during delivery (the most frequent restrictions are to avoid contact with "twin" elements, do not link or tie things, and do not weave baskets, along with the ones already mentioned). Nevertheless, when we intend to go deeper into the consequences of these restrictions, only a few people can account for the connection between the rule and its effects on the child's health. Most of them, including Jachuka, have admitted they do not know the reasons behind such

prohibitions, resorting to explanations like "it's our custom," "according to the elders it is like this," or "it is our system."

In her speech, Jachuka overvalues the possibility of having access to the knowledge and resources of scientific medicine and, at the same time, she recognizes the pertinence and efficiency of traditional knowledge and practices, passed on by her grandparents and parents. Moreover, she takes into account the knowledge provided by her husband, Alberto ("because my husband knows about health things, he trained for that"), and accepts what he says as a valid explanatory alternative or solution to a health problem. Alberto, though he prioritizes biomedical knowledge over that of grandparents, does not discard the possibility of the grandparents' knowledge being pertinent, and he seeks a way to integrate that knowledge into an explanation of the causes of his children's illnesses by taking into account various factors. As an example, we quote a passage of an interview he participated in:

> Because I think that is true, because there you have my daughter, who has parasites, and my wife said that was because we ate coatí's meat too soon, and pig's, and that is true, it has been proved, you see. But to me, and I know, in some way it has to do with cleanliness too. (AD, 32, Ka'aguy Poty, Aboriginal Sanitary Agent, 2001)

In other words, when he retrospectively looked for the causes that led to his daughter's illness, he recognizes the need for still respecting dietary taboos concerning the parents while the child is "new" (mitã pyta), thus reasserting its validity ("it has been proved") and at the same time incorporating another factor (lack of hygiene), which is prioritized by biomedical experts as a main cause for enteroparasitoses.

Let us continue examining Jachuka's speech about mother and newborn child care:

> Mothers must always be cared for because they shouldn't go around the cold, the water, the stream, because if they went around the water before two months, their belly hurts, and the head too . . . and babies must be cared for a lot too, they must be cleaned and they musn't be outside all the time, in el yard, because of the wind . . . well, sometimes until thirty days if age they can't be taken a long way . . . because of the wind, it's bad for them, they say (And the mum, where must she stay?) just in the house, she can't go out or a long way, she must stay at home and slowly clean around the house, one must be still, the brothers and sisters too (the newborn's) they have to be still because otherwise illness comes through the little head, it gets on its head (the baby's), in Mbyá it is called ojeo

> ke´a, like he can't look well and he cries too, he cries and he can't be peaceful and he can't sleep, he cries a lot . . . just born, must be looked after until ten months, until the head is open, here (she points to the suture of the frontal bone with the parietal ones) . . . I don't know what they call it because it takes time to close the head bone, and the navel is dangerous too, it doesn't close (And if that happens, can it be cured?) yes, it is cured, with remedies, chamomile, tuna (And did that ever happen to any of your children?) yes, it happened to AD and to OD (And did you know how it had to be cured?) no, well, OD is the first one, that's why I didn't know and my mum taught me and now I know (And when that happens you don't take him to hospital?) I did take to hospital but doctors don't know about that (And do you take them to the opyguã when that happens?) no, I sometimes asked for that but she (her mother) never took to the opyguã, now they almost don't take, but before they always took to the opyguã, and then sometimes the children died, older ones too . . . because they didn't go to the doctor before, but now . . . if it is something serious I always take to hospital . . . but if you have kamby ryru jere not any more (Is that an illness?) yes, it is an illness the babies catch, they have diarrhea with vomiting and it doesn't stop, it doesn't stop and it can't eat, it becomes skinny, small, it can die, it's not like any diarrhea . . . it happened twice to AD, my grandmother cured him here . . . in hospital they gave him medicine but didn't cure.

The most worrying illnesses are those affecting the gastrointestinal system (diarrheas, parasites) and those considered specific to infancy: ojeo ke´a and kamby ryru jere, which can be treated only by local healers. Regarding gastrointestinal ailments, parasitoses are the higher-risk ones for little children's health, due to their consequences on growth and development. In this sense, recurring parasitoses and diarrhea during the first months of life lead to the child being "skinny," "undernourished" (*ipirui*), "without any strength," and vulnerable to other illnesses. Another important symptom is the delay to walk, which produces great concern because it is the start of free vertical walk that indicates a change in children's status (Remorini, 2008).

Ojeo ke´a consists of a subsidence of the frontal fontanel, or its late closing.[5] To describe this ailment, it is often said that the child has "his little head split open." Typical symptoms are irritability and crying. Although this illness is not very frequent, unlike respiratory and gastrointestinal conditions, its occurrence causes great concern, and most of the time experts are consulted for treatment. It may have different origins and is not generally attributed to only one cause. It may have originated in "stress" prior to birth or because taboos may have been ignored in the family environment (Remorini, 2008).

Kamby ryru jere (literally, "rotating stomach") is an illness affecting only unweaned babies. Our informants often said that babies are exclusively breastfed until they are 5 or 6 months old, and then some solid food and bottled milk are incorporated. In this sense, kamby ryru (milk stomach) is the name for the unweaned babies' digestive organ. This ailment occurs when babies receive a strong blow or when they fall on the floor. The risk of being affected by this is the main reason why Jachuka does not want to leave the baby in the care of her younger children: "that's why one can't leave the children looking after the little ones, at least until they are 7 or 8, because they may drop them and they may get kamby ryru jere."

The diagnosis is made by observing the length of the child's legs, that is, if one leg is shorter than the other, it means the stomach has rotated toward that side. The symptoms also include vomiting and diarrhea. In that case, the diarrhea is "like water," that is, it is watery, without any consistence, which leads to recognizing "it is not *any* diarrhea." The treatment differs according to each expert. Some of them use medicinal plants, and others cure it with tobacco smoke in addition to massaging the child's legs until they are a normal length. When the child is made to lie down on the dorsal decubitus and the feet are at the same level, the child is considered cured (Remorini, 2008; Sy, 2008). Because of the uniqueness of this treatment, parents do not consult a doctor for this pathology.

On the other hand, Jachuka expresses her preference for hospital attention in cases when, in her view, traditional experts' participation does not prove effective—in particular, when it comes to facing "serious" illnesses or those requiring a fast solution. As other interviewees state, scientific medicine is preferred in those cases because, even though local therapeutic resources (medicinal plants and ritual procedures) are considered effective, a longer time is required for them to be effective. It is clear that their access to medical intervention can prevent some deaths that could not be avoided in the past. Another situation where the hospital appears to be a more efficient alternative is delivery. The arguments in favor of choosing the hospital include that it is "safer" for the woman in case she has severe hemorrhaging, her recovery is faster, the child's height and weight is controlled, and the child receives obligatory vaccinations. Likewise, many Mbyá women and men justify their choice on the grounds that there are a few old women in their community who may serve as midwives.

It should be taken into account that there are no private vehicles in these communities. Therefore, if a woman starts to feel labor pains in the early hours of the morning, she will probably give birth right there because there is no access

to any kind of public transport at that time. It is interesting to notice, then, that the decision to go to the hospital does not necessarily include the possibility of having a traditional midwife. Jachuka and two of her sisters decided to go to the hospital to have all their children, in spite of the fact that their grandmothers are experienced midwives. When asked about the reason for this, Jachuka said the following:

> I'm afraid to have, now there are a few midwives and it may be dangerous because sometimes it comes in the wrong way, or sometimes it is not born normal, a lot died at birth, sometimes, if the baby comes in the wrong way, nothing can be done in the community . . . Guaymi i (old women) think that women go to hospital and they don't want to give birth in the community (And your mum, for example, what does she think?) my mum agrees because . . . she had a baby at home before and I don't know what happened, my mum almost died because of that, then they always went to hospital . . . I saw one baby died, my mum almost died.

Para: Articulating the Inside and the Outside

Para (22) lives with her husband, Carlos (29), and her three children in a dwelling near her mother-in-law and her sisters-in-law. Every nuclear family has a different house (four altogether) that are separated by a few meters. The women, youth, and children in this extended family, whose referent is Silvia (60), Para's mother-in-law, spend most of the day together, preparing food, looking after the children, playing, talking, doing crafts, and watching television. Carlos and his brother spend most of the week away from the community, working in Posadas (a city). Silvia and one of Para's sisters-in-law are in charge of looking after the children when she goes out to study at Jardín América (a city).

Before her second child's birth, Para decided to "change" during the last months of her pregnancy and give birth in the *Chapa i* community. Her decision was based on her need to be near the women in her family she has a closer bond with, which is very valuable in these situations. Her other children were born in the hospital.

Para's life story is marked by her constant circulation between Mbyá communities and cities. Para considers this "coming and going" a way to gain access to new knowledge and opportunities. She has studied to become a health agent, and in 2003 she was training to become a professional nurse at a private institution. Her interest in community health has led her to take charge of negotiations to get appointments for people at hospitals and to get medicine for them, though she

has not been officially appointed as a sanitary agent. Her training at biomedical institutions allows her to have a somewhat critical position in relation to some beliefs "from the grandmothers," though she finds much of their advice effective. In her speech, an integration of biomedical terms is noticed, as well as the elaboration of traditional beliefs in light of scientific knowledge. This is the way Para recounts some illness episodes she went through during and after pregnancy:

> This happened to me in 2000, I felt weak, when I walked I didn't feel my feet, I was anemic . . . Chichote (her son) was very little, it was after delivery. They told me it was because I didn't look after myself (where did they tell you that?) here, in the community . . . Silvia (her mother-in-law), SB (opyguã). Because after delivery one has to beware of the cold, not to go out if it is windy, not to wash oneself with cold water. For example now, at the hospital, when I was in Posadas they told me, don't be afraid of cold water, the grandmothers of the past tell all lies, said the doctor, then I washed myself, and that time, I don't know, nothing happened, and then, with my second (son), I again wanted to do that, wash myself in the stream and the water was cold, I washed the clothes too . . . (grandmothers say that) after 15 days you can, but not after five, six or seven days, because the cold catches you, and all your blood deviates, they say, and a clot of blood is formed, it is called *tuguy roicha*, that means the blood gets cold, then when you begin to have problems there, because every time I washed myself with cold water, there I began to feel that, cold . . . and it was like this that I began with the bladder problem . . . because after your blood gets cold you suffer the consequences, that's why we are always forbidden to have cold food, cold drinks, watermelon, fruit you can't eat, sodas is cold, too. Because we are forbidden to eat like that mixing salty and sweet. One has to be careful for one month, if not you get internal hemorrhage (And with the next child, were you careful?) yes, I don't feel bad, because I was in bed for a week, resting.

Studying allows Para to get new knowledge, which widens her criteria for decision making. This marks a contrast with other women in her own generation. Her perception of the factors influencing her health and that of her children is strictly related to her contact with medical professionals. In the previously quoted passage, she establishes analogies between Mbyá and biomedical diagnostic categories.

Nevertheless, when a bladder problem arises, she consults both traditional specialists and doctors. The doctors diagnose "stones in the bladder" and advise her to get an operation to remove them. Surgery was not an option for Para at the time, and she decided to find a treatment within her community. Therefore, she visited the Opyguã, who diagnoses *ita* (stones), an ailment caused by intentional

damage from another living person or by the action of some supernatural agent (*mbogua*, spirits of the dead). These entities cause evil by means of material elements; this time they are stones introduced in the affected person's body. This new diagnosis, which is consistent with the Mbyá belief system, is reflected in what she says about the allopathic medicine diagnosis. This illness episode allows her to recall previous experiences that she finds meaningful. Therefore, based on elderly people's ways, she found that her illness was due to her neglect of certain requirements after delivery. However, at the same time, and based on what the doctors said, she had some doubts about the truth of these assertions. The value she places on traditional and biomedical knowledge and practices depends on the whole circumstance; one approach is preferred and more acceptable than the others, apart from their accessibility and truth.

With regard to children's health, Para, like Jachuka, emphasizes the events during pregnancy and the first months of life as explanatory factors of the health trajectory later in life. Likewise, she stresses the family's group responsibility in the fulfillment of the elders' recommendations:

> There are some mothers who pay no attention and children get sick, perhaps they eat pig meat 15 days after birth and that's the way they say the illness comes to them, that's why it is banned after delivery to all of them, the dad too, the little brothers and sisters already know what they don't have to do, after the brother is born, what they can't eat (And who teaches that to children?) we, the parents or the grandparents and there they grow up already knowing that.

When thinking about her children, the one who worries Para the most is the eldest, because of her low height and weight in the past 2 years. This is how she recounts the facts that, from her own perspective, led to the girl's health deterioration:

> This girl was born big, but now it looks as though she doesn't want to grow up, ndokakuaa, she fell off a bed and had a fever and the fever infected all her blood and I had to take her to Oberá for 15 days and left her alone, and there it was when she lost weight, because I couldn't breastfeed her, I was bad because she was skinny, and then she didn't recognise me, and she started to cry, she didn't feel well with me (no se hallaba), she was 8 months old, we took her to Posadas to the hospital too, but she didn't recover, she stayed like this, skinny, small, because she was born well and fat . . . but afterwards, every little thing she had made her ill, she got diarrhea and then she didn't recover. doctors forbade me to breastfeed her, because they say that if you stop one day you can no longer feed them because your milk is no use, she can get a fever, diarrhea . . . She was bad for a long time and now, she started to eat well, to put on some weight, and she has got better.

Ndokakuaachy, that is, "he/she doesn't want to grow," is an expression that is often used by parents when describing their children's health problems. Saying that a child "doesn't want to grow" means that he or she doesn't show any evidence of normal growth and development, and that the child is weak, skinny, and is permanently getting ill. They also speak of some symptoms having to do with the child's emotional state, such as weepy, sad, or doesn't find him- or herself (*no se halla*). In the previous paragraph, Para describes the reason for her daughter's successive illnesses and the doctor's advice to not breastfeed her. Breastfeeding is considered by Mbyá women—according to biomedical advice—a practice that favors the child's health and avoids exposure to illnesses. As we saw in the previous account, stopping breastfeeding or the early addition of other kinds of food cause complications in children's health and have short-term and long-term consequences. Moreover, the girl's admission to the hospital without her mother's company is considered to affect both the child's and the mother's emotional state, as well as the bond between them that is believed to be so important for the child's health.

Although biomedicine seems to be an accessible and efficient alternative of treatment for Para's family on some occasions, traditional knowledge remains the reference framework to find the causes for the illness and a healing resource when she is faced with illnesses that biomedicine cannot diagnose:

> There are things that only the opyguã know what they are, also the older ones, people like my mother-in-law, she once had a dream, and nobody paid attention, and they didn't look after the children and they got ill . . . I listen to her dreams, because I don't go to pray at the Opy (Mbyá traditional church), because the younger ones don't understand what the elders say . . . they speak with words we don't understand, with old words.

LESSONS LEARNED

We would like to finish this paper by drawing a few conclusions. What do these life stories teach us? Which relevant aspects can we identify in terms of mother–child health care? What have we learned after all these years of working among the Mbyá Guaraní?

First, and according to other contributions about the Guaraní and research developed in other Latin American societies, the woman's relevance is enhanced—both

in the past and in the present—with regard to taking care of their children and other members of the family group. As we noted early in the chapter, Guaraní women have always been described as mothers and wives. Although we have recorded a set of transformations in their activities, roles, and status, the motherly function is still the core of her everyday life.

From an ethnographic observation of a day of life, it turns out that women are the ones in charge of looking after their babies during most of the first months of life. They never delegate this task to other people, except in very special situations. As the child grows up, his or her care is shared with other members of the domestic group, including other children, and the child may even be raised by other relatives on a regular basis for some time (Remorini, 2005). During the first months of life, the relevance of the mother's breastfeeding requires mothers to carry their babies with them wherever they go, for example, when they go to other cities to sell their crafts.

Moreover, it is the mothers themselves who perceive and explain in detail a wide range of symptoms and even explain the probable causes leading to a diagnosis of their children's illnesses. That does not mean that parents or other adults have no participation—quite the contrary. The whole domestic group is usually involved in the healing and care of a sick child. Men are usually in charge of the search and collection of medicinal plants because they are usually found in the monte (rainforest), a space that usually belongs to men (Remorini, 2008). Nevertheless, it is the domestic group of women who have the greater responsibility in the care of family members' health. Our results agree with those of Price (1997), Módena (1990), Daltabuit Godás (1992), Ryan and Martínez (1996), Bronfman (2001), Osorio Carranza (2001), Loyola (1984), Queiroz (1993), Pícoli and Adorno (2006), Scheper-Hughes (1990), and Crivos (2004), to give a few examples. That is, ethnographic observation confirms this behavior as a general pattern.

Second, these cases demonstrate many strategies when facing illness. Different ways of explaining the causes and methods of healing are combined and articulated in these accounts. The availability and preference of some therapeutic resources over others depends on the person's health trajectory (Sy, 2008) and the particular situation. In their speech and practices, these women appeal to tradition, call on the advice of the elders, and rely on their previous experiences. They also consider the availability of a particular resource to justify their decisions. The Mbyá women's decision-making criteria when dealing with illness and possible remedies is simplified when there is a dichotomy between traditional versus biomedical knowledge or indigenous versus nonindigenous people (Remorini,

2008). This dichotomy, which is usually present in the women's speech—mainly that of the community elders and political and religious leaders—must be considered an element that tends to reinforce their ethnic identity in situations like an ethnographic interview.

Third, and closely related to what was previously noted, these cases reflect some points of intragenerational and intergenerational agreement and disagreement. A respect for taboos that affect people's behavior during gestation and delivery, and after delivery through the child's first living months, is emphasized both in young women's and old women's speech. The intimate connection of grandmothers, mothers, and granddaughters, as well as the continuity of their knowledge, values, and practices related to motherhood and child rearing, is favored by traditional family organization and residence patterns that are still in force (extended families and uxorial locality). As Traphagan points out, it is common in indigenous and rural societies (unlike industrial societies) to find old women providing care, more than receiving it: "particularly, as they enter into middle and old age, women often become caretakers of the collective well-being of the family" (2003, p. 127). That is, they have the responsibility for the welfare of the next generations, due to their handling of knowledge that the others cannot access.

Although we have recorded the sharing of some positions in generational terms, the elders of Mbyá communities do not represent a homogeneous sector. As Bataille and Sands (1986) point out, the women's role in indigenous societies is mostly seen as being responsible for preserving and reproducing tribal tradition. From our interviews with women of different ages, it emerges that their perspective about certain subjects does not come solely from their position in their life course or from the models they encountered in their early socialization. More than tribal tradition, what ultimately guides and justifies their actions and points of view can be found in their past experience. Tradition involves more than what is established in myths and their ancestors' legacy. It does not relate to a set of beliefs detached from everyday actions, but to a common past of shared experiences. As Malinowski (1964) pointed out, the agreement about what proved to be effective in the past specifies the possible alternatives in the present.

In spite of recognizing the symbolic, moral, and practical value of tradition, which is noticeable in the statements we gathered, the young people's actions in certain situations have moved away from the ideal prescribed by "the old ones." Their choice for alternatives that are nearer to those of the *jurua* ("the white ones") is evident (Remorini, 2006). Therefore, tradition, which is associated with their

grandparents' lifestyle, is starting to be questioned, and the efficiency of some practices becomes doubtful when they are compared to new knowledge and biomedical technology. Likewise, some young girls express their ignorance of the basics of traditional rules. There is a breakdown in intergenerational transmission, accompanied by access to formal education and new knowledge and values, where the media is a key factor. Para's statement about the relevance of listening and paying attention to what is revealed in old women's dreams and the nearly exclusive attendance of old people at *Opy* meetings shows the old people's role of translating the incomprehensible code of the ancient ones for young people. This is evident in a commonly used expression, "they say," to explain the causes of an illness. This emphasizes their intention to reproduce other people's sayings, though they do not necessarily make them their own. There is a certain tendency of young informants to restate what others say or is known in the community, thus they do not commit themselves when it comes to deciding the truth of what is stated (Crivos, 2004).

Nevertheless, young people admit that when they face uncertainty about the risk of an illness, they turn to the knowledge and experience of the old ones, and this is a key factor in their decision making. This represents for them a necessary anchor point. Likewise, they admit that certain illnesses affecting children are neither identified nor treated by biomedicine, which means that the old people's knowledge is the only valid resource.

Fourth, the old women's speech, like that of Kerechu, emphasizes transformations in health conditions and the worsening of some illnesses that have increased the child morbidity–mortality rate. Continuous reference to the fact that there was less illness before and there are new illnesses now justifies their utilization of biomedicine. It is interesting to note that this perception of the past and the elders is consistent, in part, with the present social–sanitary and ecological situation, though a certain idealization of the past times is noticeable. Transformations in the forest, sedentarism in intensively exploited spaces, the decrease in horticulture activities, the scarcity of wild animal resources, and the higher consumption of industrialized food increase the Mbyá people's vulnerability to infectious and nutritional diseases and has a high impact on children (Sy & Remorini, 2009).

Beliefs are not unchangeable explanatory systems; they are susceptible to being transformed and given a new meaning (Sy, 2008). The Mbyá women's beliefs account for the plasticity of these communities to incorporate, and they ascribe a new meaning to and complement knowledge and resources from different origins. Role transformations and new opportunities to access to formal training, together with a change in the recognition of indigenous women's opportunities and rights—favored by international movements—encourage Mbyá women to look for new alternatives for rearing and caring for their children and grandchildren, articulating the inside and the outside, and going through and communicating different contexts.

We hope our work will contribute to a greater ethnographic visibility of indigenous women and awareness of the present mother–child health conditions to foster initiatives aiming at improving this people's quality of life.

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Discussion Questions

1. How do the Mbyá integrate modern and traditional models of medicine? (Consider Para in particular.)
2. If you were to work in this community, how would you decide what traditional methods of taking care of mothers and infants should be kept and which should be replaced with modern methods? Would you see this as your role? Why or why not?
3. What do you think accounts for 90% of babies being born in a hospital, given the low rates of hospital births in many traditional communities around the world?
4. How can the hospitals that serve the Mbyá provide the emotional and psychological care for the other 10% who want to and choose to stay at home?
5. Is there a low-cost way to provide the safety of a hospital birth with the comfort of a home birth in this community?

NOTES

1. I did this research within the frame of my thesis to obtain my doctorate in natural sciences at UNLP, funded by CONICET.
2. In every community, some individuals—generally elderly men and women—are recognized as therapeutic experts, known in the Mbyá language as *Karai* or *Kuña Karai poro poãno va'e*, an expression that generically refers to people (men and women, respectively) who have the ability to cure. Moreover, some of these Karai are also recognized as religious leaders within the community, in which case they are called *Pai* or *Opyguã* (Remorini, 2008).
3. Traditional Argentinian food. Stew with different vegetables and some meat.
4. *Mitã* means, generically, "child." Within this category, *avai* is used to refer to male children and *kuña i* is used to refer to female children. For information about the categories used to refer to different stages of the Mbyá Los indios Jeguaká Tenondé (Mbyá) del Guairá, Paraguay life cycle, see Remorini (2008).
5. These illness can be consider analogous to those in other Latin American societies that are called *caída de mollera* (fallen fontanel).

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