

THE PREGNANCY AND DELIVERY PROCESS AMONG KAINGANG WOMEN¹

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¹ Study undertaken as part of the research project - The health knowledge and practices of Kaingang elderly people on the Indian Land Faxinal-PR, funded by *Fundação Araucária*, through the Research Program for the Unified Health System: Co-management in Health PPSUS - 2008/2009 - Agreement n. 179/2010.

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ABSTRACT: This study was aimed at understanding the perception of the birth process among Kaingang women. A qualitative research with an ethnographic approach was undertaken. Participants were 30 Kaingang women living on the Indian Land of Faxinal de Catanduvas-PR. Data collection occurred through participant observation, interviews and focus groups, from January to April 2011, and the data were analyzed using Culture Care Theory. The study population was between 14 and 100 years of age. The conception of delivery has changed over the generations. The oldest women believe the best way to give birth is by squatting at home, while younger women demonstrate insecurity about having children out of hospital. Women demonstrated dissatisfaction with childbirth care. Practices need to be adapted to preserve the culture of this ethnic group without exposing the women and infants to risks of complications or mortality.

DESCRIPTORS: Indigenous health. Women's health. Humanizing delivery.

PROCESSO DE GESTAR E PARIR ENTRE AS MULHERES KAINGANG

RESUMO: Este estudo teve por objetivo identificar o processo de gestação e nascimento entre as mulheres Kaingang. Pesquisa qualitativa de abordagem etnográfica, realizada com 30 mulheres Kaingang, na Terra Indígena de Faxinal de Catanduvas-PR. A coleta de dados ocorreu por meio de observação participante, entrevistas e grupo focal, no período de janeiro a abril de 2011 e foram analisados à luz da Teoria Transcultural do Cuidado. A população estudada tinha entre 14 e 100 anos. A concepção de parto tem mudado com o passar das gerações, sendo que as mais velhas acreditam ser melhor parir acorçada em casa, já as mulheres mais novas demonstram insegurança de ter os filhos fora do hospital. Foi identificada insatisfação na assistência durante o parto. É necessária a adequação das práticas de forma a preservar a cultura da etnia sem a exposição de mulheres e recém-nascidos ao risco de complicações ou mortalidade.

DESCRIPTORIOS: Saúde indígena. Saúde da mulher. Parto humanizado.

PERCEPCIÓN DEL PROCESO DE GESTAR Y PARIR ENTRE LAS MUJERES KAINGANG

RESUMEN: Este estudio tiene por objetivo conocer la percepción del proceso de nacimiento entre las mujeres Kaingang. Es una investigación cualitativa de abordaje etnográfico, cuyos sujetos fueron mujeres residentes en la Tierra Indígena de Faxinal de Catanduvas-PR. Datos fueron analizados por Teoría del Cuidado Transcultural. Trabajo de campo ocurrió de enero a abril de 2011 a través de la observación participante y grupo focal. La población estudiada tenía entre 14 y 100 años. La concepción de parto ha cambiado con el pasar de las generaciones, las mujeres mayores creen que sea mejor parir de cuclillas en casa, ya las menores demostraron inseguridad de tener hijos fuera del hospital. Las mujeres mostraron insatisfacción de asistencia durante el parto. Es necesaria la adecuación de las prácticas de atención de forma a preservar la cultura de la etnia sin, con todo, exponer mujeres y recién natos al riesgo de complicaciones o mortalidad.

DESCRIPTORIOS: Salud indígena. Salud de la mujer. Parto humanizado.

INTRODUCTION

In Brazil, it is estimated that about three million births take place every year, 97.1% of which happened in hospitals in 2006, ranging between 99% in the Southern and 90.8% in the Northern states.¹ These data reflect the predominant reality of medical and institutionalized births in Brazil, mainly in recent decades.²⁻³ The hospitalization of this process has been attributed to the need for specific care delivery to parturient women,² keeping in mind that, although pregnancy is a physiological process that tends to evolve without dystocias, complications tend to be fatal, although they are easy to manage.⁴

Considering the trend to evolve without problems, surgical interventions should always be limited to risk situations for mother and infant, reaching 15% of caesarean births at most in the care population.² In Brazil, on the opposite, 48% of deliveries are C-sections (49.8% in the South and 33% in the Northeast).¹⁻² The assessment of the evolution in C-section rates reveals that, since the 1970's, they have increased from less than 5% to more than 30% of deliveries in different countries. In Brazil, rates superior to 70% are frequently identified in private institutions.^{2,4} This panorama, marked by a large number of hospital births and C-sections reveals a scenario of standardized births, resulting in interventions independently from complications.^{2,5}

This standardization of the delivery process ignores the women's cultural aspects and the possibility of them playing a protagonist role in this event. It is known that birth-related care practices are strongly influenced by the subject's cultural context, demanding respect for these aspect in individual care delivery.^{2-4,6} Some studies present women's perception in this scenario.^{3,6-10} Research on the theme in Indian populations is scarce though, demanding studies about the pregnancy and delivery process among indigenous women.

In that sense, contact with Indian people from the Kaingang tribe, in the Central-South of Paraná, aroused the researchers' interest in the particularities of birth in this population and inquiries about the influence of health services in this process. The study was guided by the question about how pregnancy and delivery have taken place across generations of Kaingang women and about which of the aspects involved in the process are culturally determined. The researchers believe that understanding these issues will lead to advances in Brazilian midwifery care, encouraging

reflections about common practices. Therefore, the aim in this study was to identify the pregnancy and delivery process among Kaingang women.

METHOD

A qualitative research with an ethnographic approach was undertaken. Authorization was obtained from the National Research Ethics Council (CONEP/Opinion n. 760/2010) and all ethical aspects established in Resolution 196/96 – CNS-MS were complied with. Ethnography corresponds to the detailed description of standards of behavior, guided by specific cultural rules in a given group or society. In sum, the ethnographer's aim is to capture native people's perception, relation with life and apprehend their worldview. Thus, this method permits understanding the cultural influence in different people's health practices.

The study context was the Indian Land Faxinal de Catanduvas-PR (TIF), with about 600 residents, distributed among approximately 120 families. The Land is located in the city of Cândido de Abreu, in the Central-South of Paraná.

Data were collected between January and April 2011 through participant observation, focus groups and interviews, which were recorded in MP4 and later transcribed. The collected information and observations were complemented with the help of field diary notes. As this material was very extensive, all information was grouped according to the situations experienced, giving meaning to the phenomena that emerged.

The focus group activity was held in the village and involved 30 women from different age ranges, who were stimulated to talk about their children's delivery, with a view to validating the inferences reached based on the data collected during the researchers' observations. At the end of the activity, the participants were invited to answer a semi-structured questionnaire with questions about demographic aspects of the study population, with a view to identifying its profile.

As the tribe living in the reservation is of Kaingang origins, the language spoken derives from the linguistic family macro-jê, aka Kaingang. Younger women were mostly bilingual and talked to the researchers in Portuguese; older women, on the other hand, only talked their native language, demanding help from a bilingual interpreter. A bilingual school is present on the Indian Land (IL), allowing the population to learn Portuguese and gain literacy in Kaingang. Marriage and mother-

hood negatively affect women's school attendance though, as both happen around the age of 14 years.

In the transcription process of the audio files that contained testimonies in Kaingang, another native member of the research group elaborated a second translation, so as to guarantee the reliability of the data contents and information.

The data were analyzed in the light of the Culture Care Theory, which involves reading the data to look for agreements and disagreements among assertions and behaviors, which are classified for further identification of recurring patterns. The findings' structural meaning and situational context are also considered in the analysis.¹¹

In this analysis process, a descriptive report was elaborated about the care expressions observed, whose exhaustive reading permitted grouping the information according to the circumstances experienced, identifying differences and similarities between the situations and reports.¹¹ The subcategories evidenced at that moment characterized the analysis components and supported the analysis to identify care patterns, resulting in the first inferences.¹¹⁻¹²

After elaborating the inferences, they were returned to the subjects and key informants for validation, looking for data to confirm, reject or complement each. This characterizes a circular analysis process and explains the need for this process to take place at the same time as data collection. Information is interpreted and validated together with the subject who, by confirming the researcher's assertion, reveals data that used to be secret, which will again be analyzed and validated, until the phenomenon can be described as a whole.¹¹⁻¹²

RESULTS AND DISCUSSION

The women were between 14 and 100 years old, demonstrating the range of generations participating in the research. The minimum age for this population's first pregnancy was 12 years and the maximum 20 years. In addition, the study population included four generations of mothers in the same family, a relevant finding, as it permits identifying behaviors experienced at different moments in this community's lifecycle.

Only one of the 30 women reported having giving birth to a dead fetus, while two mentioned pregnancy problems followed by premature birth. It was noteworthy that both cases related to women under the age of 30 years, without any

mentions of these aspects among the elderly. This issue emerged and indicated the need for further research, in view of the impossibility to determine whether no pregnancy-related diseases used to exist or whether these situations were not diagnosed.

Data analysis resulted in the identification of two categories: "The Kaingang way of bearing children and giving birth" and "The contrast between the ancient and the new: how Kaingang women see hospitalization for delivery".

The Kaingang way of bearing children and giving birth

As pregnancy is the period to prepare for the arrival of a new family member, different changes are expected in the woman's and her family's behavior, aimed at favoring the birth of a healthy child and a healthy delivery. In that sense, the description of pregnancy among the women demonstrated the need to prepare for delivery as soon as the pregnancy was identified.

So that I won't suffer much when I'm two or three months far, I already ask for remedy from the bushes and take it for the child to lie down well, like really small, then birth is easier (M26,62).

The women reported using herbs to inhibit fetal growth to facilitate the expulsion period of delivery⁹ and attribute the appropriate positioning of the child for birth to this resource. It is important to highlight that, during the researchers' contact with the group, no reports were found on the IL about women whose children were born in breech and transverse lie. In view of these explanations, two aspects can be questioned: the first relates to the risk of intrauterine growth restriction (IUGR) due to the use of *bush remedies*; and the second is related to keeping the baby *very small*, which would otherwise be the causal factor of the low height among the Kaingang. Studies involving Indian populations have indicated that the mean height of these people is generally inferior to the national average for non-Indians.¹³⁻¹⁷

Another measure the women adopted to avoid fetal growth is to reduce the amount of food:

[...] grandma used to say that it was no good for us to eat a lot [...] because the child grows a lot and gets big inside us, making the birth difficult. You have to eat really little... you should not even take vitamins... but, nowadays, they keep on giving us vitamins, that's why I think nobody gains more at home I think. The baby's born big, fat! [laughs] And not before! It's because they took medicine for some time, for the child to stay

really small, but he was born very strong, because they also took medicine to make the baby strong (M17, 35).

Although this practice is appropriate to prevent overweight and obesity, which could hamper the delivery process,¹⁵ it may go against the calorie intake needed to guarantee the pregnant woman and the infant's health.¹⁶ Therefore, during prenatal care monitoring in the village, it is important to follow the women's diet and request laboratory tests to indicate the women's nutritional status, so as to guarantee the nutritional supply needed. Although the reduction in the amount of food consumed has been observed, no restrictions exist as to the type of food,¹⁸ as the participants reported that, when the woman wants to eat a certain kind of food, that desire needs to be attended to. The idea that pregnant women cannot feel desire: *whatever you want to, you have to eat!* (M2, 35) is not harmful and reveals great cultural baggage in this behavior. It should be highlighted that this is not something exclusive to Indian women,⁸ but is part of common practice among non-Indian women too. The convergence in this kind of behavior suggests an adaptation in the Indians' system of beliefs based on their contact with colonizers.

Despite similarities in practices during pregnancy between Kaingang and non-Indian women, some aspects remain different. In the general population, it is common to reduce physical activities throughout the pregnancy¹⁷ but, among Kaingang women, the opposite was observed. According to the indigenous system of popular beliefs, one needs to remain active during this period with a view to a calm pregnancy.

I used to work... when I was pregnant, I used to go to the fields to pick beans, I used to bring beans on my back, in those big baskets, sometimes I fell, but you have to work a lot for the baby to be born soon (M10,40).

They [old Indians] say that if you, like, shake around, the child is born soon, so you have to work a lot (M14,37).

Grandma used to say that I should not sleep during the day, you should sleep at night, otherwise your eyes get deep. And you cannot lie down during the day either, if you do the baby's birth won't go well (M7,36).

Among indigenous women, the interval among pregnancies is short, so that these women spend most of their lives bearing children.¹⁹ In combination with this reproductive function, it is observed that the social role they receive refers to activities related to feeding the family.¹⁸ Hence, the report about not sleeping during the day can be considered as a way to maintain family and

community dynamics because, if the women rested at each pregnancy, there would be nobody to develop their activities.

It should also be highlighted that, as is the tradition, Indian women have their children in the crouched position, so that work is also a form to prepare the women's muscles for delivery. In a study about the Kaingang form of giving birth, it was verified that the customary manner of performing their activities in the crouched position exercises their perineal and adjacent muscles in such a way that even Kaingang women who have given birth multiple times reveal better genital conditions, with less cases of urinary incontinence, prolapse or perineal tears.¹⁹ Through the crouched position, the vaginal, anal and urethral canals are widened and the sphincter contracts further to avoid incontinence. At the same time as the pelvic floor is trained, the pelvic muscles develop greater strength and resistance and the legs are contracted, furthering the venous return.¹⁹⁻²⁰

The Indians describe the fact of giving birth at home in the crouched position as a natural event. Reports about this kind of delivery are restricted to women of more advanced age nowadays and are frequently related to multiple births, revealing crouched birth as an ancient custom. Although they believe that the crouched position is the best form to give birth, strong pain is mentioned at that moment: [...] *it hurts a lot when giving birth, but we have to hang in there!* (M27,63). This experience, however, is understood as something natural and unavoidable.

As pain is an intrinsic part of delivery, they report taking *medicine from the bushes*, which helps during expulsion.

When we're in pain [labor], the elders take herbs from the bushes and make medicine. We get that medicine and take it until the time has come to give birth [...] (M20,60).

When the pain starts, the husband immediately goes for medicine from the bushes, to get the baby on time. You put it in hot water and drink it (M18,59).

My mother taught me how to make this medicine (M19,65).

In these statements, the presence of elderly men and women in the family is evidenced, who hold community wisdom, recognize the herbs that serve as medicines and preserve the customs. The perpetuation of practices through the elderly is evidenced in the statements, when the women discuss their grandmothers' lessons about how to behave during pregnancy: *grandma used to say; ask*

your mother and she'll explain; or it was my mother who taught me. In a study that involved midwives, the use of herbs is also described among non-Indian women. This practice is threatened with the risk of extinction of traditional knowledge, together with the elderly.²¹ Thus, the need to rescue culture is highlighted with a view to its perpetuation and maintenance of the people's ethnic identity.

When recognizing the cultural network involved in delivery, social roles can be identified at this moment. It is highlighted that the husband is responsible for warning the elder or for personally getting the *medicine from the bushes*.

The husband is waiting at the door for the baby to be born, when he's born, he goes there and cuts the baby's [umbilical] cord. He doesn't cut it with scissors, he uses bamboo wire. They [Indian elders] used to say that cutting the cord with scissors gives air in the belly, that's why they cut it with bamboo (M18,59).

The father plays a fundamental role during the delivery, as he provides the medication and cuts the umbilical cord, and should await the process at the door, showing that his presence with the woman giving birth is not allowed. Recurrent statements were identified which indicated that the woman should give birth alone.

The first child I had alone, nobody helped be. I told [that the time had come to give birth], they [neighbors] got the medicine and I took it until the day had come. When my belly was hurting, really strong, I told her [elderly] that the baby was going to be born. She told me: stay at home alone and lock the door so that nobody can see it (M5,35).

I gave birth well alone. We always do. First there was no hospital, there was a midwife who takes care of the women, but some people don't take the medicine (M26,62).

To give birth, the women lock themselves in at home to have their children, without the interference of a second person. During the first delivery, in case the woman has difficulties or doubts about how to give birth, the mother or midwife help her, teaching her how to do it. The pregnant women should go through other deliveries on her own though, in accordance with the statements. This attitude can be indicated as one of the steps of the birth ritual among the Kaingang.

As part of the subsequent phases, it should be mentioned that, after birth, the women bury the placenta, cord and umbilical stump together with medicines, so as to reinforce characteristics they desire in their children.^{3,22}

Hide the stump and the placenta. Make a hole in the ground, put medicine from the bushes, the things [stump and placenta], cover with further medicine and soil, under a very high tree. Then the boy will grow a lot. Put medicine so he won't be angry, but there are other kinds of medicine too: to grow strong, healthy, hardworking (M19,65).

These practices are also described among other American-Indian tribes, like the Jodi, and area related with the rites of birth among Indian people.²² Among the Kaingang, burying *the remnants* is important for this people's relation with the soil. The stump is left in the soil the subject was born from and, at death, the body should be buried in the same soil, so that his lifecycle is closed off and the spirit is free to leave.¹⁸ In view of the relevance of this rite for birth, the act of keeping the stump to bury it is considered one of the mother's first care acts for the baby after birth.

The postpartum period should also be marked by care for the mother. The informants' reports are focused on food, showing restrictions on the intake of pork and other *heavy* foods, like beans for example. The postpartum woman's meals are based on chicken stock, as described by non-Indians in an earlier study.⁸ These women used to be encouraged to eat sweet corn pudding with ashes to improve their milk production. According to the Kaingang, ashes contain active principles that strengthen the female organism.¹⁸

The contrast between the ancient and the new: how Kaingang women see hospitalization for delivery

The Kaingang women were culturally prepared to have their children at home, alone, through ritual acts described in this study. This reality often does not happen nowadays though, as deliveries take place in the hospital context. A primary health care unit is present on the IL, where prenatal care monitoring takes places. When labor starts, the women are forwarded to the hospital in the nearest city.

This change in the way of giving birth reveals different perceptions among the women in IL Faxinal. The elderly women and/or those who gave birth in the traditional manner, in the village, were against institutionalized birth; the same was true among women who experienced both situations, although the discourse did not necessarily reveal that the environment was rejected, but estrangement towards the way deliveries were conducted.

Yes, one child I went to the hospital, but it wasn't good for me and it isn't for the baby either. It's good to have crouched, right? I didn't think it was good to have the baby in hospital (M10,40).

The last [child] I had at the hospital [...] but I didn't like it (M9, 29).

Over there [at the hospital] we just lie down and wait for the time to give birth. And you can't use any strength when lying down (M6,34).

[it's bad] because there at the hospital the nurses open our legs a lot. It's better to push when sitting (M14,37).

We know when the time of birth has come, then [the child] it turns and we know it will be born, but not lying down, lying down is bad! [...] (M5,35).

According to the reports, the Indian women know when to give birth and what has to be done. The most recurrent complaint was related to the woman's position during delivery in the hospital context. Hospital care restricts the women to the horizontal position, revealing the shock between the indigenous culture and the obstetric routine at maternity hospitals. As observed, the position the Kaingang women need to take to give birth at an institution strongly bothers them, as lying down goes against their perceptions about how to give birth, and against the physiology of birth in which, whenever possible, the different perspectives loaded with cultural values should be respected whenever possible. Although crouched birth is defended as the intuitive way to give birth in different studies, recommending its practice as it preserves physiological principles, such as the greater diameter of the vaginal canal, lesser compression of large vessels and positive gravitational strength,¹⁹⁻²⁰ this practice is hardly frequent at the health service this population is referred to.

[...] we tell the doctor that Indian women give birth sitting, but they say that, at the hospital, what they order has to be done, because we're in charge here, they say (M17,35).

The doctor does not allow us to sit [to give birth], but it is bad to lie down when you're in pain [...] (M9,29).

The testimonies demonstrate the extent to which the women's choices and opinions are irrelevant to the professionals, evidencing the supremacy of medical professionals' technical and interventionist background, who ignore the Indian women's preparation and choice of natural birth. In addition, these women have clearly lost the possibility to participate actively in their de-

livery, as the professionals are solely responsible for deciding on what procedures are to be put in practice during the hospitalization.

As identified in the literature, the delivery route should be a choice jointly taken by the team-parturient woman-family, based on complete and enlightening information, taking into account not only clinical, but also emotional and cultural aspects.⁴⁷ The women's lack of autonomy and understanding about the reasons that culminated in medical interventions, particularly women who undergo C-sections, resulted in negative delivery experiences.

I didn't have any other disease and I don't know why they did a C-section (M6,34).

[it's bad] because they give you an injection [anesthesia] and I can't remember the time (M13,24).

In view of the above, the researchers believe that dissatisfaction with the hospitalization can be related to the way deliveries take place at the institution, including conventional practices among health professionals, who tend to neglect the cultural meaning of the moment for the subjects. In a study developed in São Paulo city, involving non-Indian puerperal women, these negative experiences are attributed to the women's feeling assaulted after inappropriate care at the maternities.⁹ In addition, practices were evidenced which the World Health Organization does not recommend during labor, including lack of privacy, episiotomy, fasting during the pre-partum period of normal birth and the Kristeller maneuver.²⁵ The impact of these situations among women who are accustomed to giving birth naturally, with as little intervention as possible, entails relevant negative connotations, as observed in the following reports:

[...] I think that the experience comes with a lot of suffering at the hospital, I think [...] the person who's around, sees everything they're doing to us (M17,35).

[...] We don't take anything at the hospital, at home we have some tea (M18,59).

[...] the doctor [to give birth] said he was going to cut down there (M3,20).

[...] the nurses there at the hospital did like this [gestures pushing the belly] wanting to take the baby out (M7,36).

[...] they also did that to me [gestures pushing the belly] to take the baby out (M9,29).

Some procedures, which may be necessary during delivery care, should be accomplished with caution and women should be informed about their need, like the vaginal touch.⁵ In this study, the

interviewees referred to this procedure as uncomfortable, underlining the negative connotation of hospital deliveries. During the visits to the village, it was perceived that the Indian women considered the vaginal touch an extremely invasive and disturbing practice. The same was described in a study about women's birth experience, in which the women reported that they did not like the procedure, mentioning pain and discomfort during its execution.³

[...] and, at the hospital, they have to put their hand there all the time, to see if it's coming [...]. It wasn't like that before, nobody touched it with their hand [...] (M7,36).

[...] not even the husband touches us and then there's another putting his hand (M10,40).

This reveals how important it is for health professionals to respect these women's different aspects, considering them as holistic beings with their own social and cultural principles.^{4,9} Sometimes, the Indian women questioned the situation in which the women felt constrained or uncomfortable, asking if they *do the same thing to white people*, demonstrating that they attribute the feeling of not receiving appropriate care to their ethnic origin. The feeling of discrimination, as reported by an Indigenous Health Agent, expresses the desire to help and, at the same time, the way companions are excluded from the birth process of Indian children.

[...] once I went there to the hospital with a woman. I opened the door of the room and she was in the bathroom with the baby on the floor, and she was unable to get up [...]. I ran for the nurses, told them that they weren't taking care of the women. They came and told me to leave the room, because visiting times were over, but I wasn't a visitor there (M17,35).

Dissatisfaction with care delivery also appeared in the statement by M18,59, mentioning that, when she had her twelfth child through normal birth in hospital, her visual field was restricted by a *raised cloth*, which prevented her from seeing the infant. One of the advantages linked to crouching during delivery is the possibility to accompany the arrival of the child in detail, perceiving the evolution after each contraction. This visual contact makes the mother feel satisfied and rewarded for the pain felt, while the baby feels safe and comforted.¹⁹ Although this may characterize an insignificant detail of delivery care for some people, for this woman, who after so many years giving birth describes the existence of a visual barrier with sadness, this aspect seems to reveal an

inappropriate procedure, highlighting that, during care delivery, small details are always relevant.

The situations described in this study justify the rejection observed with regard to hospital birth, particularly surgical delivery. On the other hand, some women acknowledged the importance of the institution to save the lives of mothers and children:

[...] I found the hospital better, because I was unable to get the baby at home, then I went there and they saved me [...] if I had the baby here I was going to die. Also, they [the doctors] that he [the baby] was placed in me, I don't know where, they had to push the baby (M17,35).

[...] they sent me to the hospital and I spent two more weeks there, then they took out the baby and did the treatment, until I got well (M10,40).

According to researchers, the C-section represents an alternative to reduce maternal-infant mortality, provided that it is well-indicated.^{4,6} It is important to guarantee that its choice is based on clinical criteria, informed to the family and the parturient woman, so that its practice is not solely for commodity's sake, as illustrated in an Indian woman's report about her Cesarean section:

[...] but it's better to have it [baby] in hospital, because it was really quick [time between labor and C-section] (M16,26).

In view of the above, one can affirm that the conception of delivery has changed across generations, with births taking place in hospital among younger women. According to the findings, it should be highlighted that information about procedures, as well as welcoming the parturient women and respect for their cultural traditions can permit interventions without annulling the individuals' autonomy over their bodies and lives, that is, guaranteeing lower maternal and neonatal mortality rates without annihilating the cultural traits of a people.

FINAL CONSIDERATIONS

The study participants included elderly women, who greatly contributed to understand the Kaingang way of giving birth, and younger women, from a generation of transition between culturally established practices among Kaingang Indians and health professionals' practices.

The interaction between the Indian women and the researchers permitted further discussion about the habits of the Kaingang population in the

pregnancy, delivery and birth process. Thus, it was evidenced that the elderly women believe that the traditional form of giving birth, crouched, in the village and without professional intervention, is the best. The younger Indian women, on the other hand, demonstrated feeling insecure about giving birth at home, despite showing that they disliked the care they received in the hospital context.

It is highlighted that the negative experience can be attributed to the doubts the women manifested, because of some procedures the Indian women find unusual, underlining the need for orientation and explanation about procedures before they are done. This reveals the need for further studies to assess these women's satisfaction and aspects for improvement in midwifery care. Similarly, professionals' distinguished look on this population would permit the adaptation of practices so as to preserve this ethnic group's delivery culture, but without exposing women and infants to the risk of complications or mortality.

Among the study limitations, the fact that a single Indian Kaingang land was considered should be highlighted. Similar research is suggested on other Indian lands, with a view to revealing aspects that can be generalized to the ethnic group and the population in general, so as to indicate new obstetric care perspectives.

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