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Paradoxes of the traditional midwives program in the context of Krahô women

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Abstract *This paper analyses the impact of the Working with Traditional Midwives Program on the daily routine of a Krahô indigenous women group. This is an ethnographic study that mainly used observation and field diary as supporting tools. Other tools were timely interviews and secondary data. Fieldwork occurred between August 2015 and December 2016 and involved ten women of eight different villages. Results point to a disassociation between the Program's main objective, which is focused on appreciating and reviving midwives' knowledge and the daily village reality. Although the Program has targeted women who already work empirically on the birth setting, there was a generalized acknowledgement in villages that women "became midwives" after taking the course. Consequently, the lack of payment and the frustrated expectation that "government" would hire them, though never assumed, were interpreted as neglect. Results reveal an ethnocentric bias of the Program, focused on disseminating scientific knowledge and delivering materials that deviate from the logic of the group under analysis. Studies that evaluate the impact of the Programs' actions in other contexts, including non-indigenous ones, may contribute to the necessary adjustments and the effective appreciation of these women's work.*

Key words *Midwives, Home childbirth, Health of indigenous people*

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Introduction

Women who act empirically in the context of delivery and birth, far from the hospital environment and the health system, carry a list of denominations and are part of the imagination and reality of Brazilian society. In 2000, when Brazil undertook to reduce maternal deaths by three quarters by 2015, these women, who were then called "traditional midwives" in official documents of the Ministry of Health (MoH), were again targeted by the public power with the establishment of the Working with Traditional Midwives Program (PTPT)[1,2]. Approaches such as this have been in place for a long time in Brazil, motivated by the improvement of health conditions of this trade. Indigenous women who support delivery and birth were included in the PTPT and in the definition of a traditional midwife of the Ministry of Health, since they provide homebirth care based on traditional knowledge and practices under the recognition of their own community[1].

The PTPT mainly focuses on the improvement of home delivery and birth attended by traditional midwives, considering citizenship and equity rights. Training actions and/or processes are set as the main strategies to sensitize managers and health professionals, as well as guide the meetings with women, aiming at the exchange of knowledge and the distribution of the "midwife kit". The kit's prerogative is to ensure the basic material conditions for the provision of home delivery and includes a minimum list of 24 items that must be delivered inside a waterproof bag at the end of meetings[1].

The state of Tocantins adopted the PTPT and, in the period 2011-2014, identified 67 active midwives. Workshops for health managers and professionals belonging to women's action area were held to stimulate support for home delivery and to link it to the Unified Health System (SUS). Among the active women, 41 participated in the training workshops, of which 39 were indigenous. On three different occasions, an average of 14 women traveled to the state capital and stayed for one week at the hotel where meetings took place. The distribution of the "midwife kit" marked the end of workshops[3].

It is worth anticipating here that all the issues and analyses evoked and provoked by this paper derive from an experience as collaborator of the program. Being part of the PTPT in Tocantins entailed a complex process of stages, reports and meetings that have sometimes walked in synchrony and some other times distant from concerns raised along the way. We can say that the driving force of most of the reflections stemmed from the attempt to fit indigenous women into the PTPT; or in other words, the perception of PTPT disengagement by directing actions to this public.

The designation and valuation of the term "traditional" added to certain people and communities is recent in national public policies. Ferreira[4] mentions that this is due to the trends of world development and the initiatives of people and communities to revive local cultures and practices, especially with the arrival of the 21st century.

In the context of the PTPT, the Ministry of Health justifies the adoption of the term "traditional midwife" as a way of valuing traditional knowledge and practices while at the same time characterizing the type of training and knowledge it holds. The inclusion of "indigenous midwives and quilombola" among traditional midwives emphasizes that respect should be given to their ethnic and cultural specificities[1].

A paradox is established when three of the items found in the PTPT are connected: fostering citizenship, respect for ethnic specificities and kit delivery. While public policies aimed at traditional people or communities bring undeniable visibility and are necessary and important tools for the exercise of citizenship, Garnelo[5], analyzing policies directed at indigenous people, warns about the risk of homogenizing the indigenous world to the ways of life of national society, inducing the adoption of values and behaviors of the hegemonic social group. In this context, it is necessary to enquire as to how training workshops and the delivery of the "midwife's kit" can be understood as respecting ethnic specificities or encouraging citizenship.

This analysis does not intend to carry out a comprehensive evaluation of the PTPT from the experience with the Krahô women, but rather a reflection on the impact of some program actions for this public. Understanding how the PTPT translates into the daily lives of villages can provide clues on the effectiveness and achievement of some of its objectives, especially those that refer to recognizing, valuing and reviving the work of midwives; ensuring materials, logistical support and reference network; qualifying and humanizing home birth care.

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Methodology

This paper is part of a larger study that sought to understand some practical implications of PTPT in Krahô women's daily life. To do so, it was indispensable to penetrate intricacies of social anthropology, especially of ethnographic tools. We used a qualitative methodology and built on the concept of culture brought by Geertz[6], understanding it *as an interpretive science in search of meaning*.

Observations, speeches and situations that emerged in the field were thematically categorized and confronted with discourses of the studies focused on health education, public policies, women's health, indigenous health and the collective health field with regard to the impact and effectiveness of PTPT actions in the daily life of women.

We would like to make a clarification regarding the choice of Krahô women as study subjects. Although women from other indigenous ethnicities participated in the workshops, those belonging to the Krahô people prevailed. In addition, the geographic location did not show impediment for the necessary incursions.

Before entering the field, anthropological and indigenous studies were discussed and further analyzed in order to improve the perception of ethnocentric attitudes and to create a prior approximation, not only with the indigenous universe, but also with history and some customs of the Krahô people.

Ethnographic work as disseminated by classical authors such as Malinowiski[7] and Levi-Strauss[8] has been modified over the years, following social and academic changes. One of the great transformations is the current time shortage, which reduces fieldwork and brings the need to explore more specific aspects of societies studied[9]. Trad[9] says that, even if overloads in academic environments and pressure for productivity are real, it is important to question the risks of an abbreviated stay in the field, such as the dissemination of superficial knowledge, which would ultimately characterize ethical nonobservance. Geertz[6] states that a specific type of intellectual effort is fundamental to providing meaning to field experience", which he calls "dense description", usually obtained through immersion in the daily life of the group under analysis, focusing on details and the background of the scenes.

Aware of such challenges, fieldwork was supported by prior planning, but also by the welcoming words of Da Matta[10], reminding us that entering anthropology is something artisanal, requires patience, something that depends "essentially on humors, temperaments, phobias and all other ingredients of people and of human contact". Thus, between August 2015 and December 2016, we performed nine trips to the Krahô indigenous territory, located near the municipalities of Itacajá and Goiatins in the state of Tocantins, with an average duration of four days per trip.

Participant observation and the field diary were the work's anchor, supported by interviews recorded at specific and timely moments and search for secondary data. The observation script was continuously modeled as reflections and attempts to understand some elements emerged along the way.

The fieldwork agenda depended on agreements with women and on the availability of G., a dweller of Itacajá, who became the informant and backbone of the research by gathering a set of characteristics: showing genuine interest in collaborating with the research, being a nursing technician and having worked in the indigenous territory for fourteen years, mastering the native language, having participated in PTPT as escort and women's interpreter, driving and facilitating the motorcycle that was used as means of transportation.

Among the 28 villages registered in the Indigenous Special Health District (DSEI) – Tocantins in 2015, eight were part of the research. The choice was made by the proximity between them, by linkages created and referred by G. After the formal ethical process and authorization from the National Research Committee, the National Indigenous Foundation (FUNAI) and the caciques (chiefs), women who participated in the PTPT were addressed and included in the study following their verbal and written consent. Two of them were also chiefs of their villages; in all, ten women and their families welcomed and supported the study.

Although efforts to understand the local reality from the attentive observation and description have been real, it is worth considering that the contextualization of statements in the discussions that follow part of our view and our way of understanding the world is, therefore, unilateral and questionable.

Respecting interlocutors' confidentiality and anonymity, women and their relatives are identified by initials M1, M2 etc. and P1, P2 etc., respectively, and it will not be possible to distinguish the villages visited in the text. Some words from the Krahô vocabulary have been included and their translations appear next to them between brackets.

Results and discussion

The formal health system and the place of delivery

The structuring of the indigenous health care policy and network has changed over the last decades. The enactment of the 1988 Brazilian Federal Constitution and the 1990 Organic Law of Health were decisive to setting the right to health and citizenship in a more feasible horizon for all Brazilians. With regard to indigenous people, they are decisive milestones in attempts to overcome prejudice and concepts or understanding these people as incapable and, thus, subject to the tutelary regime. Currently, Brazilian indigenous people's healthcare is provided through an Indigenous Healthcare Subsystem (SasiSUS) linked to SUS. The Special Secretariat for Indigenous Health (SESAI) was established in 2010 and is responsible for coordinating the National Indigenous Healthcare Policy and the management of SasiSUS[11]. Since 1999, healthcare covers indigenous people through 34 Special Indigenous Health Districts (DSEIs), Basic Complex, Indigenous Health Homes (CASAIS), Multidisciplinary Indigenous Health Teams (EMSI) and health centers. This model of care built on movements that emerged in the 1980s, based on the search for the right to difference and multiculturalism. Its hallmark is the First National Conference on Indigenous Health Protection, held eight months after the Eighth National Conference of Health in 1986. The event unraveled a discussion on the indigenous health care model and the need for the participation of this population in the formulation of public policies, in addition to inaugurating a sequence of new Conferences that are currently in their fifth edition[12].

This does not mean that the structure provided by the subsystem has satisfactorily met the health needs of indigenous people, nor does it fully incorporate their claims. There are many nuances to reflect on indigenous health care in Brazil and there is a complex debate about SasiSUS functionality, resolution and adequacy, including clear indications that it is still a marginal issue on the agenda of the National Health Policy, since it has undergone different political and operational strategies over the years[5].

Krahô people's care is coordinated by the DSEI-Tocantins and implemented by professionals allocated at the Basic Complex located in the municipality of Itacajá-TO. It has a supporting base in the municipality of Goiatins-TO, a hotel in Itacajá that shelters indigenous people in hospital treatment or in transit for health treatment, 10 health centers in strategic villages that support neighboring villages, 17 indigenous health workers (AISAN), an indigenous nursing technician and three EMSIs, consisting of five professionals (physician, nurse, dental surgeon, nursing technician and oral health assistant), and each team is responsible for a micro-area.

Epidemiological and service data are collected by the Information System for Indigenous Health Care (SIASI) fed in a decentralized manner by districts, complexes and villages[11]. Unlike other national open information systems, in which citizen's access to information is free, SIASI is available only to health managers and indigenous health workers. For the purposes of this research, we obtained data from the Technical Department of Women's Health of the DSEI-Tocantins, upon formal request and after authorization from SESAI.

Data show a population of 3,159 people living in the Krahô indigenous territory in 2015, of whom 56 are identified as non-indigenous. There was no maternal death record in the period 2011-2015 and it was not possible to collect specific figures related to neonatal deaths, since data transmitted are general, which hinders display and analysis in the context of this paper. With regard to the place and type of delivery, a change is observed. In 2012, of the 134 recorded births, 90 referred to home deliveries and 44 in hospital settings, of which seven were cesarean. In 2015, a clear inversion in the place of birth was noted, where, of the 156 registered births, 56 were home deliveries and 100 were hospital deliveries, of which 11 were cesarean. Persistent low cesarean rate even with significantly increased hospital births arises because the Itacajá hospital does not perform this procedure. If the cesarean section is necessary, women are referred to other municipalities, and Pedro Afonso-TO is the nearest hospital some 107 km away. This route comprises a 50 km stretch of unpaved road, implying a journey of approximately two hours. As for birthplace change, the event that coincides with the inverted figures is the significant contribution of physicians in the 34 DSEIs with the beginning of the *Mais Médicos* ("More Doctors") Program in 2013 that brought 340 physicians to indigenous health[13].

The indication that delivery takes place in the hospital has been a frequent request of the EMSI's doctor covering the area visited. According to G., the high number of early pregnancies among

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the Krahô leads the doctor to understand that it is a "very great risk" to give birth to this *craré* (child) in the village, which would lead him to indicate hospital birth to practically all pregnant women. Despite this, the village was singled out as the preferred place of delivery by a significant portion of women participating in the PTPT and relatives with whom a bond was established, but they lamented that younger women were no longer wanting to "give birth to the *craré* in the village. Although the hospital is recognized by some as an important place to "save the woman and the *craré*, it is also a feared place.

We can observe that distance from villages to the city may be a relevant factor to the place of birth. In the nearest and most populous village just 5 km away, home births are rare and on the rounds of conversation with younger women, their prevalent desire was to bear their children in the city. This configuration was not repeated so clearly in other villages, all ranging 30-60 km from the city. In these cases, home birth often appeared as the more comfortable, safer and better option:

Mom take my craré, it's better. (P2- daughter),

It is better in the village, you're at home. (M2)

I will get the craré from my daughter in law, I know everything. (M5).

In the non-indigenous context, shifting the place of birth from home to hospital is well discussed in literature. Although the role of midwifery is as old as humanity, relocating childbirth to the medical sphere about 200 years ago assigned to it new rituals, stakeholders, objects and meanings. Attempts to control the female body and sexuality, the superior and hegemonic academically constructed knowledge, the participation of men into the birthplace setting and technological advances are some of the pillars that sustained the emergence and perpetuation of obstetrics as a new discipline[14-16]. At this stage, health practices relocated from medical institutions are now inferior, inadequate and harmful. Consequently, midwives were no longer welcome or well looked after. Not only because they were midwives, but also because they were midwives and women. The concept of women as inferior, unequitable and defective beings takes on new contours with the arrival of obstetrics and is strengthened[16,17]. Carneiro[16] considers that, while much progress has been made in overcoming theories that undermine and/or subjugate women, this does not extend to childbirth in particular, still addressed as a medical issue and surrounded by a modern and technological imagination.

Thus, even if the influence of the geographical proximity and the way of life of the city in the personal or collective decisions in the village is notorious, it is understandable that G. perceived in the team's doctor this predisposition to contraindicate childbirth in the village.

The social cost of midwifery: where is the gain?

The Krahô social system, its cosmology, rites and the outcomes of contact with the local Sertanejo people have long been the object of interest of anthropologists and scholars, so a considerable and rich collection of bibliographies about these people is available[18-21]. During research forays, frequent encounters with other researchers, photographers and traders led to reflections on the openness of this people to the *kupẽ* (non-krahô) universe. The arrival of electric power was one of the most remarkable events during fieldwork, celebrated by many and viewed with suspicion by some. The final stage of data collection was marked by the full operation of the power grid in all villages and the number of homes with televisions, the most popular and desired household appliance in this new situation, was already significant. Now the *kupẽ* world would always be there, without filters and without having to ask FUNAI's or leadership's permission.

It will not be a great obstacle to apprehend what is heard or seen on TV; the language spoken among the Krahô is part of the Jê family, of the Macro-Jê linguistic group, but most speak and understand well or fairly well Portuguese, especially men. Women have greater difficulty in speaking and/or understanding the Portuguese. Thus, G.'s support was crucial to the research's progress.

The subtleties in the attempted communication also involved non-verbal swings such as the look, the way of sitting, the tone of voice and posture. On one occasion, M2, commenting on the lack of FUNAI agents, said:

They don't come here; they don't sit down with us people like this...like you. (*M2)*

Although non-verbal movements may be intuitive and to some extent involuntary, this comment made one realize the preciousness of posture and the unsaid, especially in a situation where verbal understanding was not complete.

The language barriers had already been perceived during PTPT workshops, however, with the use of active learning methodologies, clay, drawings, puppets and respect for the time and

form of expression of each one, as a result of the experience of years of someone conducting workshops seemed relatively outdated and not so relevant in that scenario. M1's comments give us an idea of how complex this process can be:

... because the kupẽ said: you are very smart, you will have wings to fly, see things ... when I arrived, I spent a week with that thing in my chest, thinking about what was smart ... what were wings to fly? After, my 'pahi' (chief) explained it to me and I understood it was a good thing. (M1)

If in this example a compliment charged with good intentions has not been able to fulfill the role of encouraging and recognizing, in subsequent statements, we can see that the same woman's ambiguous expressions make clear their perception of what was taking place:

In the course, we studied everything, made dolls, materials and learned. I liked it. (M1)

The course was painful to me...I sat all day without writing or reading....I felt like a Kraré… because kraré is a child. You tell them this: What is this? How do you do this? Moreover, they tell you: this is not the way to do it…they take your arm, you sit there…you see and you stay there staring. (M1)

There was a genuine concern of people who conducted the workshops in respecting each woman's time, seeking methods that did not depend on oral or written language, allowing cultural manifestations (such as dancing and music) and accommodating women's demands However, M1 said none of these issues, not even the bond of affection she created with those conducting the workshops, nor expressing that she liked the course concealed the main intention of those meetings: to transform her practice. Ultimately, she was being taught as a child, a *kraré* is taught. After all, it is a matter of putting her practice under review and reshaping it through the parameter of academically constructed knowledge. Although the PTPT emphasizes the importance of negotiating commitments with managers, workshops with midwives are the main event and are most reported and valued moments of the program, which, as Gusman et al.[3] argue, reduces the complex issue of improving homebirth care to the expertise of the midwife.

The stories reported by workshops with traditional midwives place great emphasis on this reshaped knowledge, and terms "empower", "qualify" and "certify" generally support titles and texts[22-24]. A classic example can be found in the title "Indigenous midwives: women from seven municipalities will be qualified by SESAU" of the *Roraima em Foco* news site[23]: the text body reveals that the qualification "aims to intensify reduced mother and child mortality and to extend care to pregnant women and the baby". It is childish to think of improved mother and child indicators by disregarding life conditions and the configuration of the health care network. Therefore, an ingrained naive thought emerges in that it would suffice teaching the right, dominant and hegemonic way to obtain positive results.

This attempt to reshape practice was perceived in the village and its meaning in the Krahô indigenous setting increased to unforeseen proportions when the development of the project was idealized. The first issue felt in the field was related to the categorization of Krahô women as midwives. In fact, the term "indigenous midwives" is included in the PTPT when the MoH justifies that such women are included in the traditional concept of midwife[1]. It so happens that, to Krahô women and their relatives, they were never midwives, but became so after the "course".

The first contact for the purpose of data collection took place in a celebration context of the Krahô indigenous games. Several leaders, men and women from distinct villages gathered in a single village for the competition. Thus, a certain tension settled when G. called women and their husbands to talk about the research. Pressure regarding the salary they were supposed to be receiving, the fact that they had been absent for a week and returned moneyless to the villages was immediately put on the discussion table.

The researcher was seen as the agent who should bring their dignity back, providing financial reward. After long conversations, which went beyond that moment, it was possible to make clarifications that would allow research to flow. However, until the end of the fieldwork, it was common to hear questions about the payment and recruitment of midwives. It was not an easy task to try to answer them. As G said:

When government calls us for a course, there is always a job and a salary. This is what happens with the indigenous health worker, the boatman, the teacher…(G.)

Thus, it should be with the midwife. There were many pleas. With the honorable mention in hand delivered during the seminar that closed the PTPT, M1 says:

We thought now it was a midwife job...you are a midwife now. Nobody never called me midwife… they took me in, but never called me so. They took me because they needed it. The name "midwife" came after the course, where is the money? (M1)

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Are you being paid at all? I received only bad answers! (M2)

She came back without poré (money)! Why do you pay kupẽ and not pay mehin (the Krahô indigenous)? Paré never goes back to mehin, it only circulate among the kupẽ! Why kupẽ can earn salary in hospital and mehin have to work for free? (P2-husband)

The possibility of remuneration for home-birth care by a midwife became a possibility in 1998 with the publication in the Official Gazette of the Union of this procedure within the list of the variable minimum Primary Care (PAB) table[25]. However, payment records are rare and when they occur, they are usually the result of midwife movements and/or specific political actions, as in the case of the "Traditional Midwives of Amapá Project", which provided for the payment of half a minimum wage and survived between 1995 to 2003[26]. If gaining recognition through pay is a far cry for most traditional midwives, this issue is almost unattainable for indigenous women. Issues of an anthropological, structural, legal and political nature will sustain this agenda for a long time, starting with the categorization of indigenous women as "midwives".

Langdon[27] says it is a mistake to set knowledge and practices of indigenous women and even the traditional midwife as a type of obstetrician, a frequent occurrence in state policies, which shows a limited conception of indigenous traditional medicine and the non-recognition of ethnic and cultural plurality. Some authors[27-29] point out that using the rationality of the hegemonic medical model to bring indigenous knowledge and practices closer to the categories practiced and recognized by biomedicine are impoverishing, generate a subordinate relationship and devalue of some indigenous knowledge and practitioners.

The findings of this study are very similar to those of Ferreira[4] and Scopel[28]. The main similarities lie in the fact that "midwife courses" redefined roles and interfered in social relationships. According to M3, the need for *poré* seemed larger than for other women, and the sense of this urgency was conveyed by M2's statement:

When I returned to the village, everyone thought I had poré. All knew that I attended the midwives course. So they say: you attended the course, you are a midwife now, and you must take the krará! When N. was a chief, she said to M3: you must take the kraré from my daughter, you are earning poré! M3 said that she did not have poré, but N. went out and spread the word that M3 was a liar, because she did earn poré! She was upset; this is why she does not like to talk about the course and said that she doesn't want to hear about this midwife stuff if she doesn't receive poré. (M2)

Coimbra Júnior and Garnelo[30] help to reflect on the impacts of transposing "reproductive rights" and gender issues called for in the Cairo declaration to indigenous communities without regard to sociopolitical organization and cultural context. They are assertive when they speak of the need to propose culturally-sensitive intervention models agreed upon with community members to whom the intervention is intended and based on an in-depth knowledge of cultural relationships and codes, under the penalty that such interventions, even if initially based on cultural respect may violate the precepts of a social order that we cannot change.

M3's plea illustrates the nuisance generated by the intervention and the "becoming a midwife":

Let us do what we have been doing it so far. If one is called midwife, all know that she earns a small salary and we don't have any income…so, it's no good if it is just about having a title of midwife. (M3)

There is, therefore, no identification with the "midwife" figure, which would represent a position to be assumed and not something that can translate her skills in childbirth care. Among the Krahô people, as well as in various indigenous ethnic groups, any woman can provide care during birth; practice and knowledge learned in the oral tradition or giving birth alone, "in the bush". M2 was the one who had "taken *kraré*" the most inside and outside her family circle, and in her account of how she became involved with childbirth, she firmly said:

I gave birth alone, in the bushes. I called in my husband to help me cut the umbilical cord, and I said to him: "You didn't make this child? So now, help me out here! (M2)

It is not common to receive delivery care outside of your family circle, something that only occurs when someone comes to ask for help because of some difficulty. Contact with the *kaprô* (blood) of another person makes you sick and turns your skin yellow. This is care that even the youngest need to observe when they are menstruating, and should be the last to bathe in the river. In addition, if something goes wrong during childbirth, the woman may suffer charges of witchcraft or have her reputation compromised. Thus, the logic of determining one or two persons in the village who are a reference in

home birth care, as conceived by the PTPT, does not seem to be adequate to the Krahô social organization. In fact, there was considerable difficulty in registering the indigenous women who would participate in the PTPT, since some said they had attended one single birth. It was then decided to register those who declared that they were willing to attend a delivery when called, on average two per village. Generally, it was the leadership who indicated the women, which meant that many others did not understand why they had not been called:

I took more kraré than M4, but no one came and talked to me. (P3 – sister)

It is therefore assumed that the misconception transcends the selection criteria; it is recognizing that the proposed intervention was not sensitive to the sociocultural conformation of the Krahô people.

Final considerations

Results show that in the social context of Krahô women who participated in this study, the goal of PTPT regarding recognizing and reviving midwives' work was far from being achieved. On the contrary, the fact that there is no salary and job outcome, not provided for in the project, but idealized by the community, had an important impact on villages, with a consequent comparison on how the "government" addresses and values knowledge and *Kupẽ* practice at the expense of village practices. While PTPT does not intend to certify midwives and targets its actions at women who already perform empirically delivery and birth care, it introduced an unintentional new professional category and affected the social order of women in the study.

Ferreira[31] argues that this process of scientific validation of traditional knowledge and the qualification of its practitioners through courses end up shifting knowledge, practices and practitioners from their context to reinstate them in the space of public policies, bringing new meanings and functions. Some changes are not always adequate to the target population. The midwife kit, for example, was not compatible with the needs of these women in the home birth setting. Materials were appropriated within the daily life of villages in a variety of ways other than the idealized by PTPT. However, this debate deserves to be explored further.

With regard to supporting the practices of midwives in order to reduce mother and neonatal mortality, the limited scope of the project should be considered in the face of a situation of obstacles, such as distancing of health professionals, the difficulty in providing care that takes into account the cultural specificities within the scope of the SUS, the political swings to which the country is subjected and social inequality, among others. This study is but a fragment of the PTPT outcome for some indigenous women of a specific ethnic group, and no generalization is possible, even among indigenous people. However, it shows an ethnocentrism that, despite good intentions, needs to be better analyzed in other contexts, otherwise PTPT's rationale will be reversed, belittling practices and knowledge and generating internal conflicts.

None of these questions invalidates the merits of the program. Singling out and advocating for the appreciation of midwives and their health care ways are valuable and necessary actions in the Brazilian context. The study aims to collaborate on this front, pointing out that adjustments may be required along the way.

Collaborations

CR Gusman was responsible for the field research, data analysis and article writing, DA Rodrigues and WV Villela also contributed in project orientation, critical review and essay writing.

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