BIRTHING MATTERS:

Care and Belonging in Black Rural Bahia, Brazil

By

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DECLARATION:

‘I, Laura Caballé-Climent, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.’

To Nico and his journey,
porque filhos são do mundo

ABSTRACT

This thesis seeks to illustrate black rural communities' struggle for survival in Brazil and a future through the lens of care, focusing on reproduction generally, and the process of birth, specifically. Based on 14 months of ethnographic fieldwork in the region of Baixo Sul in the state of Bahia, I engage with women and describe how these issues unfold in two spheres: their everyday relations in their rural communities; and their interactions with the health care facilities where they officially receive maternal health care.

Drawing on extended participant observation, semi-structured and life-story interviews, I describe care practices at multiple scales and multifaceted angles, attending to the diverse ways in which care may manifest – informed by the wider sociocultural and political contexts – to ultimately reveal both, sites of 'precarious existence' and fissures of 'radical possibility' for/by black rural women.

Part One, on Belonging, illustrates the many expressions of violence and death in Brazil at national and local level, and how these can impede a sense of futurity and belonging. Equally, I attend to life, and focus on how this is cultivated in black rural communities, looking at the ways in which both these contextual dimensions affect notions and processes of reproduction for local women.

Part Two, on Birthing, scrutinises the official practices of each maternal healthcare service and women's vernacular experiences in the prenatal, birth and postnatal periods. By pointing to the dynamics of visibility and invisibility, neglect and over-intervention, I allow for particular techniques, practices, and ideologies that (re)produce national and local regimes of gender and racial domination to be exposed.

The overall argument of these two sections links a colonial past to an allegedly democratic present, where the status of the Afro-Brazilian population remains a state of quasi-citizenship, challenged by a continuous creative strive to belong.

Keywords: Black rural, maternal healthcare, care, quilombola, reproduction.

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This thesis is the completion of a journey. The closing of a circle.

The completion of this circle involves many people in unique ways and in diverse places at different times.

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Hemos completado el circulo gato!! (We have completed the circle!!).

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Chapter One

INTRODUCTION

Pregnant in Jaboticaba

The sun strikes with glaring force. It is September 2018 and after months of rain and cool breezes, the heat has caught the coastal town of Jaboticaba by surprise. As on any ordinary afternoon, people move about doing their errands, but today their bodies seem to move sluggishly, they are hesitant and disoriented.

A group of women assemble under the shade of a building. They are waiting for transport to their distant *comunidade* (community) in the rural area. Squinting in the sun, I detect some familiar faces. Approaching them, I sense a subtle, dispirited mood. Irasi's words pour from her mouth like water from an open tap:

> *… I am hardly sleeping these days. I feel panicky … any sudden sound can throw me off … we are all panicky …*

Tiny bubbles glisten on her forehead under the blazing sun. As she speaks, she strokes her pregnant belly, catches her breath, and wipes the sweat from her brow with a worn-out hand towel.

> *… It was 3:00 am approximately, it was pitch black. A sudden rush, muddle of sounds and movement. Screams ordering to evacuate the house. The kids' cries. And then the shots, one after the other. We don't know how many, there were many … at that moment … it was pitch black … but the whole community awoke. The body was bundled up with sheets and thrown inside the boot of the police car. Now the room remains empty. Blood stains have been washed away but nobody wants to sleep there anymore … Tatu [a young teenager from the community] is not well, his epilepsy has come back very strong, he feels fraco (weak), he has bad thoughts. I tell him to pray, every night he needs to pray. That boy killed, he was only sixteen-years-old!! Just like Tatu. Ayyy minha filha, mas ele era bandido!!* (Ohhhh!! My darling but he was a bandit!!)

***

The story of this thesis begins with an incident that occurred a few weeks before I completed fieldwork in the region of Baixo Sul in Bahia, after 14 months of living in Brazil. Beginning the account of my research with this disturbing scene is deliberate, and it is a decision that has not been taken lightly. My own anxieties about anthropology and representation, and the dangers of contributing as an ethnographer "to a voyeuristic pornography of violence" (Bourgois 1995, 18), made me hesitant to preface my introduction in such a way. However, my hope is that on the journey through the following pages this scene will be ingrained in the reader's memory. The image of a pregnant woman expecting *life* while witnessing a youth's violent *death*, (perpetrated by the State with impunity), conveys a sombre litany, a song heard far too often in the peripheral areas of Brazil. It is one example of many, and together they form a common backdrop; one that both traverses and goes beyond the role of immediate health services and clinical encounters, national targets and internationally set goals. This research on maternal health took place against this setting.

The image in this opening vignette registers a perhaps unrecognised dimension in reproduction and maternal healthcare analysis; that, like so many images, may not need an introductory interpretation because its expressive power holds us captive (Stevenson 2014, 13). Still, in an attempt to decode this scene, I do not risk much when contending that it alludes to a juxtaposition of 'postcolonial social disorders' (Comaroff and Comaroff 2006), that ultimately reveal the ghostly presence of the enduring effects of colonial legacies, manifest still in diverse settings, qualities and scales. These legacies further merge with current global neoliberal undercurrents that illustrate the brutality of Brazil's internal contradictions. However, amid this grim scenario, Brazil is equally propelled by compelling surges of resistance and imagination that break free from these lethal internal pulses.

This thesis aims to capture and frame these tensions in the realm of 'care' in general, and 'maternal health care' in particular. The ethnographic material presented in the following pages engages with these frictions by asking, what form does 'care' take in the context of reproduction in black rural Bahia? How is care enacted in diverse settings and what are its outcomes and possibilities? These questions place women at the centre and are examined within two sites, one of which is in their everyday relations in their rural communities, while the other calls on their interactions with the health care facilities and surrounding structures where they officially receive formal maternal health care.

These inquiries largely engage with the complexity of human reproductive processes and as such encompass broader discussions in feminist anthropology related to issues of equity and justice, raising urgent topics about citizenship, power and ethics in contemporary democracies. The following sections explore these issues in depth.

Birthing and Caring in times of transition

The issues that arise from birthing and caring in black rural Bahia are manifold. One way to begin to unpack them is to stress the multi-layered importance of reproduction. The reproduction of life includes all life-maintaining and life-making activities and the institutions that support these, including simultaneously, the affective and material dimensions. Giving birth is the most evident life-making activity, but in order to maintain that life, and lives in general, other factors and networks that are absolutely essential to society (Jaffe 2020), such as social reproduction, come into play. For instance, Nancy Fraser emphasizes that social reproduction "supplies the 'social glue' that underpins social cooperation. Without it, there would be no social organization—no economy, no polity, no culture" (Leonard 2016).

Consequently, reproduction – in all its complexity – encompasses and reflects current general public and scholarly debates around broader issues, such as democracy, citizenship, racial and gender justice, neoliberal trends and global health. Laura Briggs (2017), in her analysis of public policy and economics in the USA, has recently reminded us that reproduction (again, in all its complexity), lies at the core of all politics and that many of the latest shifts in reproductive politics, such as neoliberal welfare reform, have transferred the responsibility for reproductive work to the individual. This overburdens women and disadvantaged communities, and these shifts are ultimately propelled by "white people working to maintain the racial hierarchy" (Dahl Crossley 2018, 747). Additionally, feminists writing from a Latin American perspective invite us to reflect on the need to examine reproduction from its most precarious sites, not only as an ethical obligation but because of its transformative potential (Vega, Martinez-Bujan and Paredes 2018, 16). Accordingly, reproductive justice approaches, conscious of the complexity involved in questions of reproduction, emphasize the critical importance of linking reproductive health and rights to social justice issues such as poverty, housing and welfare reform, to name a few (Price 2010). This entails "a radical, inclusive, and intersectional political analysis" where reproductive health is not split from key survival issues, and where rights are not just framed around having or not having children, but include being "able to parent children in safe and healthy environments" (Oparah and Bonaparte 2016, 15).

In Brazil as elsewhere, childbearing also mirrors and reproduces political and economic orders, as well as different sociocultural *milieus*. Research on the anthropology of reproduction has explored this tension between the reiteration of what has preceded, what is in-the making, and what has produced new outcomes (Van Hollen 2003; Pinto 2010). Current research into childbirth in Brazil contends that the country is in the midst of an obstetric paradigm shift, propelled by Brazilian social movements and led by the government through a series of initiatives. These have been implemented in order to tackle deeply concerning issues such as alarmingly high rates of caesarean section, maternal mortality, and persistent obstetric violence (Williamson 2019). These initiatives and troubling statistics do not reach or affect the population equally and, in a gender-biased country that is fundamentally structured by race, questions around intersectional health inequities remain urgent (Caldwell, 2017).

Quasi-citizenship: maternal health and vulnerability

In the context of structural and institutional vulnerability, Afro-Brazilian women move across multiple terrains of social experience in which their sense of belonging may be hindered, reinforced or contested, depending on how they 'come to matter'[1] through particular practices of care. In this thesis I do not provide an *a priori* definition of care or an overall sealed meta narrative. Instead, I search for vernacular expressions of care in order to explore its diverse manifestations in a period of socio-political transition in Brazil. What do these manifestations of care, in their myriad forms, tell us about contemporary Brazil?

As Elisabeth Povinelli (2011, 160) reminds us, "the *arts* of caring for others always emerge from and are a reflection on broader historical material conditions and institutional arrangements." The historical forces at play that underpin this thesis illustrate the transition of an era. Initiated in 2002, this period was marked by the social achievements of the *Partido dos Trabalhadores* – PT (Worker's Party) administration, a project that culminated in what many considered a *coup d'état* in 2016, when interim president Michel Temer showed full commitment to rapidly advancing an exclusionary form of neoliberalism (Saad-Filho and Morais 2018, 3).

As an illustration of this gradual decomposition, *The Lancet* published a short piece under the title "*Brazil's health catastrophe in the making*" where Doniec, Dall'Alba and King (2018) alerted readers to the consequences of the government's implementation in December 2016 of

[1] For instance, as individuals with specific lives, or as an anonymous decontextualized patient, or as a number. I borrow this expression from Lisa Stevenson (2014).

one of the harshest sets of austerity measures in modern history: the constitutional amendment PEC-55. This amendment froze the federal budget, including health spending, at its 2016 level for the next 20 years. In their piece, the authors review some of the long term implications of a neoliberal model of health care, including the exacerbation of already existing socio-spatial and socioeconomic inequalities in health, as well as the high homicide rate, and argue that "these actions show that the Brazilian Government is backing away from the core principles of universal health care, despite it being a constitutional right" (Doniec, Dall'Alba and King 2018, 731).

It is not difficult to foresee the impacts of the aforementioned measures. However, when I arrived at my field site in September 2017, the immediate consequences had not quite materialized. Nevertheless, the socio-economic turmoil was evident. A severe impasse for Brazil was in the making.

In *The Lancet's* article, the authors correctly point to the relevance of healthcare as a constitutional right in Brazil. This right is an undisputed marker of Brazilian democratic forces for an inclusive citizenship. Thus, the *Sistema Único de Saúde* (Unified Health System, SUS), which is based on the principles of universal and equal access to health services (Caldwell 2017, 6), plays a fundamental role in accessing full citizenship. An expert scholar in healthcare in Brazil, Lily Caldwell, has pointed to the limitations of a universal healthcare approach in terms of gender and race,[2] affirming that equality is emphasized in access but overlooked in outcomes (2017, 178). Certain tensions drive her assertion.

Povinelli, reflecting on the lethal conditions of late liberalism/neoliberalism and social zones of abandonment, contrasts spectacular forms of death – those we are horribly accustomed to witnessing in Brazil – with the slow, mundane processes of decay. These quasi-events are "chronic and endemic, infectious and cumulative, not spectacular and catastrophic" (2011, 144). They are nondescript moments. Gradual and corrosive, they are difficult to pinpoint because they belong to the general condition of human social life; they are "everywhere, all the time" (Povinelli 2011, 144). They also impact health care: "*Missed the transport to town,*" "*Too many people waiting in the queue,*" *"The doctor did not come in today,*" "*No money to pay for the scan,"* and so on.

Thus, when strung together, quasi-events can reveal the cadence of decomposing worlds. Inserted in the "wobbly order of the everyday," quasi-events are made of uneventful forms of

[2] There are two parallel programmes within the healthcare system designed for gender (PAISM) and for the black population (PNSIPN) (Caldwell 2017, 178).

obstacles and misery (Povinelli 2011, 144). Those who are abandoned under neoliberal forms of governmentality will tend to be blamed, and may even blame themselves: "*Too many kids,"* "*A poor diet," "Too late for the appointment," "Too few prenatal visits."*

Under the rubrics of choice and responsibility, their socio-economic conditions will be perceived as the accumulation of their individual behaviour. The pernicious backdrop will remain agentless, ticking past unnoticed. Povinelli (2011, 153) invites us to reflect on the ways in which we can sketch out the 'slow rhythms' of this lethal violence. I propose to do this through an enquiry into maternal healthcare by asking: What are the quasi-events that encircle and penetrate reproductive and maternal healthcare scenarios for black rural women?

One way to capture and read the expression of this is by looking at locations that conjure and represent both: the key sites of democratization and the marginal zones of vulnerability and abandonment, as when, for instance they manifest in the articulation of a precarious network of assistance in maternal healthcare. In this thesis, I contend that through maternal health care, black rural women are simultaneously excluded and included from a sense of citizenship and belonging. These spaces reinforce vulnerability and precariousness, meaning women are placed outside of, and beyond, the realm of citizenship, while concurrently the ability to access healthcare can give them a sense of belonging and inclusion. These seemingly mutually exclusive practices perversely reinforce the racial and gender order and both confirm and inform black rural women of their place in society. Consequently, maternal healthcare reflects this ever-present contradiction in the Brazilian democratic make-up, which is a gendered and racialised regime that has mastered the cunning art of reconciling the condition of quasi-belonging.

Battling Democracy: black lives at stake

Let us return to the ethnographic vignette offered at the beginning of this introduction: through the pregnant woman's testimony we witness the rippling effects of the disturbing killing of a young boy in his community. Apart from the devastating outcome, I am concerned by her choice of words, which invoked the figure of a *bandido* (a thug) "*But he was a bandit,*" she said. This simple statement, at some fundamental level, vividly captures the way in which clarification and closure are summoned on this brutal assault. It works as a final resolution, foreclosing the many questions we might otherwise have about this deadly event, such as concerns about the life conditions that led him to a life of banditry. This *manicheist* vision that divides the world into rigid poles of good and evil, roughly translating as a "bad victim" versus

a “good victim” (James and Alves 2018, 356), has been well documented in Brazil and is fully integrated in the national imaginary (Caldeira 2000).

The effects of these logics, which are far reaching, are constantly reinforced by the Brazilian media and are deeply engrained in current discourses on ‘the war on drugs’ and ‘the fight against crime,’ extending even to the social imaginary of those who are stigmatized by this narrative and who are more likely to be victimised as a result (Leite Lopes 2017, 36). This logic works through the construction of a clear enemy, justifiably devoid of rights and whose life is logically disposable, illustrated by the Brazilian expression “*Bandido bom é bandido morto”* (a good thug is a dead thug). This ‘killable subject’ corresponds to a specific profile: black, young and impoverished. An omnipresent domestic threat that constructs black youth as “enemies of civil society” (James and Alves 2018, 355) proves to be another expression of Brazilian racial domination through the deployment of racialised policing practices.

Situated as they are in a time of transition, the narratives gathered together in this thesis take place in a country in the midst of a socioeconomic and political crisis. In a Brazil ridden with corruption scandals, political chaos and an overwhelmed and depressed economy, already deep-seated schisms have re-emerged with force alongside unprecedented levels of violence (e.g. Foggin 2018). Brazil has also been swept up by the rise of global neoliberalism, which fosters individualism and consumerism (e.g. Saad-Filho and Morais 2018).

Given the context, authoritarian trends have been exacerbated, and both international and national observers have questioned Brazilian democratic viability. These tendencies were crystallized in the rapid deterioration of democratic discourse instilled by the far-right candidate’s unapologetic and aggressive rhetoric of racial supremacy and violence. Based on the exploitation of – the already well established – internal enemy figure (the *bandido*) in the nation’s imaginary, he openly demonised black Brazilian communities and other groups (queer, indigenous and women), thus legitimizing the use of violence against them (Bledsoe 2019; James and Alves 2018). The devastating materialization of these dynamics was epitomized in a political femicide, the assassination of Marielle Franco, in March 2018. She was an elected Rio de Janeiro City Council woman from the *favela*, queer, a mother and a black political activist. Her brutal (still unresolved) murder was a ritual killing of domination that sent a clear

message[3] to all those challenging the 'status quo' of the master's house (Souza 2019). It was an assertion that for the Brazilian nation, their lives remain expendable.

What does this scenario tell us about Brazilian democracy and the value of Afro-Brazilian lives? Authors, such as Brazilian anthropologist Jaime Alves (2012, 2016, 2018), when reflecting on Brazilian liberal democracy, have firmly argued that there is no space for the black population in Brazilian democracy. Alves contends that in Brazil, law and democracy are reified as normative universal categories, but the structural position of black lives within the regime of rights reveals the impossibility of this project (Alves 2014, 152). The positioning of the black population within the Brazilian racialised regime of citizenship indicates the ontological impossibility of fully participating in the nation as a racially democratic 'imagined community,' because it only allows black membership through a pathologized regime of power (Alves 2012, 32) that renders them 'disposable.' Brazil was, and remains, one of the most unequal countries in the world and is characterized by a mainly white male minority, who have historically devoured the benefits of growth. This group secured their position by seizing political power where, based on categorical exclusion, leadership can only be exercised by their own kind (white and male). These actions are, by definition, "incompatible with a common citizenship" (Saad-Filho and Morais 2018, 1).

Today we know of Brazil's dramatic shift to authoritarian rule, following the presidential election in October 2018. We are also aware of the on-going rise in extreme poverty (e.g. IBGE 2018). Still, in the first decade of this century, Brazil was perceived for a short moment as a major democratic global player. Emerging as part of the BRIC (Brazil, Russia, India, China and South Africa) economic group, Brazil pursued policies that involved income redistribution, an increase in social programmes, the implementation of affirmative action and the social reconfiguration of the State that became more plural by absorbing non-governmental organisations (NGOs) and social movements. Similarly, a few key actions in global health diplomacy, such as the establishment of the Brazilian National AIDS programme, granted the country a new global status, whereby it won UNESCO's Human Rights and Culture of Peace Award in 2001, and the Gates Award in 2003 (Lee and Gomez 2011, 63).

[3] See: King, Shaun King, Shaun. 2018. "The Assassination of Human Rights Activist Marielle Franco Was a Huge Loss for Brazil—and the World," *The Intercept*, March 16, 2018 [online]. Available at: https://theintercept.com/2018/03/16/marielle-franco-assassination-brazil-police-brutality/

The recognition of Brazil as a major democratic nation was further confirmed by the invitation to host high-profile international sporting events: the FIFA World Cup in 2014 and the Olympic and Paralympic Games in 2016. The government expected that holding these events would help to consolidate a new image of Brazil on the world stage. It did not work quite that way, but the efforts and resources invested in pursuing this image were undeniable. Perhaps this is what led some scholars, such as Luna and Klein (2014), to adopt a triumphant language about Brazil "as a model democracy" (cited in Fischer 2018, 397), or political analysts such as Wu (2010) calling it "a democratic revolution," (cited in Saad-Filho 2013, 661).

Though today we can read these statements as "quintessential Brazilian irony" (Fischer 2018, 397), the following questions remain relevant and may even help us understand some of the underlying forces that have brought Brazil to the alarming situation it is in at the time of writing: what is at the core of this State that has projected itself globally as a modern liberal democracy that signs up to commitments, and internally has promoted socially inclusive policies while continuing to annihilate its own youth and slowly kill part of its population? Is the present cancelling the future and reproducing the past?

Intellectuals and activists who posit structural critiques of capital and white supremacy have theorized and illustrated the way in which liberal democracy has consistently violated black lives (James and Alves 2018, 350). As rightly claimed, in Brazil the "paradox of *granting some rights and denying life* itself was never structurally addressed by liberals or progressives" (James and Alves 2018, 349), because they never challenged the anti-Black [4] structures within liberal democracy (James and Alves 2018, 348).

One way of making the nature of this lethality irrefutable is by relying on numbers. Statistics reveal these economies of death. They render visible the deadly interpellation and ongoing discrimination of racialised subjects in Brazil. For example, data from the Brazilian Institute of Geography and Statistics (IBGE) shows that poverty in Brazil has a colour: among the poorest 10 percent of the country 75.2 percent are black.[5] Between 2007 and 2017, the homicide

[4] Alves and Costa Vargas (2020, 646) define antiblackness as "a shared set of assumptions and their corresponding social attitudes and institutional practices that dehumanise Black individuals, thus rendering their lives less valuable and disposable […] antiblackness provides added explanations for economic and social exclusion, as well as social and physical death […] Antiblackness is not the only explanation for social exclusion, but it is a fundamental aspect of it."

[5] Since 1940 the IBGE has employed the categories *Branco* (white), *Pardo* (brown), *Preto* (black), and *Amarelo* (yellow or of Asian ancestry), adding *Indıgena* (Indigenous) in 1991. These statistics correspond to the

rate for non-black women grew by 4.5 percent whereas for black women the rate increased by 29.9 percent (Cerqueira et al. 2019, 39). In 2017, 75.5 percent of total homicides were of black individuals (Cerqueira et al. 2019, 49). Unemployment figures show that 64 percent of the unemployed in Brazil are black, with informal work reaching 47 percent (IBGE 2019). In 2018, the figures that looked at black and white households living without garbage collection showed 12.5 against 6 percent, while those without water supply were 17.9 against 11.5 and without sanitation 42.8 against 26.5 percent respectively between black and white populations. These figures translate into greater vulnerability and exposure to disease vectors (IBGE 2019, 5). Furthermore, despite constituting 55.8 percent of the total population in Brazil, blacks represent 24.4 percent of the federal deputies and 28 percent of the state deputies elected in 2018 (IBGE 2019, 11). Distortion in terms of representation also appears in the judiciary, with less than 18 percent of its members being black (Estarque 2018). In terms of incarceration, 64 percent of inmates are black (Moura Silva 2017, 31). The levels of illiteracy in white and black rural populations are 11.0 and 20.7 percent respectively. Finally, with reference to the arts, an investigation undertaken by the National University of Brasilia (UNB) showed that of all Brazilian books published between 1965 and 2014, only 10 percent were written by black authors. Of all the characters portrayed in national literature, 60 percent of the protagonists are male and 80 percent white. In terms of cinema, research from the State University of Rio de Janeiro (UERJ) tells us that of all the national blockbusters released between 2002 and 2014, only 31 percent have black actors, of which the majority are usually portrayed as criminals or impoverished people (Oliveira 2017).

These are the indexes where biopolitical and necropolitical power converge, creating "forms of social existence in which vast populations are subjected to conditions of life conferring upon them the status of dead" (Mbembe 2003, 40). Some scholars have argued that in these 'necro zones,' premature and preventable death is a "predictable and constitutive" aspect of Brazilian democracy (James and Vargas 2012, 193) and as such it *comes as no surprise* (Stevenson 2011, 7). This disregard, and the disparities that these numbers demonstrate (whether emerging from direct State action or energized by its negligence and abandonment), elucidate the intersections of life and death. Biopolitics as the politics of *faire vivre* and *laisser mourir* – foster life and let die (Foucault 2003) – show the ways in which governments intervene in the administration of life as, for instance, in the production and management of health through public health

categories of brown and black put together. For a full discussion on the debates around census classification in Brazil, see: Loveman, Muniz and Baley 2011.

programmes. This biopolitical care, Lisa Stevenson argues, is characterized by "a kind of indifference," because what matters is *the State's exercise of maintaining life,* rather than lives in themselves. Consequently, it is a kind of regime that manages lives while simultaneously awaiting the deaths it indifferently attempts to prevent (Stevenson 2011, 7). Brazilian anthropologist João Costa Vargas (2010) frames genocide as part of a constellation of phenomena that encompasses multidimensional aspects ranging from police terror, lack of economic opportunities and precarious healthcare, to high infant and maternal mortality. He terms this 'the genocidal continuum' (Costa Vargas 2010, 50), where "contemporary forms of subjugation of life to the power of death," namely the implementation of necro power (where race regulates the distribution of death), are manifested in concatenated ways (Mbembe 2003, 39). Thus, it is possible to establish a bio-necro conceptual collaboration by acknowledging "biopower's direct activity in death, while remaining bound to the optimization of life, and necro politics' nonchalance towards death even as it seeks out killing as a primary aim" (Puar 2007, 35).

This "everyday drift" towards premature and preventable death is not always obvious and observable unless it is "compact and eventful" (Povinelli 2011, 145/153). Numbers can make the erasure of these bodies visible; they give evidence of political decisions regarding equality and justice and about whose lives count and whose do not (Wendland 2016, 61). But not all the elements of life that matter can be measured and counted.

Povinelli (2011, 153) makes this critical point:

> Yet the deployment of a statistical imaginary to awaken a slumbering critical public and reason faces a central paradox. By transforming the invisible, dispersed, and uneventful into the visible, compact, and eventful, statistics obliterate the very nature of this kind of death.

One of the premises of this thesis is that, by addressing this tension from the perspective of reproduction and maternal health and through approaching care practices at multiple scales and from multifaceted angles, other underlying currents may be revealed. Thus, making links between its qualitative and quantitative aspects and pointing to the contrast between visibility and invisibility, life and death can usefully reveal the nature of Brazilian democracy and the way in which the State functions. For instance, contemplating not only numerical maternal health outcomes for the black population (i.e., the high rate of maternal mortality and morbidity), but also other dimensions that can be considered 'maternal death,' such as when

offspring are killed or live with the daily threat of death. This can help us grasp the quasi-events that permeate the everyday in these zones of vulnerability and abandonment, because as Povinelli (2011) argues, it is in the invisible and uneventful where new possibilities for life can be harboured.

Reproduction in Black rural Brazil: an unattended field

Brazil is structured around hierarchy and difference. This thesis offers important ethnographic material to help us understand how on the one hand, the ways in which interlocking discriminatory spaces marked by gender, race, socioeconomic class and geographic location have come to condition access and delivery to maternal healthcare for black rural women, and on the other hand, how these same women mobilize spiritual, cultural, and legal-administrative resources to grapple with inequality and foster life.

The thesis focuses on a rural area in the north eastern state of Bahia, a place occupied by a population that has historically been excluded and is therefore characterised by precarity and neglect. The images of infant undernourishment, death, and extreme poverty depicted in the renowned ethnographic account of rural Pernambuco in northeast Brazil by Nancy Scheper-Hughes, published in 1992 (based on fieldwork started in the 60s and continuing through 80s), often came to mind as my interlocutors spoke about *os tempos ruins* (the bad times). As a teacher from one of the communities in the rural area summarized: "*Here, it used to be all 'abandono'* (abandonment)." Although still far from ideal,[6] the conditions of rural life and health services in Brazil have improved in the last two decades, which has been well reported in quantitative studies (e.g Coimbra 2018). Nevertheless, research using ethnographic methods to investigate health in black rural Brazil continues to be relatively rare compared to their counterparts in urban areas, regardless of the evidence registering low quality healthcare in most black rural communities (Olivera 2003; Freitas el al. 2011, Marques et al. 2014). In addition, there has been little empirical research into maternal health in historically marginalized black rural communities, especially in the case of the quilombola (Silva Souza 2018), which are the main black rural communities appearing in this ethnography. Coimbra Jr, from the National School of Public Health Fiocruz, has called attention to the important ways

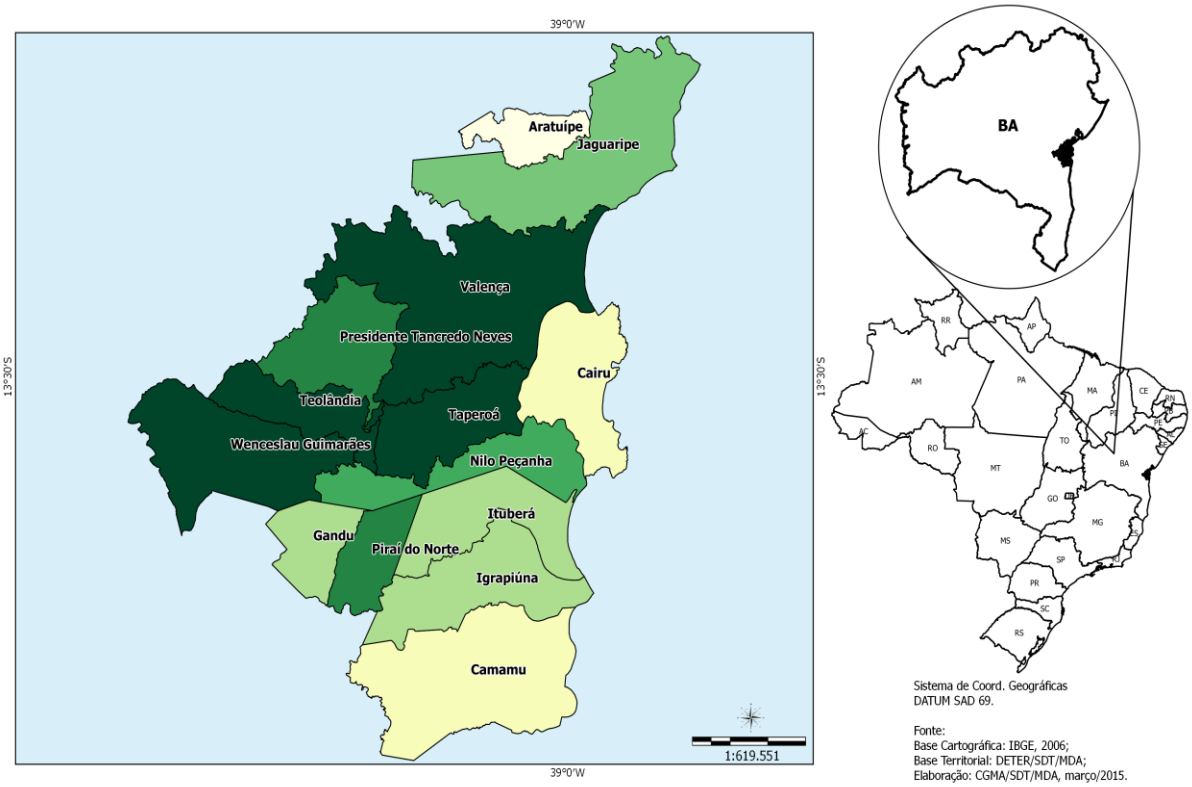
[6] For example, a study on the quilombola population in 2007 showed that the percentage of children under five years old who were undernourished was 76.1 percent higher than the general Brazilian population and 44.6 percent higher than the rural population (Brasil 2007). Data collected in a rural area of Bahia in 2015 reaffirmed this by establishing a higher prevalence of food insecurity among quilombola communities compared to other rural Brazilian populations at 35.3 percent, from the north eastern region at 38.1 percent and in Bahia at 37.8 percent (Silva et al. 2017).

in which understanding the health situation of rural populations in Brazil is key for the design and implementation of more adequate public policies in areas that remain "largely unknown and neglected" (2018, S2).

Furthermore, most anthropological research in black rural communities has focused on the defence of land and territorial claims and the corresponding political struggles. In this thesis, I channel the conversation towards new avenues of political debate by focusing on 'care' practices as they manifest in reproduction and childbearing for, and by, black rural women. This allows for particular techniques, practices, and ideologies that (re)produce national and local regimes of gender and racial domination to be exposed. This is important to help decolonise forms of governance that structure the health system and can further illuminate the links to other global expressions of gendered anti-Black violence. This includes the high level of maternal mortality among women of African descent, which is not only unique to Brazil but, alarmingly, part of a transnational pattern. Thus, I situate the experience of childbearing in black rural Brazil within larger discussions of the conditions and the struggle for life in the African diaspora experience.

As emphasized in the previous sections, this thesis is grounded in long-held feminist positions that both reproduction and childbearing are political. Given the historical, structural, and social vulnerability surrounding black rural women, it is critical to make ethnographically visible their manifold interconnecting strategies for survival and self-definition. These include their contribution to the maintenance of life in their communities as political actions that clearly elucidate the way in which those "who are socially dead are also politically alive subjects" (Alves 2018, 13). Likewise, it is imperative to dismantle subtle and overt discriminatory practices and narratives that have historically placed Afro-Brazilian practices and epistemes in subaltern positions by emphasizing how these resources are mobilized to create resistance; for example, through notions of *memória* (memory) and *ancestralidade* (origin) in black rural women's experiences as sites of radical possibility.

Mapping the Baixo Sul: land and life in time



1. Map of Baixo Sul and its 14 municipalities 2. Map of Brazil/State of Bahia/Baixo Sul

The state of Bahia, celebrated as the 'Black Mecca of Brazil' (Williams 2013), is situated in the northeast region of the country. Walking through the streets of its coastal capital, Salvador, any visitor can easily perceive a strong and lively African heritage. With 80 percent of the population self-identifying as black (IBGE/BA 2019), Salvador holds the largest Afro-descendent population in the world outside of Africa. Of great historical importance and stunning beauty, Salvador was the Portuguese empire's capital in the Americas (until it was replaced in 1763 by Rio de Janeiro), and it played a key role in the Atlantic economy (Reis 2003, 16). More than three million enslaved Africans were taken to the sugar plantations in the northeast of Brazil, with Bahia being considered one of the main Atlantic slave markets (Farfán-Santos 2016, 29). Today, Salvador offers a contrasting landscape with a glowing seaside, rundown decadent colonial buildings, and a contemporaneous vicious racial geography that generally divides the lighter skinned population into high-rise buildings (known as

condominios) and the black population into clusters of *areas faveladas* (precarious neighbourhoods). A geography of death and privilege.

Leaving Salvador by ferryboat towards the Ilha de Itaparica (this is the most common way to reach the region of Baixo Sul from Salvador), one is struck by the magnificence of the Bahia de Tudos os Santos (Bay of All Saints). For Africans in the diaspora whose ancestors were forced to cross the globe, the waters of the bay – where many of them landed and were later distributed to other ports of the Americas – are a significant part of black heritage in the Americas, representing the deadly crossing of the Atlantic Ocean during the slave trade (Perry 2013, 8). The bay embraces the inland region of the Recôncavo, where one of the most important slavery driven sugar economies of the hemisphere flourished during the 16th century (Reis 2003, 16), leading to the formation of a territory predominantly black in its "cultural practices and historical memory" (Farfán-Santos 2016, 29).

Extending south from Ilha de Itaparica along the coastline to Rio de Contas, the region of Baixo Sul encompasses a territory of 125,642 km^2, with a population 379,384 inhabitants (IBGE 2018) divided into 15 municipalities. The sociohistorical, cultural, and demographic profile of Baixo Sul resembles that of its geographical neighbours. The economy was based on the exploitation of enslaved Africans, with some regional economic differences. For instance, in Baixo Sul, sugar plantations were not developed. Inefficient government, bad soil for sugarcane, strong resistance from the native populations (the Aimores), and the presence of Jesuits, were some of the reasons (Dias 2007, 10). Instead, during the 16th and 17th centuries, Baixo Sul played a secondary but important economic role as a producer and supplier of subsistence food crops, especially *mandioca* (manioc), which was transformed into *farinha* (flour), a basic staple food for enslaved groups, and the rest of the population (Silva 2013, 78). Later, during the 19th and 20th centuries, Baixo Sul continued to supply manioc, but now to the southern *cacau* (cocoa) plantations. In addition, the opening up of the Atlantic forest for cultivation was accompanied by timber extraction and its commercialization (Renato 2016, 54).

3. Cassava Mill
Oil on canvas by Modesto Brocos Gomez (1892)

4. Cassava Mill, quilombola community.
Photo by the author (2017)

Today, the *Mata Atlântica* (Atlantic forest) is one of the world's threatened *biomes*. Covering the luscious landscape of Baixo Sul, travelling through the territory along the main road (BA-001), the speed bumps and a badly kept track enable bus passengers to appreciate the infinite tones of exuberant green. To the expert eye, this view reveals a diverse production of family-based agriculture: one can easily see a great deal of *aipim* (manioc) and *seringueira* (rubber trees), as well as many fruits such as *cupuaçu* (cupuassu), *mamão* (papaya), and rambutam. A large number of *dendezeiros* (palm) groves confirm this as an 'Afro-Brazilian landscape' that residents continue to reproduce, represent and market (Watkins 2015, 15).

From time to time, small pastel painted Portuguese churches preside over the highest hills, announcing the arrival to a new town. Mangroves grow in river mouths where *comunidades beiradeiras* (shore communities) gather their livelihood. Meandering streams meet estuaries, and on their way to join the sea, these watercourses cut through the land, drawing numerous undulating aquatic blue pathways together. Upriver, there are abundant freshwater waterfalls. The beauty of Baixo Sul is truly arresting and tourism has prospered in recent years with conflicting results. In many cases, the development of tourism has threatened the land and the natural resources of the areas historically occupied by black rural communities; these natural resources are key to their socioeconomic reproduction (Renato 2016, 72).

This dense forest and complex maze of waters fostered the proliferation of numerous maroon (quilombos) enclaves during colonial times (Renato 2016, 53). This geography of intricate freshwater channels and numerous beaches also provided an ideal alternative for the arrival and further transportation of the clandestine slave ships after the prohibition of the slave

trade in the 1850s (Santos 2017, 23). The history of Brazil, and Bahia in particular, is marked by uprisings and black resistance, as is the region of Baixo Sul (See Schwartz 2001; Silva 2000; Reis and Silva 1989). Resistance took many forms, from open and direct violent revolts to other shrewder, more subtle and mundane forms confirmed by, for instance, the use of cultural-environmental knowledge to create 'landscapes and places of memory,' thereby inscribing Africa into the New World environments as the abundance of *dendezeiros* (palm) groves attest (Watkins 2015, 17).

After the abolition of slavery in 1888, and whether originating from *negros alforriados* (freed blacks) or quilombos, black rural communities in the region continued expanding throughout the territory as a black peasantry, developing networks and progressively integrating into the local economy by supplying local agricultural products, as well as seafood and fish (Renato 2016, 54).

Nowadays *cacau* (cocoa) is a key feature of the local economy and a symbol of the land struggles that took place in the region during the 20th century. The rural groups formed by black populations in Baixo Sul were put under massive pressure due to the expansion of the *cacau* plantations that had advanced northwards from the southern territories of Itabuna and Ilheus. This agricultural activity, structured in the traditional schema of the plantation, was characterized by the usurpation of small plots of land (*posseiros*) by land-grabbers (*grileiros*) and the exploitation of wage labour (Renato 2016, 59).

It was not until the cocoa crises,[7] beginning in the 1980s and fully consolidating in the 1990s, that rural workers unions gained power. The crisis drew landowners to abandon or sell the plantations, expelling approximately two hundred and fifty thousand rural workers. The crisis contributed to the development of an organization that called for the occupation of unproductive lands through agrarian reform, arranged mainly through rural workers unions, the Pastoral Commission of Land (*Comissão Pastoral da Terra* – CPT) and the Landless Movement (*Movimento Sem Terra* – MST) (Schmitt 2015, 38). These movements were formed primarily by a black peasantry (Renato 2019, 306).

[7] The cocoa crises began in the 1980s and worsened in the 1990s. Several factors were involved: cocoa world prices dropped due to a surplus from the Ivory Coast cocoa production. In addition, the spread of the fungus known as da *vassoura-de-bruxa* (*Moniliophtora perniciosa*) reduced the production of cocoa in Bahia by 50 percent. Producers alleged that the cost of production was too high in relation to the benefits and abandoned properties (Renato 2016, 60).

The struggle over land has taken a new slant, and the economic benefits brought by tourism has also made the real estate sector expand in a predatory fashion, paralleled by some sectors of agrobusiness. This is happening in a context where the developmental model governing the territory of Baixo Sul has been characterized by the promotion of 'family-based agriculture.' Authors such as José Renato (2016), in his study of development and discourse in the Baixo Sul, remind us that settled within a neoliberal historical framework, the enhancement of public policies around family-based agriculture – starting at the turn of the 21st century – have also curtailed other political projects such as the continuation and advancement of agrarian reform among rural unions (although this was not the case with MST). Still, social movements have found a pathway through these policies to assert their demands on the State, although mediated and in many cases jeopardized by bureaucratic mechanisms (2016, 100/108). Thus, if the 1990s were characterized by land struggles, from 2003 to the present, questions such as agroecology, commercialization, and food security have gained visibility; areas that have been articulated around the rubric of family-based agriculture (Renato 2016, 128). Most important is that this agenda has created a sense of citizenship and recognition on the part of black rural communities by the State, as they are then the subjects of rights. Consequently, the struggle for land comprises much more than continued access to a piece of terrain, but also includes access to public policies that support 'life-making' (in the areas they have historically occupied), namely, access to housing, water, electricity, education and healthcare, not to mention a decent livelihood (Renato 2016, 138). The struggle to make these rights materialize continues to this date.

5. Meanders of Baixo Sul. Photo by the author

6. Portuguese churches of Baixo Sul by JotaBe.

Jaboticaba is quilombola!

The quilombola question is not foregrounded in this monograph. However, it is helpful to reflect on the topic, not only because it provides a backdrop to some of the central narratives in this thesis, but also because it brings together an important dimension of black rural resistance across time in Brazil.

The term *kilombo* is derived from the Umbundu and other Bantu languages that are spoken in sub-Saharan Africa. It broadly refers to settlements, as well as to fairs and markets. In the Bantu cultural area, the term also describes a ritual of initiation for young warriors (Leite 2015, 1227). In colonial Brazil, quilombo was historically known as maroon settlements, formed by runaway and/or self-emancipated enslaved people and their descendants (Chatzikidi 2017, 26). It was not until the introduction of the 1988 Brazilian Federal Constitution that the term *Remanescentes de Quilombos* (quilombo remnants) re-emerged under Article 68, where land rights[8] were conceded to these groups, creating a specific ethno-racial category of citizenship.

[8] Other subsequent laws have specified Article 68, as Federal Decree 4.887 in 2003, regulating the process for identification, recognition, and demarcation of land. In this decree the right to self-identify is established as enough criteria to initiate the quilombola regulation process (CONAQ). The process is long and focused on two organizations. One is the Palmares Cultural Foundation (FCP), entrusted with the task of issuing official certificates to quilombo remnant communities based on their self-identification (which in itself involves a historical report describing their ancestry, history and cultural practices). These certificates do not equal title

In essence, Article 68 established national consensus as a legal category for these black rural communities, which had previously been known across the north and north eastern states of Brazil by various other names, such as *terra de pretos* (black lands); *terras de herança* (inherited lands); *terras da santa* (holy lands); *terras de parentes* (family lands); *terras soltas* (free lands), or simply as *sítios* (sites) and *povoados* (villages)[9] (Chatzikidi 2017, 29). To avoid limiting the category to its association with the past and to the political resistance against slavery and the colonial regime (Arruti 2006), the category quilombo has been re-signified so the more nuanced dimensions of what this term encapsulates can be grasped. As Leite (2015, 1227) explains: "The term has shifted from being a form of opposition to the regime of slavery, to signifying the enjoyment of full citizenship through the inclusion of African descendants in land tenure regularization, housing, health, education and cultural policies." Thus, Article 68 represents a success for black rights and can be linked to broader demands for racial justice in contemporary Brazil (Farfán-Santos 2016, 3/5).

The term quilombola has fuelled an already latent national social movement in which thousands of black rural communities across Brazil have initiated the process to be certified as quilombos, through which they can be granted land rights and access to specific public policies and programmes. However, this has not proved to be a simple task as it has been characterized by a herculean bureaucratic[10] battle. At the time of writing, out of the 2874 certified communities that have 1533 proceedings open in INCRA, only 154 have received land titles (CONAQ). In many cases, the process is besieged by violent conflicts; the number of murders of quilombola from 2016 to 2017 increased by 350 percent, and the highest number of deaths were registered in the state of Bahia (CONAQ 2018, 51).

deeds, these are issued by the National Institute of Colonization and Agrarian Reform (INCRA) which involves the crafting of a technical report that is characterized by an uncertain number of years for completion (Farfán-Santos 2016, 113-124).

[9] Even though these illustrate how they managed to collectively acquire land and establish themselves through diverse means, such as donations from former landowners, the disintegration of lands owned by Catholic Orders, purchase, or occupation of land in disuse, these areas were not accompanied by legal titles (Chatzikidi 2017, 27).

[10] The bureaucracy built around the quilombola process has "underscored, and paradoxically reinforced a persistent historical, political, and social structure of exclusion and violence" (Farfán-Santos 2016, 3), which makes it a form of structural violence (Chatzikidi 2017, 42).

It is important to clarify that not all black rural communities are quilombola. They may be classified or self-identify as another form of *povos tradicionais*[11] (traditional peoples) based on their livelihood. Furthermore, quilombolas do not look any different from any other rural residents in Jaboticaba. Pertinently, some black rural communities could be quilombola without even knowing, or wanting to be quilombola[12] (see Farfán-Santos 2016). The problem of 'authenticity' in the process of 'becoming' quilombola and issues around who determines a legitimate black identity[13] deserving collective rights has been widely discussed and explored in scholarly work (See Arruti 2006; Almeida 2008, 201; O'Dwyer 2002, 2016; Farfán-Santos 2016). This question sits at the centre of quilombola as a 'contested category' (Arruti 2006) with multiple meanings, which Leite (2015, 1227) divides into trans-historical, juridical-formal and post-utopian dimensions. This denotes the quilombola respectively as a struggle of the African diaspora, a right, and a radical transformation of society.

In Jaboticaba (the central area of my fieldwork), as in several municipalities of Baixo Sul, the quilombola certification began through a crafty process activated by a number of mayors who learnt that extra money could be accessed if quilombola communities were present in the municipality. This was done without any discussion or dialogue with the communities about what *the political (re) construction of a quilombola identity* meant, or the possible ramifications in terms of access and management of land. To make matters worse, extra money rarely reached the communities through the implementation of the public policies (Renato 2016, 143). This offers a glimpse into the political complexities and logics at work in the region.

Today, through the committed work of NGOs active in the territory (e.g SASOP and KONIONIA), and through community mobilization, the quilombola movement in the municipality works to make sure that the local council engages with the communities and

[11] This is a judicial term emerging from the 1988 Brazilian Federal Constitution. It refers to those who historically occupy a specific territory, preserving distinct cultural forms and sustainable productive practices. Like the judicial term *Remanescentes de Quilombos* (remnants of the quilombo), these terms are sites of ongoing debates and struggles involving different Brazilian agents, from social movements to ruralists (these are large landowners and their representatives) and government bodies for and against agrarian reform in Brazil (Frajtag 2013, 16n6).

[12] The quilombola process has in some cases been immersed in internal schisms within communities. For instance, in some of the communities I visited, neo-Pentecostal followers refused the quilombola identity because they linked it to the work of the 'devil.' In other cases, some community dwellers did not agree with the idea of communal land.

[13] For interesting critiques on how standards of recognition are created and controlled see Charles Hale (2005) and Povinelli (2002).

delivers and executes whatever specific public policies are available for them. Nevertheless, this remains a continuous struggle.

As the reader follows the narratives presented in this thesis in all their complexities, s/he will come in and out of quilombola spaces. However, what remains important to remember is that all black rural populations in Jaboticaba share the embodied and collective every day and past experiences of exclusion and struggle, of survival and creativity, (of which the quilombola movement is an important and organised political response), in this specific region. This shared experience is what led a quilombola leader to conclude an interview about the history of the region and the present with the statement: *Jaboticaba is quilombola!*

Thesis outline

This thesis is divided into three sections. The introduction presents the logics of inquiry that have guided my approach (Chapter One and Two), and discusses the literature informing my research (Chapter Three). Part One titled 'Belonging,' includes Chapter Four and Chapter Five, and introduces the reader to life and death in Jaboticaba. These two chapters present pertinent background information to enable the reader to understand what it means to tend to life in places where death, and the possibility of death, is ever present. I do not refer to maternal healthcare here, but instead focus my description and analysis on the manifestations of violence and the multiple ways in which it impedes a sense of futurity and belonging. I also attend to its opposite, life, and focus on how this is cultivated in the processes of reproduction in Jaboticaba at the urban, community and household levels.

In Chapter Four then, I investigate the exhaustion and outrage expressed by the inhabitants of this locality over the current state of affairs. Despite notable socioeconomic progress and advances in processes fostering inclusion in the last twenty years, an urgent sense of crisis blurs the local landscape within the national panorama. I trace the contours of this 'failed progress' in Jaboticaba (and Brazil at large) by teasing out the effects of neoliberal governance and constructions of citizenship, coupled by past colonial legacies – such as clientelism, racism, negligence and exploitation – which have produced alarming rates of black youth incarceration and murder. As part and parcel of the Brazilian racial economy, I portray how insecurity and fear are haunting local subjectivities and imaginations, eroding a sense of community and hope for the future, all of which have tremendous impacts on the possibilities of 'raising a child.'

Chapter Five moves away from a focus on necro politics to a focus on the cultivation of life and belonging in Jaboticaba's rural communities. I do this deliberately, to escape the analytical (violent) reduction of black lives to spaces of violence and death.

Through the figures of a traditional midwife, an agrarian rural worker and a grandmother, I explore black rural women's socio-political position within their communities and the various gendered domains they occupy. Through their narratives, I navigate questions around the strength and continuity of local epistemologies, the importance of access to land, the personal and collective processes of political emancipation, and the constitution of kinship within local forms of patriarchy. I borrow from a series of Afro-Brazilian conceptions to unpack and illuminate each of these processes, paying particular attention to the importance of *ancestralidade* (origin) and *memória* (memory) as a key source of guidance for black rural womens' political projects to foster both overall life in their communities, and their own autonomy.

Part Two is entitled 'Birthing.' Here, I follow the journey black pregnant rural women undertake (mainly) through the health care system. Although they might initially seem disjointed, Part One and Part Two complement each other, and enable the reader to appreciate the socio-political and economic issues shaping the lives of the women who end up attending biomedical health facilities.

Part Two begins with Chapter Six. Here I explore the delivery of prenatal care, examining the dynamics resulting from the consultation procedure by isolating and identifying the specific practices taking place and their effects, especially in the way these alter how people come to matter. I show how measuring and registering become dominant in the consultation room, and the way in which they turn technology and documents into essential devices that ultimately hijack women's voices and relevance while making their bodies hyper-surveilled. In addition, I argue that in a context of scarcity and a lack of medical resources, these mechanisms and artefacts are deployed rigidly in an attempt to contain uncertainty. The language of risk and danger are key in disciplining women's subjectivities under neoliberal forms of governance that deviously morph State abandonment into personal moral responsibility. Nonetheless, I also capture fault lines in these bureaucratic rationales where other forms of care surface. Finally, as part of a larger system, prenatal indicators bear the double task of guiding future health planning nationally, and in global health 'prove' Brazilian development. I show the underlying contradictions, and reveal how these two schemes fail at several levels.

Chapter Seven develops ideas about uncertainty and abandonment. I illustrate the shift that takes place from a hyper-surveilled body during the prenatal period to a now, at-times-neglected, at-times-over intervened body during childbirth. The chapter begins with an introduction to the overall scene of maternal death in Brazil and how current trends in the country highlight the political meaning of these deaths, their multidimensional nature and the deeply rooted interlocking vulnerabilities they reveal. This is done by critically reflecting on epidemiological practices, such as the counting processes that affect the visibility and invisibility of populations (including the important indicator of race), and the limitations of reducing vulnerabilities to mere biological aspects. In the second part of the chapter, I reflect on these issues in the light of ethnographic data, with a view to identifying the underlying causes and effects that gaps in the network and quality of care produce. I unpack racialised and gendered forms of treatment, embodied in the experience of *vergonha* (shame), which I contend are part of a continuum of precariousness. This goes beyond the structure of the health system and rural communities' material difficulties to encompass a 'precarious existence' that links a colonial past to a 'democratic' present.

Chapter Eight examines postnatal care experiences and practices. Here, I introduce the official approach of postnatal care in Brazil and demonstrate how the tendency to reduce women to their reproductive capacities by the health system, which coupled with socioeconomic changes and the gradual shift of traditional cultural norms has produced, in some instances, a 'void in care' during the postnatal period. I track these processes by describing vernacular therapeutics for postnatal care, focusing on its ruptures and continuities. These, I argue, reveal on the one hand how in a context where local knowledge has been discredited, the continuation of traditional practices reaffirms and anchors a sense of identity and dignity, illustrating stern resistance to processes of subalternisation while simultaneously capturing generational tensions and change.

In the conclusion I move forward in time and reflect on the current political situation in Brazil (2020) and the implications this might have for the ideas presented in this thesis.

Chapter Two

Methodology: Shaping an Inquiry

> What place is there, in scholarship, for passion? Is it truly 'neutral' to remain dispassionate before unnecessary suffering? Is it always advisable to make a show of neutrality? What if one is hoping, as a writer, to 'push the world in a different direction' as Orwell put it" (Paul Farmer 2010, 434).

This thesis is based on 12 months ethnographic fieldwork in the coastal region of Baixo Sul, Bahia, north eastern Brazil (and a period of 14 months research in Brazil overall). In July 2017, I arrived in Salvador, the capital of Bahia; my initial intention was to focus my research on active quilombola *parteiras* (traditional midwives, from now on without translation), looking at their practices and cosmovisions through a lens of care, as well as their interactions with the Brazilian State and national health system. On arrival in Salvador, I rapidly became acquainted with some of the key interlocutors (in academia and social movements) who were working on reproductive health issues in north eastern Brazil and I became affiliated with MUSA at ISC-UFBA.[14] In the following month, I travelled to the city of Recife, Pernambuco state, for a one month internship with the NGO Curumim.[15] During this internship, I participated in a number of one-day workshops on reproductive rights and health in black rural communities and a three-day training workshop for indigenous birth attendants, as well as several street action and coordination meetings between feminist groups. In the course of daily exchanges with senior members of the NGO, I became increasingly familiar with Brazilian feminist activism. It was in these exchanges that I came to realise the difficulties I was going to face in finding a field site to carry out research that focused on active *parteiras* in quilombola communities, as these women seemed to have stopped attending births on a regular basis.

When I returned to Salvador in September, after several meetings with rural community leaders from different regions in Bahia, I decided to settle in the area of Baixo Sul, because of the large concentration of black rural communities in the area. Additionally, I reframed the focus of my research in two ways. First, the investigation of *parteiras* became less prominent

[14] MUSA, Program for the Study of Gender and Health**,** is based at a national centre of excellence in health research, the Institute of Collective Health (ISC) of the Federal University of Bahia (UFBA). See: http://www.isc.ufba.br/

[15] Curumim is a feminist grassroots NGO that has led the work with traditional *parteiras* in Brazil since the 1970s (while also working in sexual and reproductive rights in the northeast region of Brazil).

(although they remained a crucial link to the field); accordingly, black rural women and the processes of reproduction became the main focus of my research. Second, in order to attend more appropriately to issues arising in the field, I opened up my research to include black rural communities as a whole. This helped me to move beyond the quilombola question (although the quilombola remain a crucial dimension of black rural life in this region).

My research took place a year after the impeachment of President Dilma Rousseff[16] in August 2016. Perhaps, because of the unstable and transitional nature of this period, people were outspoken and eager to express their visions and experiences. Rousseff was replaced, via what many considered a *coup d'etat,* by the conservative Michel Temer, who ran Brazil as interim president until elections took place in October 2018 a few weeks after I left the country when the ultra-right wing *coiso*[17] was, sadly, elected. Temer was extremely unpopular; he introduced severe austerity measures to liberalize the economy and after years of social and economic progress under the PT government these reforms gave momentum to the idea that he was an illegitimate ruler. Since the economic slowdown of 2011, there was a severe economic and political crisis and Brazilian society had become increasingly polarised. Brazil was, therefore, immersed in a phase of transition. Like a sea receding at low tide, the precarity and abandonment, the fear and violence in a chronic context of racism and social inequality, were laid bare.

In this thesis I have tried to capture these lives in transition and have aimed to embrace this 'unfinishedness' by "seeking ways to analyse the general, the structural, and processual while maintaining an acute awareness of the inevitable incompleteness of [my] accounts" (Biehl and Petryna 2013, 16). Thus, after introducing the research objectives, I will outline beforehand the limits, and at the same time the strengths of my perspective, based on my central engagement with women.

This ethnographic thesis seeks to illustrate black rural communities' struggle in Brazil for survival and a future through the lens of care, focusing on reproduction, generally, and the process of birth, specifically. The research objectives are:

[16] For a brief explanation of the process access: https://www.theguardian.com/news/2016/aug/31/dilma-rousseff-impeachment-brazil-what-you-need-to-know

[17] '*Coiso,*' which literally translates as 'the thing,' is how the Social Liberal Party (PSL) candidate was dubbed in street protests against his hate speech.
See: https://www.theguardian.com/commentisfree/2018/oct/06/homophobic-mismogynist-racist-brazil-jair-bolsonaro

1. To investigate the intimate world of black rural women, focusing on questions around how they conceive, live and practice care. This includes looking beyond maternal care to care that extends to the community.

2. To examine the relationships of black rural women with the State and the biomedical health system, emphasising:

(i) the current type of maternity care that black rural women receive; and

(ii) the process of medicalising birth and how it drives *parteiras* away from assisting births.

3. To discuss the impact and reach of global health programmes in contemporary Brazilian maternal health in a political economic context of severe austerity and gender and race discrimination.

Logics on Inquiry

The logics of this inquiry are framed within what Cecilia Van Hollen has coined 'a feminist critical medical anthropological' approach. Critical medical anthropology pays special attention to structures of power (both at the macro and micro levels), while focusing on the effect of social inequality on people's health. Thus, I consider questions about caring and birthing in black rural communities as embedded in multiple scales of encompassing relationships from the 'local' to the 'global' (Van Hollen 2016).

Since I have focused on learning about women's experiences, my research plan is guided by principles common to feminist research[18] and a fundamental commitment to studying the lived experiences of gender and its intersectionalities. Therefore, I place the female subject at the centre while being critically aware of the problematics involved. Specifically, the research has been informed by a feminist epistemological standpoint[19] (Haraway 1991, Harding 2004, Smith 1990, Harstock 1998), which is based on the premise that research that is particularly focused on power relations should begin with the lives of the marginalized. As Haraway (1997, 304) aptly describes: "standpoints are cognitive-emotional-political achievements, crafted out of local social-historical-bodily experience – itself always constituted through fraught, non-

[18] The shared tenet underlying and guiding feminist research is that women's lives are important. As a consequence of placing women's lives at the centre of our methods, Reinharz (1992, 248) suggests "we discover new topics, examine the invisible, study the unstudied, and ask why it has been ignored. Feminist research is an interpretive endeavor, and is viewed as an ongoing, nonexploitive, and caring process as opposed to a value-free, objective means toward a final product."

[19] It was conceived as a response to value-neutral abstract conceptual frameworks, thus focusing on how women of a particular cultural group stand in relation to the dominant culture in understanding their lived reality.

innocent, discursive, material, collective practices." Consequently, I depart from the premise that the marginal position of black rural women creates an epistemic privilege, based on the idea that standpoints emerge from shared political struggle within marginalized lives.

The claim on epistemic privilege has helped to empower dominated groups in fundamental ways. The authority to speak for themselves, in their own terms, on the questions they want to raise, allows them to 'own' their descriptions of the world and themselves. Furthermore, starting with and inquiring into the lives of those marginalized helps to understand the distorted way in which dominant epistemologies have presented themselves and have conceived of, identified and silenced *Others.* Building a conceptual relation between epistemic privilege and social marginality, bell hooks (1989) identifies marginality 'as much more than deprivation' and reclaims it as the space for radical possibility. Marginality can be the centre of counter hegemonic discourse, where experiences of agency work to resist victimisation. bell hooks defends the marginal standpoint as a creative empowering space, linking knowledge to empowerment and change (Bat-Ami Bar On 1993, 88). This is a very constructive position because it escapes what Nietzsche conceives as a "slave morality," and instead of aligning itself with reactive thinking, it searches for sites with new meanings, possibilities and creativity (Chanter 2006, 112).

> Understanding the margins as a position and place for resistance is crucial for oppressed, exploited, colonized people. If we only view the margin as a sign marking the despair, a deep nihilism penetrates in a destructive way the very ground of our being. It is there in that space of collective despair that one's creativity, one's imagination is at risk, there that one's mind is fully colonized, there that the freedom one longs for is lost (bell hooks quoted in Bat-Ami Bar On 1993, 87).

Therefore, a feminist gendered standpoint may entail a site for empowerment and creativity. However, this needs to be approached with a critical stance where a feminist standpoint commits to a "mobile positioning and to passionate detachment"[20] (Haraway 1988, 585). The limitations involved in the construction of a standpoint solely based on gender need to be countered by intersectional understandings of multiple and simultaneously operative categories of oppression (hooks 1984, Collins 1990), paying special attention to the co-constitution of class and race in Brazil. This will be informed by rich and inspiring Afro-Brazilian feminist scholarly work and activism (e.g. Gonzales 1983, Bairros 1995, Nascimento 1990, Carneiro

[20] This allows maintaining gender as a political category of denunciation as opposed to a category of identification.

2004, Werneck 2007, Ribeiro 2018), which has focused on unveiling the interlocking systems of domination that have perpetuated and maintained the invisibility of Afro-Brazilian women in society, history and politics in Brazil (Goldstein 2003). I will also carefully examine the diverse strategies and struggles to overcome these multiple inter-locking oppressions. These scholars and activists have placed at the centre of their analyses Brazilian black women's voices and lived experiences that emphasize the crucial part these women have played in reproduction and survival, highlighting their critical roles as leaders (e.g. Werneck 2007, Perry 2013).

Nevertheless, intersectionality should not be understood as a reification of categories in a narrow understanding of identity politics, but rather as "how those categories and identities and their specific content are contingent on the particular dynamics under study" (Cho et al 2013, 803). Additionally, I aim to avoid (re)producing reified categories of "marginal/poor women" (Mohanty 2003), which might inadvertently further colonial and neocolonial Orientalist discourses. Thus, I wish to emphasize the internal diversity of such categories as 'black rural women' or 'underprivileged /marginal women'; and I do not assume any *de facto* homogeneity within these groups.

Expanding on this, I wish to place this research within current decolonial methodological debates compatible with the so-called epistemologies of the south (Sousa Santos 2014), where the central interest resides in placing other knowledges,[21] usually made subaltern by Eurocentric sciences (for instance, biomedicine), at the centre.[22] Consequently, this research departs from a position that aims to overcome stereotypes of the imperfect south (Ibarra 2006, 471), where the global north extracts unprocessed raw data for research (Comaroff and Comaroff 2012, 17). I try to achieve this by choosing to conceive my research as a space where the effects of current politics on maternity services in black rural communities in Bahia can be exposed and explored, and where local knowledge is not portrayed as an artifact from the past but "as a dynamic, evolving counterpoint to dominant discourses that seek to define and contain the marginal other" (Borland 2007, 626).

[21] This other knowledge is not entering as an absolute external episteme but rather at the intersection of the "traditional" and the "modern." They are understood as interstitial (not as syncretism) and as a "subversive complicity" emanating from memories of colonialism and geopolitical experiences where 'frontier epistemes' can emerge in these 'contact zones' (Castro Gomez y Grosfoguel 2007, 20).

[22] This should not be understood as the rescue of fundamental cultural authenticity.

The way into Jaboticaba

I made my way into the municipality of Jaboticaba* (this is a pseudonym), at a gradual pace. I rented a room in the centre of the town with the same name and soon began to meet leaders from the rural communities. These contacts were provided by a diverse group of people (other PhD students, researchers, activists) during previous visits to Salvador and Recife. Initially, leaders invited me to the meetings that were often held in the Rural Workers Union (*Sindicato de Trabalhadores Rurais* – STR), and I was also welcomed to a series of agro-ecological workshops for rural women organised by a local NGO. Once I introduced my research, I was soon invited to spend time in the communities, where my presence was met by a mixture of suspicion and welcoming curiosity. At the same time, I approached the local Secretary of Health, who received my research with interest and facilitated my visits to the local hospital, health posts, and the gynaecologist-obstetrician.

In order to understand the many complexities embedded in the process of reproduction of black rural women, I was aware that I needed to investigate multiple field sites. To this end, I divided my time in the field between three rural communities and four health facilities.

Methods and fieldsites

Research in the Communities

I focused on three communities: Caguaiba, Onça Vermelha and Santa Anna* (these are all pseudonyms). All three are isolated quilombola communities belonging to the municipality of Jaboticaba. In addition, I made shorter visits to other rural communities in the area – some of which were also quilombola, but others were settlements based on agrarian reform. I paid multiple visits to Caguaiba, Onça Vermelha and Santa Anna, with each visit usually consisting of a week's stay. I spent time with a host family in each community and visited pregnant women (ten overall). I spent considerable time with these women, going with them to their prenatal visits at the health posts and later to their postnatal visits. I participated in religious celebrations (Candomblé, Pentecostal and Catholic), as well as attending baptisms, funerals, birthdays and wedding anniversaries. Wherever possible, I partook in daily domestic tasks in the household and the fields. Due to the limited availability of transport, I was not able to directly witness any of the births of the women I followed, and only learnt of their experiences through their subsequent accounts. There was a fluid connection between rural communities in the countryside and urban dwellers in the town of Jaboticaba. The reason for spending time in both

locations, which residents distinguished in vernacular terms as *rua* (urban centre) and *roça* (countryside), ranged from family obligations and health issues to work and leisure. Consequently, I followed people and their links as they moved fluidly (in spite of the transportation limitations) between *rua* and *roça*. When I was not in a health facility or a rural community, I spent my time in the peripheral neighbourhood of Engenho Velho* (this is a pseudonym) in urban Jaboticaba, moving through my main interlocutors' networks of kin.

Research in health facilities

To understand the different elements of the health system and some of the socio-political dynamics shaping clinical encounters, it was crucial to spend time in health facilities. My time was divided between several sub-sites: the health-posts to which the Caguaiba, Onça Vermelha and Santa Anna communities were linked, and the health post in the urban peripheral neighbourhood of Engenho Velho. Here I sat in the consulting room with the doctor or nurse, depending on the day, and I also made observations in the waiting and staff rooms. Following a similar procedure, I observed weekly general consultations given to women by the only gyn-obstetrician in the municipality who worked in the public health system.

In addition, I had the opportunity to spend time in the local hospital, where the majority of women gave birth. This proved crucial, as it allowed me to develop a clear idea of the formal maternal healthcare structures and network operating in Jaboticaba that assisted birthing women. Fortunately, because the women attending the hospital had very similar profiles to my participants, namely that they were black rural women who shared common socioeconomic and racial backgrounds, this compensated for the limitation of not being able to follow the women from the rural communities through to the exact moment of birth.

Later, I decided to visit the two referral hospitals which women from Jaboticaba's local hospital were sometimes transferred to. These visits were short, and I only spent three and two days respectively in these health facilities. One of these hospitals was a Normal Birth Centre[23] *(Centro de Parto Normal)*, which is attached to a hospital further north from Jaboticaba in the town of Macaiba* (this is a pseudonym); the other was a maternity hospital in the town of Yapira* (this is a pseudonym) towards the south. Both referral hospitals were in faraway municipalities – 74 kilometres and 130 kilometres respectively.

[23] Maternity care units for vaginal deliveries without complications.

Data Collection Methods

Taking an ethnographic approach, I have tried to tap into vernacular notions and experiences by gathering data through detailed observations and active participation. Besides participating in and observing the multiple field sites described above, I carried out semi-structured interviews with: *parteiras*, pregnant women, other community members and leaders, as well as healthcare workers, politicians, NGOs and other representatives. This allowed me to develop a more systematic understanding about particular topics.

I also carried out life-story interviews with key figures in the communities. These interviews focused on the interviewees' own reflections and understandings of their lived experiences,[24] and they allowed me to develop a more detailed understanding of their local worlds and to contextualize this with current and past events, while also providing important insights about the histories of their communities, and the way in which these have been remembered.

Finally, fieldnotes, interviews and life histories were written up in dialogue with the analysis of secondary data from NGO documents, government reports and grey literature. This has been further analysed in relation to a fertile body of theoretical and empirical work carried out in Brazil and elsewhere, thereby enabling some of the themes to be discussed in relation to broader debates.

Ethics

Research was approved by the Ethics Committee (*Comitês de Ética em Pesquisa* – CEP) of the Institute of Collective Health (*Instituto de Saúde Coletiva* – ISC) at the Federal University of Bahia (UFBA), as well as the Ethics Committee of the London School of Hygiene and Tropical Medicine (LSHTM- ref- 14447). The National Ethics Committee (*Conselho Nacional de Ética em Pesquisa*, CONEP - 2.385715) in Brazil also authorized the research. Access to hospitals was mediated and approved by the directors of the hospitals concerned.

The overall aim was to do research ethically, recognizing that this necessitates a continuous exercise in reflexivity, the prevention of harm to study participants, fully informed consent, and the avoidance of deception and invasion of privacy. Consent in ethnographic research, due to its long-term nature, cannot be limited to one instance and instead needs to be viewed as a process in need of regular revision. During fieldwork, I always paid special attention to questions concerning my relationship with the participants (with the intention of remaining

[24] 'Lived experience' goes beyond people's mere experiences to focus on how people respond to those experiences. It seeks to understand the difference between experiences and life and why some experiences are "life changing and life affirming" (Boylorn 2008, 2).

aware of issues of inequality, exploitation, representation and authority). In order to protect the identity of the participants and the locations, I have chosen to use pseudonyms and broad geographic descriptions that can be found in numerous locations in the region of Baixo Sul.

Positionality and self-reflection

My ethnographic research followed a tradition of scholarship committed to understanding the way in which "past social processes, such as colonialism and slavery, continue to have profound lasting effects on health outcomes today" (Van Hollen 2016, 73). Crystallized in structural violence (Farmer 2004; Bourgois 2003 and Scheper-Hughes 2004), inequalities manifest in mechanisms that allow social axes such as gender, race and class to "become *embodied* as individual experiences" of inequality (Farmer 2003, 30).

Feminist scholars (e.g. Collins 1990, Narayan 1998, Harding 2004, Ribeiro 2019), have rejected the idea that research is carried out with a 'view from nowhere' (Haraway 1988) and have emphasized the centrality of reflexivity and the explicit location of the researcher within the ethnographic project. Paramount to my research motivation, besides an anthropological desire to understand human diversity, is my own political interest in social justice and my own gendered life experiences in care and birth politics. Consequently, I am not a neutral bystander in the research process and my positionality is placed within a framework of "conscious value-laden research" (Mies 1993, 68), where my own visions, experiences and emotions have sparked the initial research questions. Anthropologists of the African diaspora, such as Kia Lilly Cadwell (2017) and Keisha-Khan Y. Perry (2013), have argued that social science research and ethnographic practice have never been a politically neutral undertaking. Given the political context (the current Brazilian sociopolitical crises) and the thematic content on the field site (reproduction in black rural communities), I am fundamentally moved by the possibility of contributing to a better understanding of maternal healthcare in disenfranchised communities in order to ultimately argue and press for better State services for women living in disadvantaged situations in Brazil.

However, this positioning cannot be undertaken uncritically or naively. Brazil is particularly structured by race and as a white southern European woman I had to continually reflect on the symbolic location I occupied in the Brazilian social landscape and the historical power relations this position carried. Aware that whiteness emerges as a place where privileges are socially sustained, which are based upon a racist framework, and newly confronted with a whiteness I had never before experienced, I recognised the importance of self-reflection and evaluation in

my daily interactions. This became a process of continuous learning, reframing and transformation; a process that can never be completed. I place my '*lugar de fala'* (place of speech linked to my social location) (Ribeiro 2019) in what Denise Carreira has coined 'anti-racist whiteness.' This entails a subject that recognises its own incompleteness and its inherent reciprocity and interdependency with the world (Carreira 2018, 133). She states:

> To be an anti-racist white subject involves making oneself available to recognise and build on this interdependence, facing discomfort in conversations about racism and critically reflecting on how whiteness is built into our life history, into our relationships, into our social practices and institutions. By doing so we come to recognise that we have been educated not to see ourselves as 'white people' but rather as human beings who represent humanity universally […] the standard and the norm are a place of power (Carreira 2018, 134).

This means that whiteness is a place of power that manifests in a masked form of social blindness, which is responsible for reproducing discourses that naturalise racial inequalities and ignore the structures and practices that maintain and reproduce white privilege at the expense of the great suffering of racialised populations (Carreira 2018, 134). As Angela Davis (n.d) famously asserted "in a racist society, it is not enough not to be racist, we must be antiracist." Still, it is imperative that in this exercise of alignment, local voices are not usurped and we need to respect their "political place as historical protagonists of that struggle" (Carreira 2018, 135).

Additionally, there were further differences between my lived experience and those of my interlocutors due to, among other, socio-economic reasons. These have served as important points of contrast for analysis; however, fruitful analysis has equally emerged from the affinities we shared, the common views, and the similarly diverse experiences that made us relate in many other ways (e.g. political views, bodily experiences within patriarchal orders, a sense of humour, aesthetic sensibilities, spirituality and approaches to educating children, to name a few).

Given the fact that people of African descent in Brazil have been historically excluded from power, and in view of the current struggle of the quilombola movement, I have an academic and ethical responsibility to ensure that the communities are not misrepresented. One way to mitigate this has been (where possible) to have some of my interpretations revised by my interlocutors; either in the field through conversations or when writing up via WhatsApp messages and phone calls. In the criticisms I present over the shortfalls within the Brazilian

national health system, I also risk the possibility that (in these neoliberal times) these narratives could be used to delegitimize the value of a public health system. Accordingly, I have tried to balance my representations cautiously by insistently portraying the fundamental service this health system advances, with the underlying conviction that access to free quality healthcare is an essential human right.

Finally, the ethnographic encounter can take us to unprecedented and unpredictable bounds of ourselves, because as Lisa Stevenson (2014, 2) puts it, anthropology as an act of listening: "… becomes a practice of the self in which, in the interest of making common cause with others, we allow ourselves to be shaken, displaced from our customary dispositions and beliefs and even from our customary forms of love." The ethnographic exercise does not uniquely consist of observing, participating and recording with an acute eye for detail and a sharp sense of reason, but equally involves an affective-emotional process (Gerber 2015, 64) that changes us.

This whole lived experience is what later we, anthropologists, knowingly put into words with the intention to advance a native vision of the topics presented. Since all ethnographic truths are partial (Clifford and Marcus 1986, 7), what follows remains partial too. Still, I hope to guide the reader through the universe of care and birthing in black rural Bahia, showing with respect, sensitivity and in an ethical way the dignity and vision of those I encountered in the field, and with whom, ultimately, I became deeply entangled.

Chapter Three

OVERVIEW OF LITERATURE

Since democratization began in the late 1980s, Brazil has been at the forefront of progressive healthcare and health policy in Latin America, which has seen notable advances. Some of these advances have been enacted while others have been merely rhetorical flourishes, due to longstanding challenges. The tensions underlying these contradictions in healthcare are part and parcel of the inequalities that plague the Brazilian social landscape. With respect to women's health and childbirth, ongoing gendered and racialised systems interlock with socioeconomic injustices, creating specific vulnerabilities. These configurations have been further influenced by global forces and neoliberal forms of accountability in public health. Amid this setting, conceptions, experiences and practices of care manifest themselves, shaped by the wider sociocultural and political contexts. This thesis seeks to contribute to the ongoing discussions emerging from this scenario by focusing on critical questions around citizenship and healthcare, justice and reproduction through the analytical lens of care.

In the first section of this chapter, I critically examine the impact of metrics in global health, concentrating on the politics of reproduction and knowledge-making. I foreground the importance (and current lack of analysis in the literature) of scrutinizing the impact and tensions that arise in the establishment of metrics in Brazilian healthcare. I then move my focus to the 'making of vulnerability,' briefly reviewing work that explores this within the realm of healthcare in the northeast of Brazil. The section then discusses key research fundamental to understanding the current situation around childbirth in Brazil. I also pay special attention to authors exploring questions around race and gender in birth from other parts of the globe and attend to the urgent need to explore the intersection of these matters in black rural Brazil.

In the second section, I examine critical scholarship around questions of ontology and blackness, naming the analytical possibilities and limitations. I then trace, through diverse authors, Brazilian race relations and the implications this has had in placing blackness in the construction of Brazil as a nation. In the following section, I look at ethnographies that address the ways in which anti-Blackness is manifested in current Brazil, along with its gendered dimensions of which maternal healthcare remains an underexplored area.

In the final section, I address the question of care. Given the ubiquitous nature of care, I focus on three dimensions. First, I elucidate some of the more ambivalent dimensions of care,

highlighting the way in which feminist approaches have complicated assumptions around care within the structures of power and inequality, offering examples from ethnographic works. I then introduce the important entanglements between care and reproduction and how, as I show in this thesis, care practices can create social transformation. Second, I look at relational dimensions of care, discussing the ways in which care practices can create, maintain and dissolve significant relationships. I elucidate how care practices, as I contend in this manuscript, can also foster or hinder a sense of belonging. Finally, I review questions around the effects of care and the possible outcomes, focusing on ethnographic research in institutionalized care settings and on global regimes of governance. I emphasize some of the connections between structural matters, political economy and caring practices considered in this manuscript.

Contextualizing maternal healthcare in Brazil

In the introduction to the landmark volume *When People Come First: Critical Studies in Global Health*, the anthropologists Joao Biehl and Adriana Petryna (2013) call "for the need to critically analyse the social, political, and economic processes associated with global health-related initiatives and epistemologies." They are concerned "with the actual impact of these initiatives on care, health systems, and governance" (Biehl and Petryna 2013, 4). Other anthropological research has also critiqued the field of global health, foregrounding, among other things, a narrow focus on the production of numbers (Suh 2019; Guerra-Reyes 2019; Storeng and Behague 2017; Fan and Uretsky 2017; Erikson 2012, 2016) and the creation of new forms of governance and sovereignty (including Morgan 2019; Roalkvam and McNeill 2016; Adams 2016; Porter 1995 and Hacking 1983 [2015]).

Both as a "rupture and a continuity" (Adams 2016, 3) of the previous colonial and postcolonial health projects, the field of global health emerges as a new paradigm capable of transcending the limitations of the nation-state and of the politics enmeshed in delivering health (particularly in relation to political will and corruption). This is accomplished by the capacity to deploy new forms of counting based on standardization and uniformity. Widely referred to as metrics, these forms of counting now play a central role in global health knowledge, not least because they are thought to be apolitical and value-neutral, endorsing accountability and providing 'efficient' and 'transparent' ways in which to promote and assess the impact of a range of programmes. Within this health discourse, "interventions become an issue of 'scale

and measurement' rather than problems of custom, culture, or national political will" (Adam 2016, 5-6). In the following section I explore how these demands and the focus on metrics inadvertently render other phenomena invisible, raising critical questions around epistemology and economics, as well as politics and governance (Adams 2016, 8).

Metrics and the politics of reproduction

From its inherently political origins, women's health care underwent a revolution as anthropologists and feminist activists engaged in productive conversations, creating a solid theoretical scholarship and robust ethnographic studies on reproduction. A few canonical early works, including those by Martin 1987 [2001], Strathern 1992, Scheper-Hughes 1992, Lock 1993, Jordan 1993, Davis-Floyd and Sargent 1997, Hunt 1999, Kanaaneh 2002, Van Hollen 2003 and Inhorn 2006. Ginsburg and Rapp (1991), situated reproduction at the intersection of power and politics. They named this new analytical field the 'politics of reproduction.'

An implicit tenet in this thesis is about how metrics – as a mechanism of reproductive governance[25] (Morgan and Roberts, 2012) – is "a subject of great interest to governments as they attempt to determine their economic futures and demonstrate commitment to global accords on health, development and environmental sustainability" (Brunson and Suh 2019, 3). As they have rightly stated, the literature on the quantitative turn in global health and the metrics of reproduction has remained focused on important politically charged questions around the – not mutually exclusive – themes of: (i) producing measures (processes for quantification, recording and inventory); (ii) revealing the way in which numbers can become imbued with power, thereby fetishizing the indicators and (iii) capturing what metrics enact and foreclose. In so doing they have marginally neglected the uneven and paradoxical results that the deployment of this kind of data can produce when linked to broader questions about democracy and citizenship. By focusing on maternal mortality and the networks of birth assistance in Chapter Seven, I expose the multiple contextual deployment of metrics from diverse angles. Thus, an allegiance to numbers appears to showcase Brazil as a committed democratic modern nation. However, a closer look at the disaggregated numbers at sub-

[25] Reproductive governance "refers to the mechanisms through which different historical configuration of actors such as state, religious, and international financial institutions, NGOs, and social movements use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices" (Morgan and Roberts 2012, 243).

national levels paradoxically captures hidden and unresolved racial tensions, exposing the necropolitical dynamics of the Brazilian state that might otherwise remain unchallenged.

Simultaneously, the thesis reveals the multiple and tacit ways in which the production of metrics has unintended consequences in a variety of matters including access to, and the quality of, maternal-policy evaluation and, crucially, on the overall health of women. The literature shows how "erasure occurs in tandem with production" (Adam 2005, 79), with counting and surveillance creating a form of epistemic violence. These erasures refer, by way of example, to the silencing of health workers and women's narratives and experiences, thus creating univocal accounts that remove particularities, creating one grand quantitative narrative. This is critical because this almost obsessive focus on global/national metrics can cancel and foreclose the possibility of placing the "everyday challenges that women and professional workers face within a broader agenda of reducing social and economic inequalities" (Brunson and Suh 2020, 18). For instance, Melberg et al. (2018), discuss how the production of metrics in Burkina Faso directs health workers' accountability upstream, often at the expense of focusing on the needs of the women in their care. The impact of the deployment of metrics remains an unexplored area in maternal healthcare in black rural Brazil. In Chapter Six, using rich ethnographic detail, I unpack these issues in depth as they take place on the stage of the prenatal visit where tensions between what counts as an outcome has direct consequences on both the quality of the care delivered, and the way in which "people come to matter" (Stevenson 2014, 3).

Furthermore, while these 'regimes of truth'[26] (Foucault 1990) help to govern reproductive bodies, they also foster particular subjectivities, where experiences of citizenship and political economic ideologies are entangled with reproductive matters (Brunson and Suh 2020, 16). Bhatia et al. (2019) found that family planning initiatives, by capitalizing on the language of empowerment, aim to produce self-governing neoliberal female subjects. Similarly, global information campaigns aimed at raising awareness about maternal mortality promote dominant visual messages where the solution lies in having "all women everywhere [to] aspire to neoliberal subjectivity" (MacDonald 2019, 269). The overall results of these trends, underlined by political economic ideologies, place responsibility on women who – as modern subjects – must consume services and information to reduce risk and improve their health. I observed similar processes in Brazil (which I examine in Chapters Six and Seven), where neoliberal

[26] These are the historically specific mechanisms that produce the ideas that function as true.

logics placed the brunt of responsibility on the most vulnerable and are an expression of the way in which neoliberal economics comes together with reproductive governance.

The 'politics of knowledge,' maternal health and death, and the maternal mortality ratio[27]

Established by international bodies such as the United Nations, global targets for improving health have been set as part of a larger development strategy. Crystallized in the Millennium Development Goals (MDGs),[28] and currently in the Sustainable Development Goals (SDGs),[29] these targets are dependent on the regular measurement of indicators to evaluate progress. In terms of maternal health and in the context of the SDGs, they have been broadened as so many of the indicators are indirectly relevant to maternal health.

During the early 2000s, the Safe Motherhood Initiative discourse shifted from a feminist and rights-based approach to an audit and business-oriented ethos (Storeng and Béhague, 2014). A technocratic narrowing emerged and with it a total focus on metrics reduced maternal health to a maternal mortality ratio (MMR) (Storeng and Béhague 2017). Medical anthropologists (such as Storeng and Béhague 2014, Roalkvam and McNeill 2016) have illustrated this process clearly, showing how national health systems have been geared to avert maternal mortality instead of focusing on other fundamental aspects of maternal health. Some of these fundamental aspects include women's ability to achieve their preferred intervals between children, access to services that respect their choice, their quality of life during pregnancy and after childbirth, and their psychological and physical well-being. Despite the feminist principles of the reproductive health paradigm, the MDG for maternal mortality (MDG5a) has

[27] As a measure of the number of women dying of pregnancy-related causes per 100,000 live births, the MMR indicates the population-level risk of maternal death (Storeng and Béhague 2017, 163).

[28] The Millennium Development Goals (MDGs) are eight goals that all leaders from 191 United Nation member states signed in September 2000. They have measurable targets and clear deadlines for combating poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. See: https://www.who.int/topics/millennium_development_goals/about/en/

[29] The Sustainable Development Goals (SDGs) are seventeen goals adopted by all United Nations member states in 2015. They are an urgent call to action by developing and developed countries in global partnership and acknowledge that ending poverty and other deprivations must run parallel to tackling climate change and the preservation of oceans and forests. See: https://sustainabledevelopment.un.org/?menu=1300

been reformulated and integrated into SDG3, further reinforcing the MMR as the primary focus for monitoring commitment to improving maternal health (Brunson and Suh 2020). Furthermore, MMR is used to assess a government's performance and countries are ranked according to their MMR, receiving guidance if they perform poorly. In this way, indicators acquire a meaning and power of their own, obscuring fundamental information about the context in which women receive care (Brunson and Suh 2020, 2). Anthropologists have called attention to the ways in which indicators such as the MMR have become 'fetishized' (see Wendland's work in Malawi 2016) through their capacity – *as numbers* – to appear more accurate and precise than they really are (Erikson 2012). They have explored how the MMR indicator has the ability to 'shame' countries (Merry 2016) and to secure political appointments and jobs (Oni-Orisan 2016). The mere production and circulation of these numbers involves a form of accountability to the global health community (Erikson 2012; Sullivan 2017). For instance, studies such as that by Oni-Orisan (2016) in Nigeria show how in the process of establishing (as the principal objective) the production of statistically rigorous measures for maternal death, critical information regarding the experience of the women being attended to is neglected, as is the possibility of addressing key questions related to access and quality of care. Similarly, Wendland (2016) argues that maternal deaths are reduced to the identification of physiological causes, thus paying less attention to the crucial socio-economic forces that play a key role in risk and maternal death. This is what Ruha Benjamin calls the datafication of injustice "in which the hunt for more and more data is a barrier to acting on what we already know" (Benjamin 2019, 116). Ultimately, any analysis of metrics and women's health is political "as it requires an analysis of the unequal distribution of power across multiple intersections of individual identity and status" (Brunson and Suh 2020, 7). In the case of Brazil, the current literature about maternal deaths highlights the political meaning of these deaths and their interlocking vulnerabilities, but lacks ethnographic reflections essential to understanding the settings that may lead to maternal death or near-death. In Chapter Seven, I explore this scenario, revealing also the intersections between embodied experience, social relations and the political economy, thereby contributing to a growing body of critical studies that show the limitations of a focus on metrics and the urgent need to complement numbers with qualitative studies that capture other fundamental dimensions to better understand maternal death.

Birthing in Brazil

Vulnerability, social inequality and healthcare in Brazil

The Brazilian Constitution of 1988 established health as the right of every Brazilian citizen, an achievement that is proof of the powerful force of Brazilian civil society.[30] Social movements and the healthcare system (and consequently the childbirth practices within it) are integrated into, and shaped by, the profound racial and class inequalities that characterise the Brazilian social landscape (McCallum 2005, 225).

The core principles of the *Sistema Único de Saúde*[31] (Unified Health System, SUS) are universality, comprehensiveness, and equity. The notion of health equity is fundamentally important, because it integrates the principle of redistributive justice, putting emphasis on the way in which issues of justice are both directly related to and producers of health inequalities (Caldwell 2017, 11). Disparities in health are a robust reflection of a country's underlying discriminatory workings deployed through structural and institutional factors. Researchers (Rasella, Aquino, and Barreto 2013; Chiavegatto Filho, Sánchez and Kawachi 2014) have found striking life expectancy disparities between populations in Brazil with black, brown (a category known as *pardo* in Brazil), indigenous and lower classes, along with those in the north and northeast regions being often disproportionately affected by lower health outcomes.

Inadequate healthcare in Brazil, and the resulting creation of 'vulnerability' through interlocking social differences, has been well documented in two of Joao Bielh's (2005) volumes; *Vita: Life in a Zone of Social Abandonment* (2005), and *Will to live: AIDS therapies and the politics of survival* (2007). In the former, Bielh depicts the 'making' of vulnerability by untangling the complicated life and clinical (hi)story of a 'supposedly insane' woman abandoned in a hospice-like centre in southern Brazil. He illustrates the way in which a medical system that is embedded within deep social hierarchies and strangled by bureaucracy and

[30] During the 1980s a sanitary reform movement, known as the *movimento sanitário*, emerged in Brazil as a response to the ineffectiveness and precarious conditions of the health system. Composed of a broad spectrum of civil actors (such as researchers, union leaders, health professionals and students), they not only worked to define health as a human right and create a health system under the state provision, but equally aimed to transform the way health was delivered (Costa and Aquino 2000).

[31] A key element in the implementation of the SUS was its groundbreaking decentralization, which transfers the responsibility for management and financing of health care to the 26 states and more than 5000 municipal governments. It also allowed for a variety of stakeholders to be involved in the decision-making process (WHO 2010).

medical inefficiency leads to the production of profound human suffering, generating what Bielh calls 'social death' and an 'ex-human existence' (Bielh 2005).

Moreover, Biehl's latter work (mentioned above) presents the ramifications resulting from the ever-present tension in Brazilian society as progressive policies clash with chronic stark social inequalities in a context of neoliberal governmentality. Biehl explores the consequences (planned and unplanned) of this collision with the implementation of a progressive AIDS policy[32] to portray how people living in extreme poverty and sickness in the city of Salvador, Bahia, negotiate their survival amid enduring socioeconomic injustices. He shows how structural conditions are a fundamental factor in shaping policies on the ground in the context of social inequality. For instance, in the area of maternal health care and policy implementation in the city of Salvador, Eliza Williamson (2018, 285) states lucidly the nature of *Rede Cegonha* (The Stork Network, an initiative to address maternal mortality, obstetric violence and low quality of birth care in the public health sector).

> The centrality of the affective and the ethical in strategies to change childbirth renders initiatives like Rede Cegonha unable to adequately address the structural conditions of inequality that predate it and that drive the very maternal and infant health outcomes that Rede Cegonha was designed to help tackle. These structural conditions include chronically underfunded public health care infrastructures; systemic racism, classism, and misogyny; and various kinds of inequities in access to health care.

Returning to Bielh's work about AIDS in Salvador, Caldwell (2017) has noted that although Bielh's interlocutors are all African descendant individuals, in his analysis Bielh does not locate the informants' experiences in relation to their racial/ethnic positionalities, consequently reinforcing a "longstanding tradition of color-blind health research, policy, and practice in Brazil" (Caldwell 2017, 152).

Structural and institutional factors produce and reproduce gender and racial health inequities. In the case of Afro-Brazilian women, for example, adverse socio-economic situations such as poverty, racial segregation, low education and unemployment, compound to conditions frequent in particular ethnic groups (sickle cell anemia, hypertension, type II diabetes). Together, they place black female populations in a situation of vulnerability and inequality (Caldwell 2017). On the other hand, the public health system (SUS) has a limited capacity to deliver quality inclusive care despite wide coverage, due to chronic underfunding

[32] Brazil became one of the first countries to adopt an official policy of free and universal distribution of antiretroviral drugs. See: Cueto M, and Lopes, G. 2016 "AIDS, Antiretrovirals, Brazil and the International Politics of Global Health" 1996–2008, *Social History of Medicine*.

and mismanagement (Aquino 2014, S8). The two-tiered structure of healthcare in Brazil mirrors these persistent inequities. The SUS, funded mainly through taxes, provides services free of charge to all citizens within a broad and complex network of services; however, it remains chronically underfunded, thus lacking human and material resources. At the same time, there is a vast array of private[33] hospitals and clinics that can be accessed through insurance schemes and direct cash payments. The public-private structure of the health care system reflects larger schisms within Brazilian society and have become a marker of class: those with financial means opt for private healthcare, while the '*povo'* (masses) rely on the SUS. Consequently, bifurcated obstetric systems offer different kinds of care for poor and rich women (Paim et al. 2011). According to Cecilia McCallum, the trend in maternity care has been "caesareans for the rich and dehumanised assistance[34] for the poor"[35] (2005, 218). Despite strategic programmes[36] having some results, notably in unnecessary interventions and an increase of good practices (Leal 2018; Leal et al. 2019), birth in Brazil remains in crisis in 'multiple ways' (Williamson 2018, 284). Current research confirms the continuation of this trend in the maternity care divisions described earlier (Diniz et al. 2015; Torloni et al. 2016; Diniz et al. 2018).

A Nation aspiring to Modernity: Technocratic Birth

Brazilian anxieties over the path to modernity and the role of reproduction in the quest for progress date back to the early stages of Brazil's establishment as a nation in the latter half of the 19th century (Otovo 2016). By creating a 'better' nation, whether through educating poor mothers in health and hygiene – a secular form of morality – to eugenic ideologies of improving the health of the population to create a work force capable of progressing the country

[33] In terms of private healthcare, the state has traditionally protected the private sector with a large number of SUS services being contracted in. This continuously expanding sector - including multinational insurance schemes, private hospitals, and HMO-like groups operating for profit (Béhague 2002, 478) is subsidised by the state while the public sector is underfunded, compromising access to quality healthcare for those who cannot pay (Paim et al. 2011, 1787). This is particularly the case as the 25 percent of the population who have private insurance benefit from tax waivers, meaning that public money is financing a privileged minority to access private healthcare (Sanabria 2016, 32).

[34] Such as verbal abuse, certain procedures being operated without consent (such as episiotomy), and difficulty gaining access to a bed, amongst other forms of obstetric violence.

[35] Health professionals have been known to display prejudice towards black mothers, teenagers, poor women and others of such 'low-status' (Béhague et al. 2002).

[36] Two programmes have been implemented to improve the quality of labour and birth care: The Stork Network (launched in 2011) in the public sector, and the Adequate Birth Programme (launched in 2015) in the private sector (Leal et al. 2019, 2).

economically (Otovo 2016), Brazil has continuously wrestled to secure its own modernity. The quest to be modern takes on many forms, and science and medicine have acted as strong modernizing influences (Hunt 1999, Kanaaneh 2002, Van Hollen 2003, Sanabria 2016, Stevenson 2014). Furthermore, the progressive medicalization of the birthing process has played a central role in the efforts of the Brazilian white 'ruling classes' (who have traditionally aligned themselves with the European influence) to separate themselves from the 'backward' and 'traditional,' the 'primitive' and 'natural,' which they perceive as embodied in the indigenous and black populations (Otovo 2016, 35). In the early twentieth century, the gradual marginalisation of competing knowledge and practices, such as lay midwifery and traditional healers, occurred alongside the development of biomedical thought. This was perceived as modern, masculine and rational, and entailed a gendering of expertise (Otovo 2016, 20). It was not until the 1930s that hospitals became medically safe indicated places to give birth; however birthing transition from home to hospital was slowed down by factors such as women's resistance to giving birth away from home and the lack of hospitals (Mott 2002). Nevertheless, by the 1970s the transition to hospitals was almost complete, a shift that reduced deaths from postpartum hemorrhage and obstructed labour. In hospitals, the adoption of strict hygiene measures and the isolation of maternal units prevented maternal deaths in the facilities. Further, in cases of complicated births, advancement in C-section techniques saved the lives of women and their infants (Maia 2010, 34). New meanings emerged with this shift, and birth moved from being a social, physiological process that took place at home to becoming, in the hospital, a medical act where risks and complications were the main priority. This process mirrored a shared trend in the global transformation of birthing (Jordan 1993), and as modernisation has generally meant a turn towards a western hypervaluation of technology, by the late 20th century birth in Brazil had taken the shape of what Davis-Floyd (2001) coined the 'technocratic model of birth.'

Following the modern paradigm of the body as a machine (Martin 1987), in Brazil the technocratic birth model constitutes part of the 'aggressive' hegemonic approach to normal birth (Diniz et al. 2018, 19). Research shows that in birthing facilities across the country 'normal birth' frequently involves the indiscriminate supply of oxytocin, the habitual performing of episiotomy and amniotomy,[37] constant unnecessary vaginal examinations, restriction of food and water, immobilization of women with their legs apart, denial of a birth

[37] This is the process by which the amniotic sac is deliberately broken to speed/facilitate labour.

partner, performance of the not-recommended Kristeller manoeuvre[38] and other interventionist[39] practices (Diniz et al. 2018, 21). In line with the technocratic model, women are perceived to be passive recipients, their embodied knowledge is disregarded, and only machines and doctors hold knowledge 'expert' enough to produce a healthy baby (Davis-Floyd 1997, 83). Davis-Floyd (1997), drawing on Jordan's (1993) concept of 'authoritative knowledge' – the knowledge that counts – has analysed power relations at birth and the place of women within this technocratic framework. Yet Davis-Floyd's findings are ambiguous on the issues of choice and agency, questions that, as I will discuss shortly, scholars working on C-sections in Brazil have explored in depth.

Van Hollen (2003) has noted the way in which modernity and biomedicine emerge locally, rather than being transplanted around the globe as monolithic entities. In the case of Brazil, this "technological imperative" (Inhorn 2006, 356), due to Brazilian particularities around cultural constructions of gender, class, race and the nature of the health system, has precipitated an escalation of uncontrolled and unnecessary technological interventions in birth. This has culminated in the C-section epidemic, which has granted Brazil the title of world champion in C-sections,[40] mobilizing serious scrutiny, at national and international levels, from diverse disciplines and arenas (Dias et al. 2008; Freitas et al. 2008; Victoria et al. 2011; BBC 2015; Klimpel and Whitson 2016). Although C-sections do not emerge in this thesis as a focal point of analysis and only appear marginally in the discussion when linked to other topics central to this investigation, I do discuss some of the literature here. It allows for an interesting, nuanced discussion regarding women's responses and resistance and illuminates some of the dynamics around power and medicalization.

[38] Fundal pressure during the second stage of labour (also known as the 'Kristeller manoeuvre') involves application of manual pressure to the uppermost part of the uterus directed towards the birth canal. It is not a recommended practice by the WHO (2018) and involves potential risks (Hofmeyr et al. 2017).

[39] Results published regarding delivery care practices of healthy newborns in Brazil reveal the same type of proceedings: very high rates of aspiration (which is rarely recommended), as well as oxygen use, incubators, no skin-to-skin contact and the consequent absence of breastfeeding in the delivery room in the critical first hour (Ledo Chaves 2014, S3).

[40] The Brazilian Ministry of Health announced in 2017 preliminary data showing that for the first time since 2010, the number of caesarean sections has not increased in the country. C-sections were on an upward curve, but it dropped 1,5 percentage points in 2015. Of the 3 million births performed in Brazil, 55.5 percent were caesarean and 44.5 percent vaginal births. When considering only births in the SUS the situation reverses; normal deliveries are up to 58 percent and caesarean sections 40.2 percent. In 2016, the trend remains stable at 55.5 percent, (Ministry of Health 2017).

Anthropological research on C-sections in Brazil has focused on female agency and options amid multiple inequalities when accessing quality care (Béhague et al 2002; Béhague 2002; McCallum 2005; O' Dougherty 2013). Béhague et al. (2002) and Diniz and Chacham (2004) found that women in diverse areas of Brazil actively chose caesareans to avoid violent and humiliating vaginal birth experiences. In the case of Bahia, McCallum (2005), who undertook ethnographic research among a low income population in Salvador, confirmed that when asked, women preferred vaginal delivery but that the idea of a painful damaging experience had led them to opt for a caesarean section. In the case of women with private insurance, women are usually persuaded by their doctors throughout antenatal consultations to choose delivering via C-section (Domingues et al. 2014). Other studies show that many Brazilian women actively prefer C-sections over vaginal birth (Portela 2018), with many fearing the consequences childbirth can have on their bodies (Edmonds 2010). Health insurance is a great marker of class distinction making public and private birth sectors constitute each other in a "symbolic way" (McCallum 2005, 225). McCallum (2005, 216) notes that women's culturally conditioned choices are "enmeshed in and generated by the day-to-day workings of specific socio-economic and political orders." Thus, aspirational class dynamics are intertwined with stories of the consumption of medical services, with the C-section becoming a marker of 'modernity' (Maia 2010).

As stated, Brazilian modernity is always in the making, and medical techniques may acquire their own "mystique," which Edmonds (2010), an anthropologist studying Brazilian plastic surgery, validates "as a fetishism of technological progress" (67-68). Following this, Béhague (2002) argues that the mystification of technology is an oversimplification of the complexities involved in over-intervention. She states that this type of analysis equates biomedicine with a negative form of control and is interested in exploring the negotiations that may take place in these encounters. In her ethnographic research in southern Brazil, she concluded that for some women, having access to technologies to control their births had important implications for their social status; and this, in turn, resulted in them accessing better quality care (Béhague 2002, 474). Béhague went on to argue that "interventionist birthing can empower women and provide them with a tool for asserting their own medicalized position" (Béhague 2002, 477). Thus, medicalization may not always be disempowering. As an illustration, Frazer's (1995) and Bridges' (2011) investigations – in a predominantly impoverished southern African American community and in a public New York city hospital correspondingly – have confirmed that for historically disenfranchised communities, medicalization can "signal[led]

symbolic if not fully realized inclusion" (Frazer 1995, 57). Still, Chadwick (2018), following Garry's (2001) argument about the fundamental difference between medicine and medicalization), defends the position that to desire medicine does not mean one "become[s] redefined as dysfunctional and unable to proceed without medical intervention or treatment" (2018, 27).

Despite the richness of research into medicalization, authoritative knowledge, and technocratic birth in Brazil, ethnographic research on these issues is mainly focused on middle class or urban peripheries and the workings of the maternity hospitals women from these social groups attend. Little is known about the situation in rural areas. With this in mind, in Chapters Six and Seven I scrutinise the network and services in both public hospitals and small health centres in selected rural areas, to help fill an important gap in the literature of maternal health care in Brazil.

Birthing bodies: Gendered, yes and racialised, too.

Anthropologists working in the domain of birth (e.g. Jordan 1993 and Davis-Floyd 2003) have explored how techniques deployed during birth are laden with meanings and values around gender, race, class, nature and power; ideas tied to practices that become (re)confirmed and strengthened each time they are performed. Irrespective of whether they have been driven by the possibility of choice, intervened or not-intervened bodies can become markers of class. Equally, technocratic birth care in Brazil, by constructing women's bodies as weak, defective, "unpredictable and consequently dangerous" (Diniz 2009, 318) leads to overestimating the benefits of interventions. This makes their adverse iatrogenic effects invisible, thus dangerously normalizing and turning women's suffering into something natural (Diniz 2009, 318), which, ultimately, can silence them. This carries important consequences, given that some women will experience and accept these abuses, not only as an inevitable part of their reproductive journey, but also as a confirmation of their inferior place in society.

Abuse and violence in maternal health care have received a great deal of attention from scholars working in Brazil (e.g Aguiar 2010; Parto do Princípio 2012; Andrade et al. 2014), and in Latin America more broadly (e.g Belli 2013; Dixon 2015; Castro and Savage 2019). This work typically falls under the rubric of 'obstetric violence.' It is considered a form of 'gender violence' (Smith-Oka 2015), wherein gender prejudices against women manifest in the way care is both conceived and provided. In Brazil, as a response to the abusive practices that occurred during the late 1980s and 1990s, a movement labeled the 'humanisation' of birth has

emerged. Due to the work of international organisations and national birth activist pressures, the Brazilian government has launched a series of programmes.[41] Research around the humanisation of birth in Brazil has also been prolific (Diniz 2001; Tornquist 2004; Rattner 2008; Carneiro 2015; Williamson 2019). Overall, these studies reveal humanisation in Brazil to be a predominantly urban middle-class movement exhibiting longstanding shortcomings regarding the universalisation of privileged women's perspectives, such as the language of 'choice' (which silences issues having to do with inequality), family (centred around a heterosexual couple), essential femininity based on 'white' European patterns (McCallum and dos Reis 2006), the romanticisation of 'nature' and the idealization of 'normal' birth (Tornquist 2004). Apart from the idea that 'normality' is ideological (Foucault 1990), the most important point is that generally the humanisation movement does not address issues concerning racialisation, as "white women are largely exempt from discourses that censure and condemn their reproduction on the basis of their race" (Bridges 2011, 15). In this thesis, I aim to fill this gap in the literature by focusing on black rural women's experiences by scrutinizing their subjection to biomedical control and the making of their vulnerabilities, as well as their reproductive agency.

In Brazil, women's bodies are not bio-medicalized identically. As mentioned earlier, perceptions and experiences are hugely dependent on the public and private healthcare split, which is also highly racialised. Here, because of their relevant insights into the processes of racialisation within maternity care (and similar socio-historical contours in Brazilian society), I would like to highlight two anthropological works from two disparate geographical settings, though both have a shared history of racial segregation. One is an ethnographic research project based in an inner-city New York public hospital that attends to the disfranchised urban poor (Bridges 2011); while the other is based on birth narratives from a broad socio-economic spectrum of women in South Africa (Chadwick 2018).

Khiara Bridges' research analyses the processes through which race is inscribed on birthing bodies and reiterated silently without being explicitly called upon. This Bridges calls a "deracialized racialist discourse" (2011, 180). She illustrates how, whether through a pervasive eugenics discourse in family planning, or through the still-present unshakeable colonial myths in medical schools that portray black women as more physically equipped to give birth (because they are supposedly closer to nature and by proxy less civilised), to 'imagined' ideas

[41] See footnote 34 in Chapter Seven (Birth) for a full description.

around welfare queens (in Brazil this corresponds to a '*Bolsa de Familia'* beneficiary),[42] pregnant women become "othered" in a healthcare system equipped with the latest technology to attend to these over-surveilled 'unruly bodies'(Bridges, 2011, 96). While offering important insights into the State's regulatory apparatus during pregnancy and its particularities in the practices of racialisation, Bridges' focus is limited to the pregnant body and the scope of quality care and health outcomes, thereby missing the opportunity to establish links to broader processes of racialisation that can illuminate and situate the specifics of the clinic. In Chapter Four of this thesis, I contextualise the pregnant body by following the 'reproductive' pathways that lead to wider local and national sociocultural and political landscapes, linking important questions about reproduction and its broader political implications to critical processes of death in Brazilian society (of which racialisation in pregnancy is just one expression). This adds a fundamental layer of necro politics to Bridge's biopolitical analysis.

Paying attention to these dynamics and more in accord with the setting I encountered in my fieldsite, Chadwick (2018) describes the South African public healthcare system as plagued by inadequacies and a lack of resources. In her analysis, she emphasizes the systemic practices of invisibilisation and neglect taking place as a consequence of ideas about racialised women being 'stronger' and therefore naturally better equipped to give birth. She explains how this results in certain women being left to give birth on their own with hardly any assistance or no assistance at all. In these settings, she argues, biomedical power takes diverse forms with an *absent* medical gaze. This is an expression of the politics of 'erasure and abandonment', connected to wider relations of societal power, that ultimately reflect one of the multiple ways in which some lives are more valuable than others (Chadwick 2018, 100). Although I concur with this over-arching argument, my work probes these questions further. I do so by engaging with the body before and after birth, that is, in the prenatal and postnatal period, issues that are explored in Chapters Six and Eight respectively. This allows me to capture the emergence of diverse forms of care in these circumstances and the processes underpinning them, providing an expanded and nuanced understanding of reproductive body politics in general, and more specifically in Brazil. Overall, these processes of racialised patriarchy entail an element of

[42] For a discussion on the welfare queen in USA see: Golman, Michele. 2014. "The return of the welfare queen." *Journal of Gender, Social Policy & the Law*, Washington, 22 (2); 247-279. For a discussion of the *Bolsa de Familia* beneficiary stereotype see: Marins, Mani. 2018. "O 'feminino' como gênero do desenvolvimento." *Revista Estudos Feministas*, Florianópolis, 26 (1); 1-14.

despised fertility, which creates a form of stratified reproduction.[43] Here, gendered regimes intersect with racial regimes, producing scenarios where the reproductive capacities of specific populations are undervalued or stigmatised through mechanisms and practices that reflect, reinforce and intensify the same inequalities that originally produced them (Colen 1995, 78). These scenarios are usually characterized by the provision of unreliable maternal health care, precarious birth experiences, and a hostile future for childrearing, which in Brazil (and other countries of the African diaspora), are all an expression of a broader context of anti-Black violence. The next section discusses the research that has shaped the framing of this dissertation in relation to this analytical framework.

Situating Race Politics in Brazil

Questions of Ontology and Blackness

Critical scholarship from numerous disciplines has raised important questions around the sturdy permanence of racial inequality after juridical emancipation and civil rights. It has also investigated "the conflation of blackness as the ontological negation of being[44] with Black subjects and communities" (Sharpe 2016, 14). These works (e.g Sexton 2014; Wilderson (2003, 2008) and others), inspired by the ideas of previous black scholars (e.g. 'social death' (Patterson 1982); black fungibility (Hartman (1997) and Spillers (1987); civil society as opposed to black (Fanon 1963), to name a few) have all been roughly conjoined under the term Afro-pessimism. They share a lens of interpretation that accounts for the ontological

[43] This approach allows us to explore critical questions emerging from the intersections of reproduction and stratification. Stratified reproduction posits that certain categories of people in a society are stigmatized and punished when reproducing and parenting, while others are encouraged and rewarded. Thus, reproduction is regulated, controlled, and stratified along gender, sexual orientation, ethnicity, racial and economic class lines. Stratified reproduction extends social justice critiques to biological and social reproduction (Agigian 2019).

[44] One of the central tenets of Afro-pessimism departs from the work of Orlando Patterson, who reframed the understanding of slavery. In this, slavery is not a relation of labour (however forced), but a relation of property. The slave is legally made an object, as a commodity to be used and exchanged. Thus, contrary to the worker, whose labour-power is commodified, in the case of the slave it is their very being. The consequence is that they are precluded from the category of 'human,' and are not recognised as social subjects. Their social death extends to their being, defining their ontology (Afro-pessimism: an introduction 2017, 8).

impossibility of black civil existence within the paradigm of a civil society. Theorizing blackness as a result of structural violence,[45] they argue that:

> Black existence is simultaneously produced and negated by racial domination, both as presupposition and consequence. Affirmation of blackness proves to be impossible without simultaneously affirming the violence that structures black subjectivity itself (Afro-pessimism: an introduction 2017, 10).

Moten (2008), who is identified most closely with the stance labelled as Black Optimism,[46] critiques this position and maintains that this antagonism (that is, blackness/humanity) denies black subjectivity. At the core of his argument, he contends that black agency lies logically and ontologically prior to an order that pathologizes blackness and he is interested instead in the political possibilities that may emerge from the refusal of this positioning. Adding to this, critics such as Brown (2009) have argued that 'social death' not only forecloses agency, but impedes the 'hope' necessary for insurgency and political resistance. Other authors[47] have problematised in different ways the consequences of the exceptionalism[48] that Afro-pessimism contends. Shulman (in Gordon et al. 2017, 123), for example, highlights the way Afro-pessimism is limited through its claims to exceptionality in relation to other forms of oppression. Thus, by positing difference as categorical and absolute (not historical or contingent), Afro-pessimism approaches limit the possibility of depicting the mutual imbrication of other forms of domination (race, class, gender, sexuality and so on). A more productive approach would engage with "the intractable grip of antiblack specificity amid multi-dimensional intersectionality […] tracing how antiblackness has entwined with settler

[45] Following the 'non-event' of emancipation (Hartman 1997), the former structural violence that sustained slavery continued, preserving the calculation that black equals socially dead (introduction to Afro-pessimism 2017, 9); that is, "black positionality is defined through the work of death" (Alves 2014, 144).

[46] Sexton (2014, para.18) has responded to these critiques by depicting Afro-pessimism and black optimism as two sides of the same coin. He says: Rather than approaching (the theorization of) social death and (the theorization of) social life as an "either/or" proposition, why not attempt to think them as a matter of "both/and"? Why not articulate them through the supplementary logic of the copula? In fact, there might be a more radical rethinking available yet.

[47] See: Olaloku-Teriba Annie (n.d) *Afro-pessimism and the (Un)Logic of Anti- Blackness* [online]. Available at: http://www.histOricalmaterialism.org/index.php/articles/afro-pessimism-and-unlogic-anti-blackness and Angela Davis [online]: https://www.youtube.com/watch?v=DVjg6l-4LS8

[48] Exceptionalism refers to the way in which only 'blacks' are perceived as non-humans and subject to gratuitous violence. Afro-Pessimists argue that other categories, such as worker, women and native, for instance, are junior partners in a white civil society who benefit off the profit of non-blackness. It is only blacks who are always positioned as ex-slaves and non-human beings (Gordon et al. 2017, 123).

colonialism, patriarchy, and capitalism," but a focus on exceptionalism hinders this potential analysis (123).

Nevertheless, despite its limitations, this vision contributes to unravelling what Hartman (2008) named the afterlife of slavery. To quote:

> If slavery persists as an issue in the political life of black America, it is not because of an antiquarian obsession with bygone days or the burden of a too-long memory, but because black lives are still imperiled and devalued by a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery-skewed life chances, limited access to health and education, premature death, incarceration [and] impoverishment (6).

Thus, exposing the false optimism of post-racialism illustrates the insufficiency of civil rights as well as the limits of coalition politics, progress and liberal democracy. It offers a platform from whence to question western political thought, and "the mystification of concepts such as freedom, human rights and civil society" (Alves 2016, 145).

In dialogue with this literature, studies such as Christina Sharpe's *In the Wake*[49] (2016), is interested in "attesting to the modalities of Black lives lived in, as, under, and despite Black death" (20). Sharpe, drawing from numerous sources such as personal history, historical archives, cinema, visual art and literary works to name a few, undertakes this task without resorting to explanations for this ongoing exclusion "in terms of assimilation, inclusion or human rights." Instead, she focuses on depicting "the paradoxes of blackness within and after the legacies of slavery's denial of Black humanity" (14). This is what she calls *wake work,*[50] a form of consciousness, a counternarrative to hostile representations of blackness and its continuous abjection. To quote: "to be in the wake is to recognize the ways that we are constituted through and by continued vulnerability to overwhelming force though not *only* known to ourselves and to each other *by* that force" (Sharpe 2016, 16).

[49] She evokes the ripple effects in the image of the wake in the transatlantic slave trade passage as the figuration of the ongoing "black exclusion from social, political and cultural belonging" (Sharpe 2016, 14).

[50] About this she says: "I mean wake work to be a mode of inhabiting *and* rupturing this episteme with our known lived and un/imaginable lives. With that analytic we might imagine otherwise from what we know *now* in the wake of slavery" (Sharpe, 2016, 18).

This is crucial. As geographer[51] Katherine McKittrick (2011) has clearly pointed out, it is important to move beyond analyses that identify black suffering and then limit their analysis to racism and its opposition as the sole conceptual framework through which to understand blackness (2011, 947). Paradigmatic perspectives on race and blackness "deny an entangled racial history produced through geographies of encounter" (950). For her, spaces of encounter rather than "transparent and completed spaces of racism and racial violence, hold in them useful anti-colonial practices and narratives"[52] (955). Given that racial violence (including institutional racism, hate-speech, economic exploitation, assumptions embedded in biological determinism and so on) shapes, but does not fully define black worlds, an over emphasis on racial violence can leave no room to attend to human life. She is critical of a system of knowledge that calcifies racial codes attached and fixed to blackness and dispossession that create a linear narrative (partly based on biological survival), where the dying body is always "the racial Other to the white liberated human norm, precisely because *black death proceeds and is necessary to the conceptual frame*" (McKittrick 2011, 954-978). This replicates a linear tale of white survival where 'the condemned' already dead "have nothing to contribute to this ecocidal and genocidal world" (McKittrick 2011, 955).

In order to refute this, McKittrick refers to the work of Sylvia Wynter, who states:

> Yet that plot, that slave plot on which the slave grew food for his/her subsistence, carried over a millennially other conception of the human to that of Man's [referring to the western idea of 'Man'] … that plot *exists as a threat. It speaks to other possibilities*. (my emphasis, cited in McKittrick 2014, 20).

Although still ethically honouring anti-Black violence, those possibilities for McKittrick unfold from "the iterations of black life that cannot be contained by black death" (McKittrick 2014, 20). This thesis is transversed by this conceptual tension which I have aimed to capture ethnographically through the analytical layer of care.

[51] For a discussion of black geographies in Brazil see: A Bledsoe, 2015. "The Negation and Reassertion of Black Geographies in Brazil." *ACME: An International E-Journal for Critical Geographies*, 14 (1); 324-343 32.

[52] For instance, in her paper "Mathematics black life" McKittrick (2014) goes through the accountancy books of the transatlantic slavery trade, which talk about humans exclusively in terms of property related to insurance and numbers, and finds there recorded a note where a young enslaved girl states that *she was born free*. McKittrick then focuses our gaze on the impact that this voice makes, an statement of freedom and humanity, and also the possibility of another type of reading beyond violence and death.

Silencing race/Embodying blackness in Brazil

In her ethnographic study of race and language in Rio de Janeiro, Jennifer Roth-Gordon (2017, 129) asserts that in order to fully grasp the workings of Brazilian racism it is fundamental to understand the avoidance of blackness as its backbone. This exercise can unravel what sociologist Edward Telles has described as the "enigma" of the coexistence of inclusiveness and exclusiveness within Brazil (2004, 6). Beyond highlighting the important role that race plays in upholding Brazilian inequality, this finding has implications regarding questions around the place of blackness in the construction of Brazil as a nation. Indeed, pervaded by this tension, black 'citizenship' in Brazil contains a paradox: blackness is accepted and negated simultaneously. Recent anthropological work demonstrates how black life in Brazil is interrupted through ongoing processes and actions of indirect subjugation (such as lack of education, jobs, housing and healthcare), and direct annihilation (such as death squads and police violence), while black populations are celebrated nationally and internationally by promoting some of their cultural aspects through, for instance, the celebration of Afro music, dance and food (Alves 2014). In the case of the state of Bahia, the anthropologist Christen Smith (2016) (whose work on blackness, performance and violence in the city of Salvador I explore in depth in the following section), situates Bahia as a space where a sexualised and racialised fantasy of blackness (especially created for tourist consumption) and black death go hand in hand. I take this tension as a point of departure, locating and scrutinizing black citizenship in the realm of maternal healthcare. Thus, rather than focusing on the utilitarian and celebratory aspects of black culture in the construction of the Brazilian nation, I focus on the efforts and investments that profile Brazil as a democratic modern nation, whose corresponding opposite facets are the genocide of black youth, and maternal death (in a broad sense). As Smith states, these two contrasting and paradoxical facets are equally "two sides of the same coin" (2016, 3).

One side of the aforementioned equation (celebration/death) endorses an everlasting vision of racial harmony in Brazil. Attributed to sociologist Gilberto Freyre and his ideas about Luso-Tropicalism,[53] the construction of Brazil as a racial democracy remains strongly present in the

[53] Luso-Tropicalism is the doctrine expounded by sociologist Gilberto Freyre, who in 1933 published his major work, *Casa Grande e Senzala* (The Masters and the Slaves). In this he ventured to challenge scientific racism, proposing that Portuguese colonialism was characterized by a special form of race relations exemplified in the act of miscegenation, which was characterized by cordiality and non-discrimination. This became a new paradigm in Brazil when forming a new national ideal of antiracism. This substitution meant essentially that a

social imaginary of the nation, and externally too. Black scholars and activists (Gonzalez 1983; Munanga 2004; Lima 2006; Costa 2010; Ribeiro 2019, to name a few) have worked hard to debunk this deeply ingrained myth and to unveil the workings of this ideology. As the prominent Brazilian artist, activist and intellectual Abdias do Nascimento (in Levine and Crocitti 1999, 379) put it in 1968, "They [elites] created a fabric of slogans about equality and racial democracy that has served to assuage the bad national conscience. Abroad it presents our country as a model of racial coexistence; internally the myth is used to keep black people tricked and docile."

The transition from the ideology of scientific racism and the politics of *branqueamento*[54] (whitening) (see Schwarcz 1999) to that of racial democracy was key to the formation of the Brazilian national identity. Proud to have never enacted segregationist laws (in sharp contrast to the cases of the USA and South Africa), Brazil never officially established a binary black/white racial system (that is, the one drop rule, which refers to the process of being racialised black when someone contains any amount of black ancestry). Thus, a transformation into virtual 'cordial' race relations was made possible by what Elia Larkin Nascimento (2007) has called *The sorcery of colour*, which she proposes "as a metaphor for the Brazilian standard of race relations, which transforms a perverse system of racial domination into a pretense of antiracist ideals" (2004, 861).

This is best illustrated in daily social interactions where even within a family it is possible to find a vast array of skin shades. In this context, multiple colour categories[55] and their fluidity in a colour continuum is endlessly deployed to deny the existence of racism in the country.

race mixture could be accepted as a link to whiteness rather than rejected as degeneracy (Larkin Nascimento 2007, 43).

[54]As an illustration of the immigration policies to whiten Brazil: Between 1890 and 1914, more than 1.5 million Europeans arrived in the state of São Paulo alone, 64 percent of whom had their fare paid by the state government. See: Weinstein, Barbara. 2015. *The colour of modernity: São Paolo and the making of Race*. Duke University press.

[55] For an alphabetical listing of 120 terms people used to identify their skin colour in the 1976 National Household Survey, see: "What Colour Are you? National Household Sample Study National Institute of Geography and Statistics." In: James N. Green, Victoria Langland, and Lilia Moritz Schwarcz, (eds). *The Brazilian Reader*. History, Culture and Politics. Duke University Press. 2019.

[56] The *moreno* (a Brazilian mestizo) is a magic mixture of the three races, in this combination the *moreno* transforms and it comes to be considered almost as a white person (Larkin Nascimento 2007, 64).

This miscegenation ideology is rooted in a concealed aspiration to whiteness[56] (where the notion of African inferiority remains the basis of the whitening ideal embodied in the supposedly neutral – read white – figure of the de-Africanised *moreno*). This has managed to make opaque the reality of racial discrimination (Larkin Nascimento 2007, Munanga 2004b) and the consequential "social and racial imperative to embody whiteness" (Ruth-Gordon 2017, 96). Larkin Nascimento goes on to argue:

> I suggest that the success of the Brazilian race ideology derives precisely from its pretense of suppressing biological notions of race, which are translated into a dissimulated vernacular and continue to operate in the same way as white ethnicity: unnamed, implicit, and reigning in silent hegemony (2004, 862).

The pervading silence around race (e.g Calderia 1988; Sheriff 2000; Costa Vargas 2004; Ruth-Gordon 2015) has loosened in recent decades. Discourse and debate about racism has become fairly open in public spaces. However, past currents remain strong. Coinciding with the affirmative politics[57] era, there has been a shift and the ideology of racial democracy has been substituted by what Smith calls a form of Afro-nationalism. Here, "the country symbolically performs rituals" of black inclusion into the national fabric (Smith 2016, 5); for example, emblematically emphasizing one aspect of Afro-Brazilian culture, such as samba, in a national parade.

Yet, this inclusion remains within the parameters of what she calls the '*negro permitido'* (permissible black); that is, an acceptable form of blackness defined by the dominant power (Smith 2016, 6). Moreover, the ongoing problem of the dispersion of racial identities into colour categories remains an issue for the fixed racial categories in which affirmative action policies[33] are based (Farfán-Santos 2016, 63). Which at the same time have a strong and important role in the gathering of statistical data for the framing of policies (Caldwell 2017).

In this morphing journey of inclusion and exclusion within the national identity, the anthropologist Elisabeth Farfán-Santos has pointed out that what really is at stake is the

[57] See: Telles, Edward and Paixão, Marcelo. 2013. "Affirmative action in Brazil." *Debates LASA forum* [online]. Available at: https://forum.lasaweb.org/files/vol44-issue2/Debates4.pdf

[58] Based on his work in Central America, Charles Hale (2005) described neoliberal multiculturalism as a form of politics of cultural recognition that swaps the long-established discourse of homogenizing *mestizaje* for one of difference. This new regime of governance "delimits and produces cultural difference rather than suppressing it" (Hale 2005, 13). In order to control this process, cultural recognition grants the right to difference "without necessarily changing the unequal structural distribution of rights" (Farfán-Santos 2016, 67).

ongoing omission of "the everyday experiences of racial exclusion and racial violence that blacks have lived throughout the history of the nation" (2016, 48). Her ethnographic research is set in the Recôncavo Baiano, a geographical area situated between Baixo Sul and the capital of Salvador that resembles the sociocultural contours of my field site, particularly in regard to Afro-Brazilian culture and resistance. In her monograph, she meticulously explores the complicated process of accessing land titles for quilombola black rural communities. Beyond pressing matters about the limitations of neoliberal multiculturalism,[58] the politics of cultural difference and authenticity, and bureaucracy and the actual implementation of rights, she points to the shortcomings at issue when progressive politics are engrained in a system of racialised domination. In this case, impeding the redistribution of land, which for these communities encompasses much more than mere economic production, including as it does the reproduction of life. Most relevant in her critical approach is her emphasis on the importance of steering the focus to the 'embodied experience of blackness.' This refers not only to the broad spectrum of skin colours within quilombola communities, but also to the narrative they are required to enact in order to fit the quilombola description set by the government. In this, Farfán-Santos highlights the difficulty communities face in, at times, inserting an embodied narrative into the logics of the state apparatus. For her, the quilombo clause is rooted in politics that focus on cultural difference to the detriment of racial justice.

This is important because this focus brings to the fore the "urgent need to speak to racial injustice and everyday reality of blackness" (Farfán-Santos 2016, 64). Blackness can have multiple meanings, but as a historical, social, political and racial category it embodies an experience that cannot be diffused by multicultural theories of flexible identities, which have for so long been deployed in Brazil. This is because they interrupt the possibility of accessing the daily reality of racial discrimination experienced by black Brazilians and their communities and thus recognizing the existence of anti-Black violence in the country.

Racial formation is dialogical. It is not a natural essence anchored in the body, but a social fact that depends on an encounter. These encounters "produce and embody racial meaning" (Smith 2016, 14) and constitute blackness as a social experience. In Brazil, this unfolds in a contradictory context of social relations that simultaneously negate the relevance of race generally, and blackness in particular, while displaying "a hyperconsciousness of race, and blackness specifically, as normative parameters from which behavior, representations, and

institutional arrangements draw" (Costa Vargas 2012, 6). As Santos (2006) has argued, when it comes to discrimination, the media, employers, the administration and police do not have any trouble deciphering who is 'black.' It is from this 'experience of blackness' that black movements are organizing. Several anthropological studies have investigated this in different realms of black experience, such as in the context of lethal state violence and urban youth (Alves 2018); in the fight for land by peripheral community women leaders (Perry 2013); in mothers' relentless attempts to denounce the killing of their youth (Rocha 2014), and in reproductive rights grassroots movements (Santos 2008). I join this discussion by adding the neglected and fundamental layer of maternal healthcare and reproduction in rural Brazil, thereby illustrating further the fight to the right to 'life' in black Brazil.

Ethnographies of anti-Black violence in Brazil

Ethnographic research about citizenship in Brazil has referred to the Brazilian State in a multiplicity of ways, including the State of (in)security (Penglase 2014); a *terrocratic* police State (Alves 2018); a State of *anthropophagic*[59] nature (Alves 2014); a State absently-present (Denyer Willis 2017); a State inducing segregation (Caldeira 2001); a sex-ing State (Williams 2013), and a lethally-negligent State (Smith 2016). James Holston's (2008) exploration of citizenship in Brazil has emphasized how even with the advent of democracy in the 1980s, citizenship remains a dominant aspect of Brazilian modernity, and a mechanism to distribute inequality in what he terms "inclusive inegalitarian citizenship." To quote:

> This formulation of citizenship uses social differences that are not the basis of national membership—primarily differences of education, property, race, gender, and occupation—to distribute different treatment to different categories of citizens. It thereby generates a gradation of rights among them, in which most rights are available only to particular kinds of citizens and exercised as the privilege of particular social categories (Holston 2008, 17).

In a paper published in 1999, Holston and Caldeira describe Brazil as a "disjunctive democracy."[60] They discuss their preoccupation for what they see as a form of political

[59] See Paixão, Marcelo. 2005. "Antropofagia e racismo: uma crítica ao modelo brasileiro de relações raciais." In: S. Ramos and L. Musumeci (eds). *Elemento Suspeito: Abordagem policial e* discriminação *na cidade do Rio de Janeiro* (1-45).

[60] The political aspects remain democratic, but the civil component of citizenship is unfulfilled with the rights of citizens being violated, so are thus 'disjunctive' (Caldeira and Holston 1999, 692). They follow T. H. Marshall's (1950) approach – although not his cumulative, linear approach – on their understanding of 'civil.' Civil

democracy that, while giving membership and granting the vote, is still a place where "violence, injustice, and impunity are often the norms", thus violating its civil aspect, namely, social rights (Caldeira and Holston 1999, 692). Anthropologist Roth-Gordon (2017, 53) mentions the work of Rosa-Ribero (2000), who explains that in Brazil 'rights' do not belong to the realm of legislation but are rather a quality that a few particular individuals carry inside them. Perceived as a highly moral quality, it is solely associated with whiteness and civility, conversely situating 'non-white' outside of the citizen realm.

In this scenario, underlined by rigid class stratification and profound social hierarchies, political citizenship is granted to all, while civil citizenship is denied to many. Some scholars have paid close attention to these interactions, bringing up critical questions around the paradoxes and contradictions embedded in black citizenship. Pushing beyond previous work on racial discrimination in Brazil, they argue that anti-Black violence is constitutive of modernity and nationhood in the contemporary state, and accordingly conclude the impossibility of black citizenship under this current context.

Anthropologist Christen Smith (2016, 82), states that in Brazil "black citizens are denied not only social rights but also the right to life." Her ethnographic research in the city of Salvador, capital of Bahia, explores the contours of anti-Black violence in a city with the largest Afro-descendent population outside of the African continent. Committed to paying close attention to practices of collective cultural resistance, Smith follows two grassroots organizations working against police terror across the periphery of Salvador. Using 'performance' as her analytic lens, she questions the relationship between blackness and state violence, unveiling the processes of racialization that take place in the spectacular (direct police killings) and the mundane (everyday non-verbal interactions), a chain of mechanisms that ultimately configure Brazilian necropolitical governance and illustrate the ways in which national belonging is constituted in contraposition to blackness. She concludes that: "the denial of black citizenship is not *in spite of* a functioning political democracy but rather, it is *constitutive* of democracy (2016, 82).

Brazilian anthropologist Jaime Amparo Alves (2018) also focuses his ethnographic explorations on state terror, black suffering and political resistance. Working in São Paulo, the largest urban centre in Brazil and South America, he examines the strategies arranged within

components of citizenship are thus separated from the political, socioeconomic and cultural aspects. Civil entails the sphere of rights, practices and values that deal with liberty (negative and positive) and justice as the way to achieve rights (Caldeira and Holston 1999, 692).

the new 'soft' approach to security in the peripheries of the 'neoliberal' city of São Paulo (which he renames as the black necropolis). He confirms that the idea of an 'unruly black body' underlines these new 'soft' security initiatives (such as human rights training and community security councils). By reproducing structural vulnerability, these initiatives continue to produce 'racialized zone[s] of non-being' where the black (unruly body) remains a killable object. He argues that "police terror is a symptom of neither dysfunctional nor failed democracies." Instead, "anti-Black policing creates the very conditions for whites to exercise their civil rights" (Alves 2018, 3).

What makes these claims particularly distressing is that they are historically located at the height of the affirmative politics of the Brazilian Workers' Party, PT (*Partido dos Trabalhadores*) government. Both ethnographies gravely portray the tension and central paradox of the Brazilian nation, and the limitations of a democracy where a rhetoric of black rights goes hand in hand with practices that make the black body expendable. As Brazilian anthropologist Costa Vargas has stated, "from the perspective of the Afro descended, Brazil is a fraud" (2012, 4). Furthermore, these ethnographies focus their investigations, beyond the immediate deaths, on the repercussions and extended effects of this violence on families and communities focusing on the struggle of black women speaking from their position as mothers (see Rocha 2010). This thesis builds on this body of work by asking how, if at all, these issues emerge in the provision of maternal health care in black rural Bahia. It also looks at what mechanism may underlie a gendered antiblackness, which reproduces and secures enduring traits of a past colonial and authoritarian order, not as static and unchanged, but "as symbolic reservoir whose energy dissipates into contemporary formations of race and gender" (Costa Vargas 2012, 7).

Centering care

The final section of this overview of the literature addresses the question of care, highlighting the multiple ways in which ideas of care are deployed, and the malleability of the term. I look at this through some key works in anthropology, while also highlighting some crucial feminist contributions. The reflective exercises these works offer about care are helpful, because they present nuanced understandings of the complexities of care in diverse settings, notably by casting 'care' off the ropes of limited, normative and crystallized interpretations. In addition, they allow the many possibilities and potentialities of care to unfold by paying

analytical attention to the myriad of ways in which these experiences and practices occur as they are informed by wider sociocultural and political contexts.

What is care?

Care is a complex, evasive and ambiguous concept. Attempts to define it have been contested and productive, and authors continue "to affirm care despite and because of its ambivalent significance" (Puig de la Bellacasa 2017, 2). Care is a culture bound concept and consequently it escapes *a priori* definitions; still "care is omnipresent even through the effects of its absence" (Puig de la Bellacasa 2017, 1). Therefore, to move care across contexts may not be feasible, as it possibly carries too much cultural weight (Buch 2015, 279). In addition, care is difficult to put into words "because stressing the verbal too much misses much of the non-verbal component" (Mol, Moser and Pols 2010, 10). In this, Johns tells us that it is not so much that the concept of caring is vague, "but that its nature eludes and defies the reductionist approach because caring can only be known within the moment or moments connected together through time in the form of an unfolding narrative" (Johns 2001, 244).

Thus, questions about what care is and what it means and involves opens up dimensions and possibilities: is it a moral obligation, a type of work, a relation, satisfaction or burden, a disposition or a learnt practice? Care may mean all of this and more. Although it remains open-ended, there is on-going theoretical discussion of care "as a 'generic' doing of ontological significance;" while simultaneously, specific inquiries emerge from diverse angles and perspectives so "the generic does not resolve in a closed theory" (Puig de la Bellacasa 2017, 3-7). Therefore, care is "unthinkable as something abstracted from its situatedness" (Puig de la Bellacasa 2017, 6) and considerable anthropological research (e.g. Garcia 2010; Ticktin 2011, Fassin 2011; Han 2012; Aulino 2019 to name a few) has explored the ambiguities of 'care.'

The ambiguities of care

Care is not only ontologically but also politically ambivalent, and feminist approaches have noted that care should not be embraced innocently (Puig de la Bellacasa 2017, 7). The ways in which we think about care are deeply connected and shaped by existing structures of power and inequality. Mol, Moser and Pols (2010) maintain that what sets care practices apart from other practices is their particular concern with questions around "the good." However, care cannot be rendered solely as an altruistic activity with a positive outcome. Care may also be

linked with control and surveillance[61] (Martin 2012). Feminist approaches have complicated care, relentlessly reclaiming it from idealized meanings from a "somehow wholesome or unpolluted pleasant ethical realm" (Puig de la Bellacasa 2017, 8). When observing care practices we may wonder, what is sought, fostered, hoped for? What is performed and perceived to be 'good'? What is avoided, resolved, or excluded and what is performed and perceived as 'bad' (Mol, Moser and Pols 2010)? The answers are not clear cut. Complexities and ambivalence are entangled where the good and the bad coexist, explicitly conditioned not only by the contextual ground but also by the perspective taken. Carol Sufrin's (2017) ethnographic exploration of obstetric care within the Californian jail system investigates the tensions that emerge in the delivery of care in punitive contexts. Sufrin, in her role as an ethnographer and clinician, reflects on the ongoing "peculiar ambivalence of harshness and nurturance that is animated in the social entanglements of care" (2017, 76). Most importantly for this thesis, her investigation illustrates the possibilities of intimacy and the intersubjective negotiations of care between patients and clinicians in a context of domination and discourses of deservingness. Looking at the daily ethical grounds and power relations that unfold in these ordinary negotiations is something I explore in the prenatal clinical encounter (Chapter Six) and the assistance of birth (Chapter Seven). These are sites of significant ambiguity, where pursuing 'the good' becomes an extremely complicated outcome. These outcomes are not only shaped by the unequal power relations embedded in clinical contexts, but are also greatly influenced by the material scarcity present in an underfunded health system such as the Brazilian SUS. Through this work, I aim to contribute to a better understanding of the ways in which ethics, political economy, and intersectional discriminatory practices manifest in particular 'enactments of care' and illustrate how some of these manifestations in the reproductive realm can also entail an engagement with liberatory practices.

Care as a relational practice

Sufrin also shows us (as other feminists have done) that care is basically relational.[62] Feminist care ethics highlight a fundamental theme: the commonality of human vulnerability,

[61] For instance, particular forms of compassion that provide care in ways that differ from the wishes of those whom they seek to help (Buch 2015). This has been explored in relation to humanitarianism assistance (Fassim 2011, Ticktin 2011).

[62] Some ethicists prefer to understand care as a practice more fundamental than a virtue or motive because doing so resists the tendency to romanticize care as a sentiment or dispositional trait. Virtue ethics is more

not just at the beginning and end of life but as a constant condition (e.g. Tronto 1993; Ruddick 1995; Sevenhuijsen 1998). However, this should not be taken at face value. As Uma Narayan has argued, if care ethics establish that we are all essentially interdependent, "they do not go far enough if they fail to worry about the accounts that are given of these interdependencies and relationships" (1995, 136). In many cultural settings, care is a highly moralized and normative social practice. Doing care "in the right way" involves a series of norms and prescriptions to which the carer subscribes, duly replicating this order or transgressing it. This applies equally to the recipients of care and touches directly on the fact that certain care practices may contribute to reinforcing asymmetric power relations and patterns of dependency within groups and communities (Drotbohm and Alber 2015, 13). For example, negotiations concerning care can accentuate intergenerational and gender inequalities, and even create new hierarchies, differences and conflict, or instead recuperate fractured relations (Buch 2015, 287). I take these questions into the realm of postnatal care, an under researched and neglected area in the literature on reproduction (Alderdice et al. 2016), and in Chapter Eight of this thesis I pay attention to the intergenerational power dynamics embedded in postnatal care. Additionally, I focus on the ways in which these dynamics highlight the connection and fissures between global political-economic transformations and the most intimate aspects of daily life (Buch 2015, 278). These links are illustrated by showing how 'traditional' postnatal 'care' therapeutics end up being discarded, giving way to 'voids' in postnatal care.

Some authors, such as Mary Weismal (1995), have referred to kinship as lived and created through care. New kinship studies see care as an activity that "presumes, produces and confirms" kin relations or perceptions of relatedness. Care can confirm biological or juridical understandings of kinship, but care can also provide an alternative way of creating kinship in the absence of biological ties (Drotbohm and Alber 2015, 7). Thus, through kinship, care is understood as a "social action performed among people who understand themselves as belonging to each other by kinship and who are performing belonging through care" (Drotbohm and Alber 2015, 7). In Chapter Five of this thesis, I provide an analysis of vernacular forms of care that emerge in the local collective initiatives to protect women, and in the negotiations involved in creating households and kinship in a context of unequal gender power relations. These are important points, because as Tatjana Thelen (2016) states, centering care practices as social organizations that create, maintain and dissolve significant relations means we

individualistic and feminist ethics is relationist at its core, as Noddings (1999) has stated: Caring is a relational state.

disentangle care from kinship and the exclusivity of the family. As a result, it may be possible to overcome common dichotomies such as private-public, good-bad, modern-traditional and micro-macro.

In her doctoral dissertation about reproduction in a rural village of Baixo Sul in Bahia, Patricia de Souza Rezende (2015) sheds light on the multiple ways in which the process of reproduction is constituted within a relational world; that is, on one hand, in the relations established daily between subjects (within networks of affinity and kinship), and on the other hand, in the relations with the health services and the state (in a context of unequal power relations at the intersection of class, race and gender). She also identifies the macro and micro socio-political forces that interfere in the reproductive lives of these women, and pays attention - as I do in this thesis - to vernacular practices of care and relationality (such as *'consideração'*) as a key element in the reproductive process. My thesis differs from hers in several respects, but here I wish to emphasize our distinctive approaches to the analysis of relationality and the way forms of care may be constituted in the communities. While Rezende does an excellent critical analysis on the gendered and racialised dimensions in interactions with the State, and presents an acute investigation about relationality at a family and intra community level, my exploration focuses on 'ways of belonging' that have to do with collective action, autonomy and the defense of a territory connected to a specific way of life (See Chapter Five) and the way in which the State can hinder this sense of belonging (Chapter Four).

Outcomes in care

So far I have emphasized the way in which care is understood and approached, highlighting the point that not all care practices are voluntary or infused with good feelings, nor are they necessarily practiced to secure a relationship or to reproduce life itself (Thelen 2016, 509), with these points having direct effects in the various outcomes of care. For instance, Angela Garcia's (2010) ethnography about heroin addiction and care in a context of dispossession in New Mexico poignantly illustrates how notions of care reflect actions, such as providing and injecting heroine with and for your mother, acts that are simultaneously destructive and productive. As she states, these are "practices of care that are not always remedial, and which bring unexpected, even dangerous, consequences" (2010, 121). In addition, Garcia illuminates the consequences and outcomes linked to the failure of acknowledging a relational self, which is common in bureaucratic regimes of care that, by solely focusing on the individual, can isolate them. She portrays the consequences of this obliteration: an institutional, mechanic and

managerial care model that (re)produces loneliness and defeat among addicts. This is blind to the contextual forces at play that shape the daily lives of this population, difficulties that are deeply embedded in the troubled history of this region.

Thus, care is "moral, relational, historically specific and embedded within forms of governance and global political economic transformations" (Buch 2015, 287). This contextualization is crucial when posing ethical and political questions around care, illustrated by expressions of outrage and condemnations about its absence, or about the questioning of controlling policies that regulate what is considered legitimate care (Puig de la Bellacasa 2017, 6). These tensions in care are explored in depth in Chapter Seven of this thesis, where I focus the analysis on the contrasting positions of an over surveilled body, and situations of neglect. This does not solely refer to the nature of legitimate care, but also to who is perceived to be eligible to receive care; namely, care revolves around recipients in legitimate need who deserve to be cared for. Human 'needs' change with historical, cultural, class and other contexts. These contexts involve power relations and impact the content, definition and distribution of caring practices (Fisher and Tronto 1990, 40). A definition of 'need' is not easy and power comes into play, as these definitions can be established to suit dominant ideas and interests whereby care-receivers may have little say in defining their needs (Fisher and Tronto 1990, 40). A clear illustration of this in birthing settings occurs when women giving birth undergo episiotomies without consent, or when racialised women do not receive the procedures they require (see Chapter Six).

In institutional settings, needs have to be presented in specific ways so they fit the bureaucratic standardization that governs the institutions. Anthropological accounts of institutionalized care have paid close attention to issues related to regularization and standards. For instance, Lisa Stevenson writes of care as "the way someone comes to matter, and the corresponding ethics of attending to the one who matters" (2014, 3). Her ethnography about care in the Arctic explores the Canadian state's responses to two pandemics among the Inuit, tuberculosis and suicide, in two different historical moments. She grapples with the aforementioned fundamental questions around care: *ambivalence and the removal of a relational self under bureaucratic regimes*. In her work, bureaucratic forms of care are mainly concerned with the maintenance of 'life itself.' She illustrates how this translates into a form of logics of care that concerns more than just policies enacted on populations, to including the ways in which individuals engage with other individuals while adhering to these logics, which ultimately results in a form of indifference (Stevenson 2014, 4). She links this to the persistence

of colonial forms of care, which she presents as an "insistence on caring anonymously – the insistence that care should be administered indifferently, without it mattering for whom" (Stevenson 2014, 5). In this thesis, I ask whether these same logics underline the Brazilian delivery of maternal health care and expose the contradictions intrinsic in a State that delivers healthcare to a population that it may also end up annihilating through the killings of black male youth and the symbolic/affective killing of their mothers, partners and communities. In Chapter Four I illustrate the local contours of this violence, while Chapters Six and Seven unpack the dynamics of these forms of bureaucratic-anonymous care in the delivery of prenatal and birth care.

Thus, when talking about global health projects, it is important to acknowledge how they can enact 'regimes of care' that can have perverse consequences when they harness forms of knowledge that imagine apolitical suffering subjects as separate from broader socio-political circumstances. In a similar vein, Narayan highlights the way in which care discourses have "justified relationships of power and domination between groups of people, such as the colonizer and the colonized" (1995, 254). As Buch has rightly noted, "by individualizing, anonymizing or medicalizing responses to human suffering, these forms of care can foreclose structural or collective responses to injustices." Organizations or programmes may provide care in ways that differ from those whom they seek to help, potentially undermining that which makes life worth living (Buch 2015, 280). With this thesis I aim to contribute to this urgent discussion by illustrating the complex factors that influence maternal health outcomes for black rural women in Bahia and in this process further highlight the value of placing care as an analytical domain that adds yet another dimension to the complex intersection of reproduction, citizenship, and justice.

PART I
BELONGING

"*Eles* combinaram de nos *matar*, *mas* nós combinamos de *não morrer*"[63]

Conceição Evaristo (n. d)

[63] Translation: They organised to kill us, but we organised to survive.

Chapter Four

NATIONAL PANORAMA: LOCAL LANDSCAPE

Maria não amava João,
Apenas idolatrava seus pés escuros.
Quando João morreu,
assassinado pela PM,
Maria guardou todos os seus sapatos[64]

(Lívia Natália, 2015)

What happened to Jaboticaba?

The weather feels gentle and warm. The sun, embraced from time to time by puffy white clouds, creates shadows on the uneven cobblestones. No menace of rain, a nice winter's day.

Dreamily, I walk up the steep hill towards the *Cidade Alta* (the upper city). As on every Sunday the streets are empty, only the vultures watch me pass by. This silence and solitude, a blessing, a threat … alert…

I pass the stalls left from the recent *Junina*[65] festivities. They stand at the edges of the deserted square, shuttered with boards. Various decorations mixed with flowery textiles recreate a plantation and a signpost framed in fake grass indicates *a fazendinha* (the little plantation). A music stage, now empty, presides over the lonely scene.

I think of the outraged complaints I have heard lately: *The local council spending all that money on this party!!! We need other things…, give people music and beer that's all they want… 'o povão é burro'!!* (the masses are stupid!!).

In the distance I can see a parade of people moving towards the church. Today is the official commemoration of Jaboticaba, the day of its political emancipation. The magnificent church stands out, its massive doors wide open, its classic Portuguese features washed in baby blue. Inside, local officials (notably lighter skinned) congregate to celebrate the day and I recognise the local health teams, elegantly dressed.

The sermon:

> *Jaboticaba, one of the oldest cities of Brazil, has fallen … vice and corruption prevail. As a son of the city, a child of its mangroves and rich traditions … I am witnessing how local children are becoming thieves, 'perdidos'!!!* (lost!!!) – the priest exclaims in anguish – *The current chaos is due to a lack of morality, a moral crisis, what has happened to Jaboticaba? ... where is the 'bençăo,'*[66] *where is respect? the good*

[64] Translation: Maria did not love João, she just idolized his dark feet. When João died, murdered by the Military Police, Maria kept all his shoes.

[65] After Carnival this is the second most popular national festivity in Brazil, especially in the northeast region. Celebrated in June, it commemorates a series of Catholic saints.

[66] Translated as 'the blessing,' it is a form of greeting that shows respect to elders.

manners… Today you have to be afraid of children because you don't know what they will do … Something needs to change…

After a pause for reflection, which seems to last forever, the priest assumes a more didactic tone. Making reference to the Brazilian flag where the phrase '*ordem e progresso'* (order and progress) is inscribed, he then talks about a document from Pope Francisco in which a new model of progress is put forward; *a new world vision* he declares, with his right arm in the air, index finger pointing forward, as if towards the future.

After some singing, a woman approaches the microphone and addresses the politicians in exalted tones, simultaneously pleading and commanding:

Change the fate of this city. God wants to change the destiny of Jaboticaba's children through you. He [God] *has allowed you to become mayor of this city so you can change its fate. God sent you.*

The mass reaches its end with a solo of squeaky opera followed by the hymn of the city sung in chorus. Marking the closure, massive flags of the city are waved by young Catholics as they make their way out through the central passage of the church shouting:

Viva/salve a cidade de Jaboticaba!! (Hurray/Hail to the city of Jaboticaba!!)

***

A sense of corruption, insecurity and exhaustion was pervasive in Brazil throughout the time of my fieldwork, and Jaboticaba was no different. Local interlocutors expressed little faith in politics. Descriptions of Jaboticaba's recent political history included a fugitive mayor leaving municipal council funds empty, budgets diverted, vote-buying bribes and a perpetual lack of transparency in municipal accounts. On one occasion, I conversed informally with a nurse and a teacher over dinner about the local situation in the areas of health and education. They became so exasperated as they recalled fraud and irregularities they had witnessed over the years that both stood up from the dinner table to get some air. Local experiences blurred with the national atmosphere of chaos, which was constantly reaffirmed by a relentless media bombardment that foregrounded the widespread national violence, insecurity, corruption and lies. The idea that the crisis in Brazil was not just political and economic but also moral was a common claim, illustrating how the notion of an all-pervading crisis in Brazil was chanelling deeply felt frustrations across several layers of society. An ever-growing conservative wave was sweeping across Brazil, giving voice to social and religious demands that were ideologically undermining the results of years of progressive agendas. Turned into a 'moral panic,' this was expressed in middle-and upper-class resentment towards 'the poor's' social mobility, whose presence they now had to tolerate in spaces traditionally inaccessible to them, such as airplanes and shopping

centres. For them, the masses had become a subsidized population in which the State, through compensatory policies, was cultivating attitudes of laziness and entitlement (Saad-Filho 2013, 661/662). Likewise, reactionary religious factions (mainly conservative evangelicals) portrayed the advancements of recent decades in the areas of sexuality, gender and reproduction as threatening both 'the family,' the overall order and the right progress of society. They argued these were the sources from where many other social ills, such as crime and corruption, were emanating (Almeida 2020).

This crisis in Brazil was a 'total social fact' (Almeida 2020). The national panorama was perceived to be morally, socially and politically out of control and so was the local landscape of Jaboticaba. In this rural area, 'progress' had failed the population, but in what ways? Material life had improved and so had access to land. However, violence had increased substantially, insecurity was haunting the national and local imaginary, plaguing and intensifying anxieties about the future through what some perceived as a generational crisis in values. This was posing serious challenges around notions of democracy; as one interlocutor asked me rhetorically: *"is it democratic to live in fear?"*

In this chapter I ask: what are the underlying processes contributing to this scenario? What are the consequences for the people of Jaboticaba? How does it affect their sense of belonging and hopes for the future, especially in relation to reproduction and child-rearing?

The chapter is divided into four sections to address these questions. The first two sections provide an overview of what it is like to be a young person in Jaboticaba, detailing the new generations' opportunities and limitations as they acquire a sense of being citizens. Through local narratives, I explore some of the effects derived from neoliberal practices of citizenship in a context of social abandonment which is directly connected to structural racism and impaired development caused by longstanding corruption and clientelism.

In the third section I identify links between these local processes and the wider racial economy of violence in Brazil, focusing on violence against young black males. I explore how this violence extends beyond the 'counting of bodies' and how it is simultaneously normalized and ordinary but equally experienced as part of an outrage that is lived through with indignation and horror. Finally, I focus on this 'normalized outrage' and scrutinise the way in which it constitutes an assault on social relations, subjectivities and a sense of belonging, highlighting its structural links to a brutal past and the devastating effects it has on the possibilities of 'raising a child' today.

Wasted Youth: Dead Youth

It is so easy to get trapped in a bad life around here ... To go to waste … But I was lucky, Jesus saved me, the young caretaker at the health post in the Bairro of Engenho tells me in a confessional tone. I have known him for a while, and he is always polite and quiet. Today the activity at the health post is slow and we have more time than usual to talk. João is twenty-one years old and is studying at night-school to complete his formal education. He wears glasses and his hair is trimmed; nice ironed shirts and tweezer trousers complement his clean look. *I have had difficulties,* he says, as he starts sharing his troubled ventures with drug trafficking with me. In the beginning he was given his first 'highs' for free. He then slowly became indebted and soon afterwards began working for the dealers, running errands. But there was more to it than just vice and paying debts. It was also a way to earn money: *Unemployment is high and so is temptation,* he reflects. *You want your new 'boné'* (cap), *a good pair of shoes and a watch …*

Your day will come… competing dealer boys would whisper as he crossed them in the streets. On one particular day, two of them were waiting for him at the end of a *ladeira* (hillside). He saw death coming and ran into the house of a Pentecostalist – his only chance to escape. In desperation, he promised he would accept Jesus if he could be saved. When he walked out of the house, the two men had disappeared. However, he quickly forgot about the incident and continued listening to the *inimigo* (the devil). Soon afterwards, he was almost kidnapped and taken to the *fundo* (depths, meaning he would disappear). His mother took him to an aunty in a nearby city, where he started going to a Pentecostalist church. Now he has returned to Jaboticaba, having accepted Jesus in his heart and, miraculously, everyone on the streets has forgotten about him. They do not remember his name; his past has been deleted. *Jesus can do that, you know? They do not recognise my face anymore,* he tells me smiling, his eyes shining with religious passion.

On Saturdays he spends time with his family. Sunday is a church day. Some nights he evangelizes on the streets of Jaboticaba with a group of young *crentes* (believers). It's dangerous, but before they head to the streets, they *orar* (pray) fervently and prepare themselves for the journey. Jesus accompanies them.

The nurse comes to the back of the *posto* (health post) at the perfect moment as João has now gone into full evangelizing mode. He heartily recites fragments from the Bible and insists that I visit his church. I have not been at that *posto* for a few weeks and when the nurse sees me she screams happily: *Laura!*, waving a clip-board in her hand. *Look! Lots of new 'gravidas'* (pregnant women), *they are all under-aged* ... She rolls her eyes, then shows me a list of names – a number of them have a pen-mark next to them. *You see this,* she points to the pen-mark, *infected by syphilis … these young girls are only worried about wearing short pants and dating …* '*Sem juizio!!!'* (No common sense!!!).

***

João set himself up as a good example. Redeemed, he is an emblem of hope, an alternative to the other available options: a drug-trafficker, a teenage body carrying STDs (Sexually Transmitted Disease), a bad son, a bandit wearing expensive clothes, a lost soul. *To go to waste… temptations are so many…*

Joao's story reflects some of the perilous paths available for young people in Jaboticaba and their potential outcomes. They are linked to situations of vulnerability and to the dynamics of social exclusion, although they are usually portrayed by the media and institutions of law and order within discourses of collective pathology and criminality (Calderia 2001).

Jaboticaba, as part of the region of Baixo Sul, ascribes to a model of territorial development based on tourism and sustainable family-based agriculture (Renato 2016, 33-34). Despite its rich historical heritage and astounding landscape, the town is little more than a conduit, via land and water, between nearby and distant tourist destinations. Located at a crossroads, Jaboticaba is a strategic bypass for drug trafficking and consequently feeds into the circulation of money and weapons, with local media reporting that the trafficking of weapons is becoming a serious issue. Locals insisted that a *facção* (faction) from the *Primeiro Comando*[67] *da Capital* (PPC), considered one of the largest Brazilian criminal organizations, was operating in the area. The recruitment of young boys by organised crime to sell and consume drugs was, in local terms, the reason for the rampant violence, although there are many forms of violence in Jaboticaba.

Recruiting young boys is probably not difficult to achieve as Jaboticaba is short of opportunities. The vast majority of its young residents struggle to access stable work, and their livelihoods are precarious. In 2010, just over half (50.70 percent) of the population were in households with monthly incomes of up to half the minimum wage per person[68] (IBGE/BA 2020). Confronted with the difficulty of accessing cash, many move back and forth to Espiritu Santo (a southern state close to Rio de Janeiro), where they work as seasonal labourers in the coffee plantations.[69] Others migrate to a megalopolis: São Paulo, Brasilia or Rio de Janeiro, or to closer cities such as Salvador and Feria de Santana. The few enclaves of tourism in the region (such as Barra Grande, Ilha de Tinharé and Itacaré) also present work opportunities. However, this labour market, entrenched in Brazil's structural racism, is restricted to 'particular profiles'[70] and locals run into fierce competition with whiter middle class southeastern

[67] One of the most important drug cartels in Brazil. For further reading on the PCC see: Manso, Dias, C. N. A guerra – *A ascensão do PCC e o mundo do crime no Brasil*. 2. ed. São Paulo: Todavia, 2018.

[68] Set at the time at 510 reais per month, approximately £180 (Countryeconomy 2010).

[69] For a full report on the lack of rights for these workers in Brazil see: MONITOR # 5 Certified coffee, rightless workers, [online]. Available at: https://reporterbrasil.org.br/wpcontent/uploads/2016/12/Cafe%CC%81_ING_Web.pdf

[70] As an example of these practices in Rio de Janeiro during the 1940s and 50s, the term *boa aparencia* (good appearance) was used as a euphemism for 'white' when advertising work positions (Caldwell 2007, 66; see Roth

Brazilians (particularly *mineiros* and *cariocas*[71]), who move to the area to work in the tourist industry in a setting marketed as 'paradise.' Here, Brazil's very alive racial hierarchy is in full display with black locals occupying spaces like the kitchen, cleaning and labour services, and southeastern white Brazilians working in management or public-facing positions.

Working as daily labourers for plantain and cocoa plantations, young men and women from Jaboticaba also participate in the local informal urban economy, where they do not necessarily perform regular services or receive regular wages. In 2018, the proportion of employed persons in relation to the total population was 7.9 percent (IBGE/BA 2020). An example of this was a young man I made friends with during my initial visits to the town in the early days of my fieldwork as I spent a lot of time 'hanging around,' trying to meet people and find a way into local life. Thiago would often help tourists by carrying their luggage from the bus to the motorboat's docks. Always chatty and curious in my presence, he shared the difficulties of accessing cash in Jaboticaba: *"there is no work"* and *"nothing to do."* With time, I learned he was an occasional user of crack. Thiago also told me things that other young people later confirmed. Acquaintances, old school friends, neighbourhood faces, cousins of cousins, people they may have known, both past and present, had been killed or jailed. In attempting to give shape to my questions about this, Dona Cosmiana, a quilombola leader told me: *"Look, you know the boys, the young boys with the wheel barrels?*" She was referring to the young boys who offer to carry your shopping for a few *reais* outside the local supermarkets and also offer their services at the Saturday street market. About 13 years old, they can usually be found laughing and joking as they wait for a client; other times they might be fighting with bare fists because a customer was stolen from them or because someone's mother was insulted. *"Out of a group of twenty from a few years ago there must be only four or five about, the rest jailed or dead…"* Cosmiana tells me as she arranges the fruit on her market stall.

Local voices have consistently described how Jaboticaba's political history was trounced by clientelism and corruption, which impeded the delivery of quality preventive public policies to match its growth and transformation. Policies key in the prevention of crime include those focused on public security, urban planning and social prevention, as well as those targeting education, social assistance, culture and health (Cerqueiras et al. 2017, 20). In Jaboticaba these

Gordon 2017 for an expansion on this). This is now prohibited through laws on racial discrimination, however in hiring practices "appearance can be disciplined in informal ways" (Edmonds 2010, 109).

[71] These terms signify people from the states of Minas Gerais and Rio de Janeiro, respectively.

were, in a few cases, only partially implemented, with the majority of these fundamental strategies waiting to be put into action.

The most recent population census in 2010 recorded a Human Development Index (HDI) of 0.565. Jaboticaba's illiteracy rate (in those aged 15 or over) was 24.6 percent, and only 31.4 percent of all permanent private households had sanitation considered adequate, decreasing to 12.4 percent in rural areas (IBGE/BA 2020). When discussing the services in CRAS – *Centros de Referência da Assistência Social* (Reference Centres for Social Assistance), women complained that these were just *façades* with nothing inside. Indeed, *façades* with nothing inside materialized across the municipality of Jaboticaba manifested by incomplete buildings for schools and health posts. Opinions based on direct experiences with the services of the *Conselho Tutelar* (Child Protection Services) were also negative. These were all instances of Brazilian democratic rhetoric; promising policies and services that the labyrinths of bureaucracy and corruption turned into nothing. During my fieldwork, a joke circulated among the women regarding the intervention in a public talk given by a senior female social assistant, who called on women "*to be patient*" with gender violence and *"to look up to Jesus who suffered even more on the cross."* To call for patience in the face of violence is to invoke complacency, ultimately demanding its acceptance and normalisation. Patience is always inscribed in a context of waiting, invoking an undetermined horizon that conjures up an uncertain future. These circumstances leave the population of Jaboticaba in a state of limbo. In this setting, justice fades and the absence and neglect of the State grow sordidly visible as inclusion becomes a mirage based on certain forms of citizenship.

Inclusion as illusion: the mirage of citizenship

João talks about temptations. These are manifold and refer not only to the escape of the soul when consuming toxic substances, but also indicate those emanating from the earthly material world: 'things' as consumer goods. In Brazil, post-millennial political-economic policies have nurtured a type of citizenship tied to visions of modernity that are connected to consumer practices and culture. The 'Lula era' (starting in 2002 when Luis Inacio Lula da Silva, founder of the PT, was elected president, and finishing with the impeachment of Dilma Rouseff in 2016), implemented the most impactful wealth redistribution programmes in the history of the

Brazilian republic, with some of them such as *Programa Bolsa de Familia*[72] (PBF) being acclaimed internationally (Saad-Filho 2015, 1127).

The PBF was highly popular among the poor; votes obtained by Lula and Dilma Rousseff in the 2006, 2010 and 2014 elections were correlated with the distribution of beneficiaries (Saad-Filho 2015, 1236). However, despite significant achievements during this time, such as a decrease in the extreme poverty headcount from 12.7 percent to 4.9 percent and a poverty decline from 33.9 percent to 13.9 percent of the population (Mendes Loureiro 2020, 65-66), ultimately cash transfers have not transformed the conditions and life chances of the poor. These policies have become a palliative that subsidises the reproduction of poverty and inequality. This is because they do not tackle the root causes of poverty, namely economic vulnerability – low pay, and precarious housing and employment – and the lack of asset ownership – because it is concentrated elsewhere (Saad Filho 2015, 1247-1248). Framed within 'left neoliberalism' (Diderot and Laval, 2016); these policies are a poverty-reducing variety of neoliberalism.

In Brazil, State power was used to include individuals in constantly growing formal circuits of commodity production and consumption. The government provided income to the poorest, while it also passed legislation to allow for financial innovations and subsidised the provision of privately owned services. In this way, though deprivation in multiple aspects was diminished, it was achieved through advancing the commodification of social reproduction and increasing the chains of debt (Mendes Loureiro 2020, 24). Thus, a large portion of the population were allowed to participate in the consumer society, while serious social issues – such as access to good quality education, health care and public security – remained unresolved (Fontelle and Possebon 2018, 11). Overall, driven by the imperatives of political stability, and reinforcing a system of accumulation, Brazilian social policy has not created social integration and economic change but rather supported the reproduction of prevailing patterns of social exclusion (Saad-Filho 2015, 1243).

[72] The Brazilian *Programa Bolsa de Familia* (Family Grant, PBF) is one of the world's largest Conditional Cash Transfers (CCT) programmes. *Bolsa de Familia* provides benefits to extremely poor families (per capita monthly income below R$ 70, or US $25 in early 2015) and poor families (income between R$ 70 and R$ 140). The variable benefits are conditional on school attendance, vaccinations and medical follow-ups on children under seven, check-ups and prenatal care for women aged 14 to 44 and checks on babies and lactating mothers. Logically, PBF is extremely popular among the poor. Votes received by Lula and Dilma Rousseff in 2006, 2010 and 2014 were strongly correlated with the distribution of beneficiaries. PBF is transferred monthly to the female head of the family (Saad-Filho 2015, 1233).

By the time I arrived in the field in 2017, cash transfer policies had lifted millions of people out of poverty (IPEA 2019). Supported by a sophisticated media network, reaching the remotest areas in the country (Edmonds 2010, 25) the 'otherwise destitute' had equally entered a dynamic of consumption (Fontelle and Possebon 2018, 3). In Brazil, citizenship was/is a 'work in progress,' marked by few advances and huge obstacles and difficulties, including a long history of authoritarianism and extreme social inequality (Fontenelle and Possebon 2018, 11). Furthermore, much of what is considered as an outcome of neoliberalism in Brazil is in fact deeply rooted in "historical modes of abandonment and long-standing forms of governance premised on institutionalized racism" (Denyer Willis 2017, 87). Historically, in Brazil, there has been an uneasy disjunction between blackness and citizenship. Today, black citizenship is often cancelled out by diverse mechanisms whereby "black people rhetorically have rights that do not manifest practically" (Smith 2016, 81). Neoliberal rationality is specifically endorsed "by this game of illusions that co-opts the discourses of freedom, choice and consumer sovereignty (Fontenelle and Possebon 2018,6). The Afro-Brazilian philosopher Sueli Carneiro has pointed out that, especially among Afro-Brazilian youth, this form of inclusion based on consumerism works in such a way that it veils racial conflict and consequently truncates the emergence of the radicalism necessary for proper social transformation to take place. For her, "in this neo-racial democracy, the capacity for consumption stands as the limit for black citizenship" (Carneiro 2003). To this another dimension must be added; namely the consequences when these marketed models of life, identity, and sense of belonging based on consumerism are unachievable due to economic exclusion.

There were many Joãos in Jaboticaba. Stories like his piled up in the territory, like bodies in the local cemetery. "*Buried two palms from the ground, one on top of the other*," a community health worker told me. The concern of a 'wasted youth' *(juventude perdida)* plagued locals' imagination and contaminated the possibility of projecting into the future. For many, the danger and possibility of losing the young to these 'temptations' could only be counteracted by the action of the community and the family. This meant not only following closely the actions of 'the young' by observing and maintaining a constant dialogue with them, but also inculcating discipline and respect, so they could be "*brought back to reality, away from this 'sistema doido'* (crazy system) *placed in young people's minds.*" In this *crazy system* consumption offers "potentially at least, respite to the consumer as a form of belonging, even citizenship, that is perhaps otherwise unavailable" (Miles 2012, 219). To those historically excluded it provides a sense of belonging, if only a momentary one. As Edmonds (2010, 112)

explains, "when citizenship is defined through consumption, rights can be re-signified as the ability to acquire prestige items, while the antidote to social exclusion is imagined as market participation."

This *sistema doido* has another perverse effect on youth in the locals' eyes, which was often brought up in worried tones by *lideranças* (leaders) and elders in community meetings. They spoke about a lack of political engagement by youth, and the need to push them to participate and engage in the *luta* (fight). One community leader, reflecting on these issues, explained how consumerism had created an *espejismo* (mirage) for the youth. Conditions of life had improved but the youth were *apagados* (asleep) "*because they found everything already 'done' and do not know about the 'dificultades'* (difficulties)." In some cases, the vision of the youth as *apagado* could be perceived as one key reason for falling into these temptations. As we spoke about youth and opportunities, an active community health worker elucidated the most important underlying issues in this matter:

> **Health agent**: Well … it's like this … here in Jaboticaba we have this link with tourism … those kids close to it receive tips, sometimes also run 'particular errands' … the boy starts and before he realises he is fully immersed in it…
>
> **Laura**: already inside…
>
> **Health agent:** But the majority of people in Jaboticaba blame the boy for this situation, they do not distinguish. People say the teenager is like that because he chooses to, then comes the talk that he needs to be killed and violence comes…
>
> **Laura**: and now this is happening also here in the rural area?
>
> **Health agent**: Yes, the violence has reached here as well … the police will do it [kill] … but we never hear of police killing a '*filho de papai*' (rich kid) … Those who are killed are us, poor and black …

This community health worker lucidly highlights a common double process: a context in which there is a naturalisation of police violence, and worse, police violence being seen as the solution. As Teresa Caldeira (2006, 109) states, in Brazil "police abuses indicate one of the most perverse ironies of this universe: the fact that the police who kill may, in fact, be acting according to the expectations of citizens who are frustrated with the inefficacy of the justice system and who cannot believe in the possibility of security in a system with immense social inequality." The case of Jaboticaba illustrates this perverse irony, with those who see tough policing as the solution often coming from the same social group as the victims; that is, they are poor and black. However, I observed that this is not done blindly or naively. Indeed, local

people simultaneously display a deep distrust of the police based on their everyday experiences and encounters with State police forces.

The ways in which 'blame' is allocated and understood reflects neoliberal ideologies of self-choice and self-control. These discourses erode historical and structural factors. Authors studying violence in Brazil note how this blame often extends to the mothers of the 'wasted youth,' who are accused of failing to educate their children (Reis 2005, Dalsgaard 2004). Thus, violence is multifactorial and in Jaboticaba it was not only the result of neoliberal regimes and subjectivities, but was also immersed in powerful historical dynamics of racial exclusion and social abandonment.

Christine Sharpe (2016, 78) asks starkly:

> In the afterlives of *partus sequitur ventrem*[73] what does, what can, mothering mean for Black women, for Black people? What kind of mother/ing is it if one must always be prepared with the knowledge of the possibility of the violent yet quotidian death of one's child?

The level of violence in Brazil exceeds that of some countries wracked by civil war[74] and the shocking numbers of violent deaths among youth in Brazil has become an issue of serious concern. Many authors, (e.g Reis 2005, Feffermann 2015, Smith 2016, Alves 2018), and staff working for national and international social movements, contend that there is a genocide[75] of the Afro-Brazilian youth, a mass extermination without war. In recognition of the seriousness of this issue, several actions have been taken at federal, state, municipal, and district levels (e.g. the Living Youth plan launched in 2014) (Gomes and Laborne 2018, 9). Statistical studies[76]

[73] Literally meaning the offspring follows the mother, that is, the child inherits the status of the mother, and in the case of slavery, the non-status/non-being (Sharpe 2016, 15).

[74] Brazil registered more victims of intentional violent deaths (or assassinated people) in five years than the Syrian war did during the same period (Lima and Bueno 2015, 6).

[75] The term genocide has been re-signified and expanded. This term was adopted by the Federal Senate in the final report of the Parliamentary Commission of Inquiry (PCI) on the Murder of Young People which states: "This PCI, in line with the concerns of the Black Movement, as well as the conclusions of scholars and experts of the theme, SF/16203.78871-55 34, takes the phrase black population genocide in this study as the most adequate to describe the current reality in our country, as to the murdering of young black people" (Cited in Gomes and Laborne 2018, 5).
To see the Amnesty International Campaign: https://www.amnesty.org/en/latest/campaigns/2014/11/young-black-alive-breaking-the-silence-on-brazils-soaring-youth-homicide-rate/

[76] The edition of the *Atlas da Violência 2019* produced yearly by Ipea, *Instituto de Pesquisa Econômica Aplicada* (Institute of Applied Economic Research) and the FBSP, *Fórum Brasileiro de Segurança Pública* (Brazilian Forum for Public Security). Based on official data from the SIM, Sistema de *Informações sobre Mortalidade* (Mortality Information System) of the *Ministério da Saúde* (Ministry of Health (SIM/MS).The reports state that

confirm this, and in terms of the statistics that are available on violent deaths in Bahia, independent observers such as the researcher from Rede de Observatórios da Segurança (Observatory Networks of Public Security), Luciane Silva, condemns the lack of State transparency in the publication of data about violence, declaring that "there is still a great deal of invisibility about what happens in peripheral neighbourhoods" (Rede de Observatórios da Segurança 2020). It is a well-known fact that in Brazil the police are part of the problem of violence and therefore co-responsible for the high levels of deaths (Caldeira 2001, Alves 2012, Smith 2016).

Mass black youth incarceration[77] remains an equally imperative issue and an aspect where the local landscape of Jaboticaba once more reflects the national panorama. One afternoon, as we drank coffee with an old *raizero* (traditional herbalist) in Dona Jeje's house, located in the economically deprived neighbourhood of Engenho Velho, our conversation flitted from herbs and remedies to old anecdotes about the neighbourhood. As we got deeper into the *situação* (the situation, as the *raizero* called it) the *raizero* eventually stood up, exasperated, his arms moving like a whirlwind pointing in all directions, eliciting family names and the condition of their young males: *morto* (dead) or *preso* (jailed), he repeated over and over, adding finally a distressed: "*how can this be?!"*

Many scholars have explored the ways in which racial questions (amongst other social issues) are directly associated with mass imprisonment (e. g Wacquant 2001, Gilmore 2007). Brazil's Centre for Information on the Penitentiary System (Infopen 2018, 11/33), states that

in 2017, 35,783 young people were murdered in Brazil (69.9/100,000). This horrifying number represents the highest rate in the last ten years. Thus, young men account for 94.4 percent of the total youth homicides in Brazil. In Bahia, this figure is registered at the ratio of 228.7/100,000 (Cerqueira et al. 2019, 25-28). In 2017, 75.5 percent of the total homicide victims in Brazil were black; that is, 43.1/100,000 in comparison to non-blacks (whites, yellow and indigenous) at 16/100,000. For each non-black person killed therefore, 2.7 black people were killed (Cerqueira et al. 2019, 49). Studies also show that black youth are 2.5 times more at risk of dying by homicide than white youth (Sinhoretto and de Souza Morais 2018, 18). In the state of Bahia, the scenario in 2018 was even more alarming; during that year 5,427 black men were killed, while the number of white men killed was 350 (while bearing in mind that the black population in Bahia is large). When these numbers are disaggregated by age (focusing on the 20-29 age range), the death rate among young blacks reaches 236/100,000, and for young whites, 55/100,000. In other words, the number of violent deaths is 4.3 times higher for black youth (Rede de Observatórios da Segurança 2020, 3/4).

[77] Since 2000 Brazil has had an average annual growth rate of 7.14 percent in its prison population, with the situation within prisons being extremely precarious and seriously overcrowded. In Bahia this translates as prison occupation at156 percent of capacity (Infopen 2018, 8/9/22/27). It is possible to infer that a high proportion of inmates are young (up to 29 years old), calculated as totalling 54 percent in Brazil nationally, and 57.6 percent in Bahia. Prisoners are predominantly black: 63.6 percent in Brazil and 87.7 percent in Bahia, and male: Bahia having 16,196 males in comparison to 633 female prisoners (Infopen 2018, 11/33).

Brazil has the third largest prison population in the world, with 726,354 people imprisoned, in Bahia, this translates to 16,829 people.

These numbers reflect the 'terrible calculus' of necropolitical governance, where "reading violence as apolitical or non-racial is inadequate for theorizing the totality of this experience" (Smith 2016, 19). Research about violence in Brazil by Cerqueria and Moura (2014) has confirmed that socioeconomic and demographic characteristics explain only 20 percent of the differential between black and white homicide victimization. Thus, explanations must not neglect the perverse workings of racism, which not only brings "physical extinction but also plays a part in thousands of symbolic deaths behind the loss of opportunities and personal growth in the face of racism in Brazil" (Cerqueria and Moura 2014, 10).

As Amparo Alves (2012, 33) states: "Mass incarceration, unemployment and police lethality constitutes a spatial strategy of racial domination in which the state appears as a murderous agent even when it is not explicitly implicated in such deadly practices." In Jaboticaba, the pattern of juvenile victimization echoes the Brazilian national economy of racial violence, part of "a social mechanism of pain and death" (Flauzina 2008, 115), either via direct action in youth killings or negligence through State abandonment.

Pervasive (n)ever-naturalised violence

The steps to Maria de Jesus's house, located downhill on a dirt road in the barrio of Engenho Velho in urban Jaboticaba, are steep and tall and I cannot help wondering how she manages going up and down without falling. I gather my energy and move upward, with Dona Jeje joining me in this movement. We like to visit Maria de Jesus. She is an old *parteira* from the isolated quilombola community of Terra Brava in the municipal territory. So is Dona Jeje and both now live in town, not far from each other. Dona Jeje left Terra Brava when her son was murdered and Maria de Jesus left because she was getting too old.

Dona Maria de Jesus is sitting in a plastic chair by the entrance to the door. A flowery skirt and crystal-bead necklace combine nicely with the light creamy scarf tied around her head. When she sees us, she looks to the sky and says: *Graças a Deus!* (Thank you, God!) and summons us to hug her. The skin on her face is like thick wrinkly parchment paper; set in the middle are two dark marbles, her sparkling eyes. With a stunningly lucid memory, she shares stories from the past as we drink homemade *caldo de jenipapo* (juice from *Genipa Americana*, a local fruit).

Maria de Jesus receives visitors frequently. She is well-known in the area because *she can see things.* Another *parteira* told me, *she will know if it's better to spend the money on medicine or on a caixão* (coffin).

Oi Mariaaaa!! A loud voice from the street seeps into the open house. I look out and see a bare chested twenty-year-old young man waving his arm as he walks past. *You see…*, Maria says proudly, *filho de umbigo* (a child born into her hands). He is one of hundreds in the area.

Suddenly, a figure at the entrance blocks the light for a second. It is Marilene.

Come on in girl …. Maria de Jesus stands up slowly. She is serious now and continues talking to Marilene in a cautious tone. *Listen, I had a look at what you asked me … and you should not go, minha filha* (my dear girl). *They will kill you!!*

Marilene has moved from the doorway and is now sitting on the couch next to me. She looks concerned and disappointed after hearing Maria de Jesus' warning words. She wants to go to Espiritu Santo to the coffee plantations as a seasonal worker so that she can make some money. She has three children with three different men and the father of the youngest is currently sporadically living with her. On her left cheek is a scar from a machete attack. The lover of her last *marido* (husband) *tried to kill me in a boteco* (small bar), she explained on another occasion.

It's not enough with what you have? Maria asks gently. Marilene replies, *Just enough*.

She sells home-made pastries in the streets … *but not enough for other things…* Marilene looks down defeated ...

Not long ago, during a previous visit on a hot afternoon, Dona Jeje slept on the couch while Maria de Jesus recounted the birth of her granddaughter. I recorded her. Driving past, a car with a megaphone announced a burial, a common practice in Jaboticaba.

Can you hear?? … – Maria de Jesus told me distressed and frustrated – *… that boy, that boy being buried … I told him not to go! NOT TO GO!!! But he did not listen…*

***

Marilene feels hopeless, the fragile possibility – even if temporary – of a respite from her day-to-day material hardships dissolves in light of the crude prognostic of a probable deadly outcome; her own death. Although the knowledge of our future and of the time of our death escapes control, at times we all anxiously ponder the unknowability of fate. Maria de Jesus creates order in this uncertainty by determining the lines between safety and danger: she can predict uncontrollable violence. There is no ambiguity in her words, she does not hold back her verdict.

Magic and the image of a sure death intermingle in this scene revealing the multidimensional aspects of violence and the interlocking vulnerabilities at play, expressing their connections in "chains, spirals, and mirrors," and illustrating how violence exists in a *continuum* (Scheper-Hugues and Bourgois 2004,1). Expanding beyond its bodily physicality, violence assaults personhood, dignity, a sense of worth; its tentacles permeate affects and lived experience. It is for this, among other reasons, that violence cannot be readily objectified and quantified (Scheper-Hughes and Bourgois 2004, 2). As Smith states (2016b, 38), "a focus on body count limits our ability to gain a qualitative perspective on the extent of this violence."

In Jaboticaba, collective understandings of violence oscillate between its naturalisation as part of the everyday, and an ever-present sense of astonishment and outrage. It hijacks conversations and the way people move, as if under a constant sense of threat. As I slowly became used to this agitation I kept reminding myself that although the threat of violence[78] in Jaboticaba may be the norm, it should be considered and was deemed as an abnormal situation. This paradox became evident during the festivity in a quilombola community, where I received the heart-breaking news of my father's unexpected death back in Spain. As I grieved quietly, kneeling on the floor, women made a circle around me and touched my shoulders with their hands. Many articulated how important it was to die of a natural death: "*be happy that he did not die violently, be happy that his time came naturally, that is how death should be.*" These words highlight clearly how the possibility of violent death is ever present in Jaboticaba. Perceived as abnormal but deep-rooted in the everyday, it is an 'outraged normalisation.'

Known as the *interiorization* of violence in Brazil (Ceccato and Ceccato 2017), it is a fact that violence in the northeast has spread alarmingly to the smaller cities of the *interior* (rural areas) (Cerqueira et al. 2017, 14). Overall in Bahia, the rate of registered homicides from 2005 to 2015 increased by more than 100 percent (Cerqueira et al. 2017, 10). In 2014, the then governor of Bahia, Jaques Wagner, declared in an expression of total helplessness regarding the disturbing increase of violence in the *interior* that, "if anyone knows the way to contain this frightening violence, he is welcome to knock on my door" (Franco 2014). In December 2017, the mayor of Jaboticaba released a note expressing a preoccupation with the level of violence and calling on the state government[79] to act on the issue. The population of Jaboticaba 'feared' public spaces and longed for the days where one could walk about *"sem tanta confuçao"* (without so much confusion/messiness). These days houses display steel bars in their front doors and windows. After dark, streets empty and the threat of *asalto* (assault) or *tiroteo* (crossfire shootings) seizes the town. On numerous occasions I heard the following phrase "*This is hell, we live locked up in fear."*

[78] In the Municipal Health Plan (2018, 27) this was precisely acknowledged as figures informed that the main deaths from 2014 to 2017 for external causes (21.73 percent) were due to violence by sharp objects or firearms, accounting for 65.03 percent of the total external deaths. This rate could be higher, as 13 percent of deaths are not classified.

[79] Issues of public security are under the responsibility of the state government.

"*A dead body here, just down the road:"*
Fear, mothering and belonging

Contact with violence is by no means new in Baixo Sul. Historically exercised by those in powerful positions, social memory is tainted by violence and is part of the regional social order (Pina-Cabral and Da Silva 2016, 68). The history of the inhumane colonial plantation slavery system and the authoritarian rule exercised by local landowners over rural workers is reflected in people's memories and narratives. For instance, in the quilombola community of Caguaiba, Iracema explained one day as we tended the fire in one of the ovens: "*If the babies of the enslaved women cried too much, the owner of the plantation would grab them and throw them in the oven.*" Seu Miguel, an older quilombola leader who has been active in the union movement of rural workers since its inception, had many accounts of exploitation and abuse. He has witnessed labourers being killed so wages did not have to be paid by landowners, as well as murders due to land grabbing by *grileiros* (land grabbers). However, there was something new about this violence that made people scared. Unpredictable, it could happen anywhere, anytime, to anyone; and there was a strong sense of not being in control. People could not recall if things had been so bad before, but they were sure that *"Jaboticaba is not what it used to be."* The monopoly over violence had shifted, diffusing itself throughout a myriad of hubs. Violence is now perpetrated as much by non-State actors as by the State and its network of powerful allies, such as landowners and local oligarchies.

Adding to the narratives of assaults, police murders, revenge, and extortions, the use of images through social media circulated in spirals. Almost every household has a mobile phone, and if not, neighbours share news and images. These images often include very graphic pictures of violent events that have taken place locally. Illustrating the scale of this I had to ask one of my informants, a fourteen-year-old girl, to stop forwarding these images to my number as they were so disturbing. Yet, it was not only through TV and social media that the spectacle of violence was disseminated. When things happened, especially in the countryside, people would walk miles to witness the dead bodies. People walked in groups to the scene and came back with full descriptions. I could never manage to understand the rationale of bearing witness to such macabre scenes. When I commented on this to a local doctor, he admitted that he also engaged in these morbid voyeuristic practices, arguing that it prepared one for what may be encountered; "*In Brazil you always have to be prepared for violence,"* he explained solemnly.

It was indeed not uncommon for dead bodies to appear on the street in the peripheral neighbourhoods of the urban centre. Dona Creusa, one of the older *parteiras*, complained about this: "*In the past you would not see this. The other day a dead body lay here, just down the road, and the children, my grandson, walking around, all exposed, blood everywhere, this cannot be normal … but it is happening.*"

In a similar vein, Dona Ana told me, "*I cry a lot, but I still have to go and see."* Sometimes she knew the victim, other times she didn't, but she would always cry. When I asked her why she cried for those she did not know, she stated: "*We all have a mother, don't we?"* I then thought about an incident that took place months before I left for fieldwork. A boy was stabbed to death close to my home in Cambridge. He was the same age as my son. That night, I lay in my bed unable to sleep. My chest was heavy, the dead boy's mother on my mind.

The effects of violence are many; the most obvious one is fear. When violence circulates in both words and images "fear is both felt and reproduced, and violence is both counteracted and magnified" (Caldeira 2001, 19). These invisible effects cannot be underestimated, they confiscate dreams and desires, cancelling the possibility of conjugating life and community in the future tense by spreading distrust and eroding social relations. In Jaboticaba, fear forced people to stay at home, behind bars. This doubly affected the way in which the public space was experienced. Whether in the *roça* (countryside) or *rua* (more urbanised areas), it impacted the way in which people related to each other. In recent years, the number of homes in Jaboticaba that have been enclosed with bars and double doors has increased exponentially. In working class Bahian neighbourhoods, the *rua* traditionally becomes an extension of the home: doors are open, neighbours come in and out, people play dominos on improvised tables, drink beer, chat, play. In an atmosphere of fear, new movements become suspicious; tension escalates quickly. Eventually, people end up being scared to occupy the spaces crucial for their social lives.

Even in rural communities, isolated by sometimes un-drivable dirt roads, people take security seriously. Doors are carefully locked at night and no one sleeps alone in a house. Routines have changed and activities are restricted. An illustration of this is the story of Dona Ana, who used to have a little bar in front of her house in the quilombola community of Caguaiba. She told me that the small bar in the front room, now a shed, was where she used to sell popcorn, candy and drinks. *"But now I am scared that 'bandidos'* (bandits/thugs) *will come looking for money, so I've stopped."* Beyond these activities, violence also restricts movement.

Nobody walks alone these days, especially not women, Dona Anna being one of the few exceptions. She continues to move about freely through the *Mata Atlántica's* green maze. When I ask her if she is worried, she replies casually but firmly: "*Esta é a terra da gente"* (this is our land). In this statement Anna reaffirms her sense of belonging and resists the way violence can hinder relations to land and community.

In the context of widespread threats, communities work hard to maintain their sense of belonging, which shows how the effects of violence go beyond the physical killings by damaging many other aspects of the social fabric and life experience. Dona Jeje's son was murdered in her community a few years ago. She left and was never able to return again; "*too much pain*," she would say. Several authors (Alves 2018, Smith 2016, Rocha 2014, Reis 2005) have explored the deep psychological and emotional scars of black mothers in Brazil from a black feminist discourse. Christen A. Smith (2016, 2016b), in her analysis of the gendered dimensions of state lethality beyond the physical, uses the notion of *sequelae* to unravel the qualitative analysis of anti-Black state violence. Smith (2016b) borrows the term from her conversations with the Brazilian activist doctor, Andreia Beatriz dos Santos, who explains that "we work most of the time with numbers concerning death or imprisonment, but beyond that there are long lasting, lingering wounds (*sequelae*) that we can't quantify or qualify" (cited in Smith 2016b, 39). The concept of *sequelae* is important here because it makes visible the rippling waves, the aftermath, the not-so-bodily effects of State violence that would otherwise remain invisible.

Sequelae also captures the cumulative impact of violence on the family. As a further illustration of the way *sequelae* operates, in Jaboticaba at a women's gathering run by an NGO, one of the leaders from a rural community explained how she was suffering from what from her description seemed to be severe anxiety, after her current partner had been accused of and imprisoned for alleged drug possession.[80] Due to the local courts ineffectiveness, he was still in jail after six months with a very unclear outcome (the rate in Brazil of pre-trial detainees is

[80] Sinhoretto and de Souza Morais (2018, 19) inform us that the large number of temporary arrests in Brazil (almost 40 percent) are the result of overt policing based on 'identification of suspects' and criminals, and not on police investigation. They argue that the large number of black people and juveniles in jail is not because the 'most violent are jailed' but rather because the core of criminal policy is based on punishing crimes against property linked to illicit drugs, thus following a 'war on drugs' doctrine.

[81] Here the author refers to motherhood, but other studies show how (abortion, pregnancy and childbirth) are dimensions where women experience State violence through institutionalised racism, I explore this in Part II of this thesis.

33.19 percent, in Bahia this number reaches 51.62 percent (Infopen 2018, 16). This uncertainty put the family under financial and emotional pressure, leading to fights and conflict. Observing the intersections of black rural women's life experiences, "their struggle to survive encompasses not only their own fight against poverty, racism, patriarchy, and gender discrimination but also entails the consequences of violent acts perpetrated or facilitated by the state upon their families" (Smith 2016b, xii).

Violence marks all family members. It can kill in multiple ways, slowly over time and indirectly; it also hinders projections of the future. "Feelings of trauma and loss related to maternity,[81] by direct or indirect experience, are commonly one of the dimensions through which Black women experience state violence" (Smith, 2016b, 36). Authors such as Hortense J. Spillers, have stated that black life in the Americas is an "enforced state of breach" where mother and family are both identities that lose meaning as they "*can be invaded at any given and arbitrary moment by the property relations"* (Spillers[82] in Sharpe 2016, 77, emphasis in the original). References to this past brutal condition shed light on the way in which black lives are still threatened and crushed by "a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery – skewed life chances; limited access to health and education, premature death, incarceration, [and] impoverishment" (Hartman 2007, 6). These conditions were captured in the gloomy mantra some women in Jaboticaba repeated to me over and over: *Não tem como criar menino* (there is no chance to raise a child).

Conclusion

In this chapter I have emphasized how, despite reports of socioeconomic progress and increased inclusion in the last two decades, there was a sense of exhaustion and outrage by the inhabitants of Jaboticaba, reflecting some broader patterns in Brazil. Blurring the local landscape with trends in the national panorama, these patterns ultimately exhibit the fragility of Brazilian democracy and the rule of law. In order to track the outlines that give contours to this silhouette of 'failed progress' in Jaboticaba, I have foregrounded the way in which a lack of access to resources through secure and well-paid employment, and the insufficient provision

[82] See Spillers, Hortense J. 2003. "Mama's Baby, Papa's Maybe: An American Grammar Book." In: *Black, White and in Color: Essays on American Literature and Culture*, edited by Hortense Spillers, 203-229. Chicago: University of Chicago press.

of social services (drivers of poverty and exclusion), coupled with a neoliberal construction of citizenship (based on a consumer citizen), have produced irresolvable tensions in peripheral urban contexts and rural areas alike. This has created spaces of social abandonment and death, of which Jaboticaba is a part, and which reflect the local landscape of a necropolitical national panorama.

To support this claim, I have illustrated the complex play of the forces at hand and discussed how these extend beyond the immediate neoliberal socio political and economic scenario by showing how in Jaboticaba past colonial legacies – such as clientelism, racism, negligence and exploitation – are producing alarming rates of black youth incarceration and murder. Through diverse forms of violence, Brazil condemns black populations to overwhelmingly hostile environments. Additionally, I portray the processes that, in this context, allow insecurity and fear to haunt local subjectivities and imaginations, eroding a sense of community and hopes for the future, while deeply impacting the possibilities of 'raising a child.' In this context, a sense of belonging, membership and citizenship is undermined and put into question. Overall, this chapter illustrates the critical importance of framing questions around reproduction (both social and biological) within a reproductive justice perspective, so structural inequalities and intersectional oppressions can be fully understood in reproductive processes.

Chapter Five

PAST LEGACIES, CURRENT VOICES: Three Women

Dandara do meu quilombo
Me faz livre e voar
Rainha do meu congo
Me *dá forças pra lutar*[83]

(Nina Oliveira,2015)

Celebrating women's day in *Jaboticaba*

On the 7th of March, summoned by the *Articulação de Mulheres do Baixo Sul,*[84] (Organisation of women from Baixo Sul) women from the territory gather to celebrate International Women's Day.

The gathering is held in the historic colonial building where the *Sindicato dos Trabalhadores Rurais* (Rural Workers Union) is located in Jaboticaba. On the top floor the outside heat is countered by the cool tiled floor. Ample wooden windows are opened wide and a high ceiling helps to create a sense of breeze. Looking for a respite after their journeys across the territory, women sit on plastic chairs. They chat, greet and praise each other as they fan their sweaty faces with whatever is available. The atmosphere of celebration and fraternity is undeniable. Most of the women know each other from past activities, workshops and other gatherings; many are also extended family members who live scattered across the region.

The gathering begins with a speech from a lawyer, who describes the services offered by the local *Centro de Referência de Atendimento a Mulher* (CRAM, women's services centre). This draws both sneers and grins. Murmurs and sighs of anger and frustration are heard amongst the public. The tension is palpable and I quietly ask Dona Ca'u what is happening – *All lies* – she explains whispering – *they do nothing for us …* On her lap, her youngest grandson Joazinho, lies asleep. Looking bored and hanging heavily around Dona Ca'u's right arm is her teenage granddaughter Dita.

With the talk over, the mood quickly changes. The NGO representatives hosting the ceremony, well-known and respected by rural women from years of interaction, introduce the upcoming speakers. The female leaders of the rural *comunidades* stand up, confidently waiting to be handed the microphone. An urban-looking woman with braided long hair stands amongst them, smiling. The president of the rural workers union, Julia, a quilombola leader, focuses on the hardships endured by rural workers and the need to continue fighting as *our rights are threatened.* Hardship is exacerbated when you are a female; *from childhood you are working, caring, cleaning, cooking and sometimes 'violentada'* (raped). She claims that none of these

[83] Translation: Dandara of my quilombo, make me free to fly, queen of my congo, give me the strength to fight.

[84] The *Articulação de Mulheres do Baixo Sul* was formed by women from diverse social movements, organizations and unions who continue to fight to improve the lives of women and families in the region.

activities are valorised in their own right; they are only considered 'help', *but we are not helping, we are WORKING!!*

Her sister, known as Nene, a leader from an *asentamento* (rural settlement), and a community health worker, emphasizes the advances made, *in the same way that now as women we can also be unionised we need to carry on moving forward, conquering spaces*. The tone of these women is firm and serious. As the microphone moves to Dona Cosmiana and Benedita, both leaders from quilombola communities, the speeches take on a celebratory spirit, as they stress the satisfaction of being together, *of knowing ourselves as citizens, Brazilians, from Jaboticaba, Quilombola!! black women!! with our hair free!!* Dona Cosmiana explains that even though she did not study, she *can talk* and points to how *these spaces need to be multiplied regardless of men's opposition.* Applause and little cheers follow.

The microphone is then handed to the guest from Salvador, Olivia Santana[85] – the first black women to be elected to the Legislative Assembly in Bahia. After reviewing the current political chaos (including the impeachment, Lula's imprisonment, the austerity measures), she highlights the serious implications this may have for the future: *these people* [those behind the impeachment and Lula's imprisonment] *do not like blacks, poor people and workers. They don't like us to conquer spaces*. She then describes an instance of racism, which she recently suffered and which was covered by some media.[86] She goes on to say:

We, black mothers, must educate our children in praise, tell them they are beautiful, tell them: you can be whatever you want [Her body becomes more energetic] *We have the right to dream. We do not need to repeat the story of our mothers: a domestic slave in the back room. You … we!! have the right to so much more … but this is only achievable through public policy, outside public policy… there is nothing!!!*

She finishes her speech by pronouncing: *History is not made by those who observe but by those who go to battle.*

A week later the feminist, human rights activist and city councillor, Marielle Franco, will be brutally assassinated in Rio de Janeiro.

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In this chapter, I delve into the ways in which life is maintained and reproduced in the rural area of Jaboticaba by exploring, as an entry point, the lives of three women. Each story illustrates a different dimension of the strong colonial legacies that persist in Brazilian society. However, my main interest resides in underlining women's strategies and approaches to fostering 'life' in adverse circumstances, through the lenses of reproduction and care. I begin

[85] For a full review on the situation of black representation in Bahia and the election of Olivia Santana see: https://blackwomenofbrazil.co/olivia-santana-elected-the-1st-black-state/
(Travae 2018)

[86] Olivia Santana, on her arrival at a celebration in a well-known hotel in Salvador, the capital of Bahia, was told to 'go back to the *favela* (shantytown)' by two of the women participating in the event. Olivia Santana was due to appear as a government representative for her public office.
See full report in: https://g1.globo.com/ba/bahia/noticia/secretaria-denuncia-agressoes-racistas-apos-mulher-dizer-que-ela-tinha-que-voltar-para-favela-na-ba-duas-foram-detidas.ghtml

each story by describing, in rich ethnographic detail, the daily features of these rural women's lives.

Through the story of Dona Ca'u, a traditional midwife, I explore the life journey of a *parteira* and the two vital factors that embody the kind of care developed by these rural figures, *carinho* (affection) and *paciência* (patience). I then link the erosion of these 'types of attention' to processes of *epistemicidio* (knowledge eradication), where undermining local knowledge is essential for the advancement of the national health system, which is framed by a univocal modern discourse. In order to understand vernacular approaches to these circumstances, I draw on the Afro-Brazilian notion of *encrucilhada* (a crossroad) as a conceptual tool capable of capturing the plural and paradoxical nature of healthcare practices in Jaboticaba.

Through the story of Dona Cosmiana, a rural worker, I reflect on the fundamental role that land presents in the reproduction of life at multiple levels in rural communities. I illustrate the ways in which, besides being a source of livelihood and well-being, matters around land prompt black rural women to create networks of solidarity and to organise themselves politically. As a way to present this topic and portray the female ancestral resistance that inspires the courage and cooperative nature of female leaders in black rural *comunidades,* I borrow the Afro-Brazilian figure of the *Ialodê.*

Finally, in the story of Dona Anna, I focus on the domestic sphere where the reproduction of bodies and households takes place. By presenting narratives about the undervalued and exploitative care work that black rural women have traditionally performed in private white houses, I expose the racialised and gendered spaces these women have occupied, revealing the way in which, as exploited subjects, they have been denied their most basic rights. I then focus on the journey from oppression to freedom, self-definition and autonomy through the Afro-Brazilian religious concept of *Ori*, a term which metaphorically stands for both individual and collective 'black consciousness.' Continuing in the domestic realm and staying with ideas of autonomy I then describe the constitution of households within the restrictions of the local patriarchal order, and show the way in which women navigate and negotiate within the existing limitations of their social location in the processes of reproduction.

A traditional midwife: *Dona Ca'u*

"Dona Ca'u is back from São Paulo, she asked after you!!" a WhatsApp audio updated me with the latest news.

I met Dona Ca'u at the beginning of my fieldwork. A well-known *parteira* in her fifties, she was highly respected in her community and surroundings. Ca'u is her nickname, and her real name is Maria Concepção. When she was a child her teeth were so white they looked like cocoa pulp (locally known as *cacau*) against her obsidian skin *…"so everyone started calling her Ca'u,"* her daughter Giseli explained. Shortly after my first visit, Ca'u began to show signs of weakness, her head was light, her legs were frail, fever would occasionally appear, one arm felt funny … She went back and forth to the local health centre, receiving no clear diagnosis.

Whenever I returned to Dona Ca'u's place after visiting other *comunidades*, there was little or no improvement, "... *maybe the ovaries, perhaps a tick bite, dengue, Chikungunya …"* Finally, after a few months, as she leaned against the wall of her house searching for shade, she told me: "This is *doença do ar* (air sickness), some people also call it *derrame* (stroke)."

Dona Ca'u belongs to the quilombola community of Santa Anna. Although she was born *"around here a bit further up,*" she settled in Santa Anna twenty-five years ago. In common with most of the population, she grew up on the cocoa plantations in "*terra dos outros"* (other peoples' land), she says this with disdain. Her husband clarifies, with a mixture of amusement and pride, that for three years as he moved around from plantation to plantation making a living, Dona Ca'u preferred to stay in a rundown wooden shack in the middle of the bush, alone with her four children, rather than live in "*terra dos outros*." Dona Ca'u has nine living children (she gave birth to twelve). The oldest two are from a first marriage; he was violent and the relationship did not last. The other children are from her second and current marriage to Seu Zeca, it is a strong, loving relationship. Her house is made of brick, turquoise blue on the outside, avocado green on the inside. There is running water and electricity and a table next to the TV displays the *Santo* (the Saint, as home altars are commonly called). She declares herself Catholic, although she has known *caboclos* (spirits/entities from Afro-Brazilian religions). On numerous occasions, she has made the pilgrimage to Lapa,[87] especially when promises were made and miracles took place. Underneath the altar, she keeps some herbal remedies. The first

[87] This is a very popular Catholic pilgrimage that takes place in the Sanctuary of Bom Jesus da Lapa in Bahia, Brazil.

time she showed them to me, she lamented that these days in the *comunidade* only Dona Maria had an altar in her home.

When I first met Dona Ca'u, she was taking care of three grandchildren. The two youngest were the last offspring from her daughter Giseli, who had left for a nearby tourist area in search of work. Giseli had eight children, and they were being cared for in different households. Dona Ca'u was also raising a teenage grand-daughter, Dita, who had always lived with her. These were not the only children she had cared for; in the past she had taken in the children of two criminals who were left unsheltered when their parents went to jail. Dona Ca'u and Seu Zeca's children were now scattered, with some living nearby and others in distant cities like São Paulo or Salvador.

When I walk into the room, eager to see Dona Ca'u, I find her sitting on the couch. Still recovering, she moves slowly. A big white smile illuminates the room when she sees me. Seu Zeca walks in and profuse hugs follow. Seu Zeca is eager to explain. The journey to fetch Dona Ca'u in São Paulo was not easy; when he saw her in the hospital he cried. She could not talk and could hardly move. Dona Ca'u had travelled to the megacity with her grand-daughter, Dita, to visit one of her daughters. She planned to leave her grand-daughter with her auntie for a while, with some rumours suggesting that it was a scheme to keep Dita away from an older boy she was seeing in Jaboticaba. The family did not trust him; and community dwellers and close relatives kept commenting that she was very stressed by Dita's situation and her other childrearing responsibilities. On one occasion, Done Ca'u even told me she was "*tired of raising children."* Her reproductive labour was taking a heavy toll.

Before she left for São Paulo, Dona Ca'u had been 'prayed over' by three *rezadeiros* (folk healers). A few months earlier Dona Ca'u said that "*With 'doença do ar' the prayer needs to come from three different healers at different times. The folk healers also need to be powerful, not everyone can do this, because 'doença do ar' is strong, it can stay inside you and come out forcefully."* I learnt that this illness comes through the wind or air, "[which] *are invisible, aren't they?*" If it moves from the inside to the outside it will leave *alegamento*, a crooked mouth, perhaps difficulties moving … if it moves from the outside to the inside, it is only *ameaza* (threatening). The stress of São Paulo intensified Dona Ca'u's other preoccupations provoking the sickness, which was inside her, to came out powerfully.

When Seu Zeca went to São Paulo to bring Dona Ca'u back to Bahia, he took a bag with all the remedies from the *raizero* (herbal healer): "*banho de folha, defumação, chá e esfregação"*

(herbal baths, herbal smoke, tea and herbal rubs). Seu Zeca proudly said: *"... the doctor and the nurse congratulated me for my care. They could not believe the recovery was so fast!! Of course, I did not tell them anything about my remedies. Because some illnesses are not for doctors ..."*

Seu Zeca and Dona Cau's partnership was reflected in the care they displayed for each other and those around them, including their narratives about assisting births in the *roça.* Seu Zeca, giggling, would repeatedly say "*she was the* '*parteira' but I was her ally. I would wait outside drinking 'temperada'* (cachaça with medicinal plants) *in case anything was needed!!"* He then looked at Ca'u and told her: "*Well, everybody knows that a 'parteira' always has a companion,"* moving his hands up, looking up to the sky, he seemed to insinuate a spiritual force from above. When I asked Ca'u if she had ever felt a 'force' or something alike, she laughed and replied: "*I don't know ... I just know a few prayers ... and place all my faith in God"*

7. Dona Cau's clay figure made by a community member.

Becoming a *parteira*

The journey to become a *parteira* in Baixo Sul does not follow a single path, although there are similarities in some of the paths taken. Some women became *parteira* by accident – in other words, they first attended a birth because of an emergency and then continued to practice; others felt a calling because they had a *dom* (a gift), given to them by God; and finally, many learned their skills by accompanying older *parteiras* who taught them how to practice. In Dona Ca'u's case, she became a *parteira* through her involvement with the *Pastoral da Criança.*[88] In those days (1980s/1990s) infant malnutrition was high, and she volunteered to weigh the children from the community and the surrounding rural areas. Women knew her and they started asking her to attend their births. She had given birth to a number of children herself, and it was assumed she knew a few things about the process. She then attended courses through the Rural Workers Union and other organisations, thus broadening her knowledge, *"in some things but not in others ... you just say: yes, yes, and pretend to know nothing."* That local people 'know nothing' has long been the official narrative, and Ca'u had experienced this many times in her life.

In Brazil, the figure of the *parteira* is enmeshed in many debates. Envisioned as an obstacle to modernity during the development of the Brazilian nation in the 19th century (Otovo 2016, Barreto 2008), the perception of *parteiras* as primitive, dangerous and a threat to the health of the population continued. By 1945 programmes[89] to train *parteiras* were developed as part of the larger project of hygiene and modernisation (Otovo 2016). Using the figure of the *parteira,* these programmes aimed to transform and spread strict hygienic values and habits to rural populations, whose knowledge and practices around health were considered ignorant and backward (Silva and Ferreira 2011).

[88] The *Pastoral da Criança* is a social agency of the Catholic Church, constituted by the National Council of Bishops of Brazil (CNBB). Founded in 1952, it works "for a world without preventable mother-child deaths and where all the children, even the most vulnerable, can live in a favourable environment to their development." They base their activities in community organizations, training community leaders who then assume the task of guiding and following up the neighbouring families on issues of health, education, nutrition and basic citizenship actions.

[89] Run by the Special Public Health Service (*Serviço Especial de Saúde Pública*, Sesp), the Division of Health Education aimed to train *parteiras* in strict hygienic standards for delivery and newborn care, and also to popularize other sanitation actions. However, this model was based on value judgements that considered popular culture as constituted by "ignorance and bad habits responsible for people's health problems" (Silva and Ferreira 2011, 96-97). PAISM (Comprehensive Women's health programme) included in 1984 measures to improve *parteiras'* work and in 2000 a programme named PTPT (working with traditional *parteiras)* was initiated. PTPT justifies its work on the premise that, given Brazilian's cultural diversity, it is necessary to adopt different forms of birth assistance, which include home births with a qualified *parteira* (Ministry of Health 2010).

More recently, with the advent of democracy in the 1990s and with the expansion of 'humanisation' discourses in maternal health in the last twenty years, *parteiras'* knowledge and practices have been symbolically appropriated and approached in different ways by diverse agents involved in Brazilian birth politics. Some factions of the movement for the humanisation of birth in Brazil have romanticised *parteiras* as symbols of an ancestral knowledge more attuned with nature[90] (Tornquist 2005, 62). As the Brazilian anthropologist Soraya Fleischer (who studied *parteiras* in the Ilha of Marajo in the state of Para) has pointed out, this can be highly problematic because it reifies *parteiras* as entities anchored in the past, at the opposite pole of biomedicine, thus reinforcing dichotomies[91] between traditional/indigenous and modern/cosmopolitan divides reminiscent of colonial birthing scenarios (Fleischer 2007).

The demise of the *parteira* followed a similar pattern throughout rural northeast of Brazil (Otovo 2016, Barreto 2008). In Jaboticaba, the arrival of the national health system during the late 1990s was paralleled by a campaign of criminalization, persecution, and the devaluation of *parteiras'* knowledge and practices. Dona Ca'u liked to attend births, but her son (who is a community health worker) and other family members persuaded her to stop doing so because *"if anything happened,*" she could be prosecuted. I encountered this apprehension in many *parteiras'* life stories, with many fearful of admitting that they were or had been involved in attending births. These days, Dona Ca'u, like many other *parteiras* in the region, only attends births when deemed *"absolutely necessary,"* which means in an emergency. Emergencies are assessed contextually, but mostly entail difficulties in reaching health facilities. Although in Jaboticaba it appears at first sight that all women are searching for health facilities to give birth, there are some women (albeit a small number) who still give birth in the *roça.* Their accounts, which defend homebirths, include fear of mistreatment in health facilities, difficulties of transport, and most importantly, praise for the *carinho* (affection) and *paciência* (patience) of the care provided by *parteiras*.

[90] This is a common approach in some studies where the focus remains on ritual, prayers and the type of plants used. For a discussion on problematizing the concept of natural birth see MacDonald (2006).

[91] In Brazil, the studies of Tornquist (2004), Sacchi (2005), Mendonça (2004) and Fleischer (2007) surpass these dichotomies by discussing *parteiras* in relation to broader contexts such as their training, state politics and social movements.

Care with presence: Carinho and paciência

Care is enacted with 'a particular type of attention,' involving activities and emotions to fulfil needs, "so we have to understand 'what counts' in context" (Aulino 2012, 4). My findings during fieldwork in Jaboticaba resonate with what other studies in Brazil have shown about *parteiras'* care (Fleischer 2007; Borges et al. 2009; Barbosa et al. 2013; Siqueiras 2016). Forms of attention-giving and receiving by *parteiras* revolve around key practices of *saber/fazer* (know-how). The next sub-section highlights the guiding references through which these care practices unfold: *carinho* and *paciência*. To illustrate these points, I show how these forms of 'doing' with 'a particular type of attention' present themselves as more than moral coordinates to sustain particular patterns of interaction with the world. As one community health worker put it: *"carinho and paciência are a different type of 'conhecimento'* (knowledge)."

(i) The *Carinho* of Dona Jeje

Today is Friday, the day of *Oxalá*[92] and Jeje is dressed in immaculate white. I get flashes of her body moving at the back of the house, immersed in some chore. Crossing the threshold into the open house, I shout a protocolary: *with permission!* – and she replies – *Come in my dear!* As she moves towards me her white skirt glides rhythmically with her steps, her bare midnight feet feel firmly grounded.

As we hug, loud *arrocha* music from the neighbour's house surrounds us. We have arranged to go and visit an old friend and I am sweaty, flustered, wired. Her piercing eyes perceive this quickly – *what is going on girl?* I laugh timidly. Dona Jeje has scolded me before for my fast pace; *essa correria danada* (that sick 'rush') that governs me.

For Jeje, *things, to be good, to have a good outcome, need to be done with 'carinho.'* She instructs me when I record an interview, and when we are cooking. When I play with her grandchildren, she happily confirms, *you play with them with 'carinho.'* When she collects medicinal plants and prepares a bath for my protection, as well as when she talks about attending births, she says, *everything is in the 'carinho.'*

Jeje often repeats this and I know it is important. When I first met her, she told me what happened when she attended the birth of a nearby neighbour. People were reluctant to assist her because she was a crack cocaine user, but Dona Jeje could not abandon her, she treated her with *carinho, because that woman is also a human being,* she said. Dona Jeje has also received *carinho,* a key part in the process of her overcoming the murder of her only son. People embraced her with their *carinho* and she felt held.

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[92] *Oxalá* is the chief of the *Candomblé* Yoruba pantheon, the father of the Orishas and also associated with Christ. He is always dressed in white. Friday is his day and he loves eating chicken, ewe goats and doves. He is regarded as the deity of peace and love. White is also the organizing principle of his sacred pharmacopeia (Murrell, 2010, 173).

When we do things for/with others with *carinho* we recognise them, we search for a good outcome (whatever that may mean contextually). *Carinho* may be guided by responsibility, compassion, kindness or joy, but is never a principle in a normative sense. At the crossroads of a moral and relational practice, *carinho* is a way of engaging with the world with a particular pace and presence, a particular type of attention. In relational terms, it means attuning to others' rhythms, in this way we allow 'the good outcome' (again whatever that may be). *Carinho* is an absorption into the activity of the moment with the other. By being fully there, attuned, we attend.

(ii) The *paciência* of Dona Esther.

We are walking up the steep hill under the scorching midday heat on our return from running an errand for a neighbour. Dona Esther's *petite* legs are moving slowly but steadily up the hill; recovering from a leishmaniosis infection, her nose and faced are badly scarred and her legs are weak from the more than twenty-five injections she has received.

Look Laura! She points to the abundant trees and bush around us, a tiny wooden shack hidden amongst them – *all of this was made by God*. She moves her head from side to side slowly, focused, as if recording every single detail. I mimic her solemnly in hope of finding something. *Sometimes you look and you do not see, but when you look properly, you see things; and if you listen, you can also hear, with 'paciência,'* she remarks.

Paciência is what prevents her from doing *toque* (vaginal examination) in birthing women, *I only touch the belly and observe the woman … the most important thing is to not frighten her.* It is also *paciência* that draws the mentally ill in her community to hang around her place. Dona Esther has been going in and out of *Pentecontalism*[93] for a while, but she defines herself as a different type of *crente* (believer). This is because she has *paciência, In this world there is all sorts,* and she is keen to accept everyone on the same terms, *whether they go to Lapa or Samba de Roda.*[94] If you ask Dona Esther if she is a *parteira* she replies: *Nooooo, I only help women give birth … I just stay by her side and help when needed.* For Dona Esther, these needs unfold contextually and she attends to them guided by the pace of her *paciência.*

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Perceptive and accepting of what may come, tuned to audible and visual cues, *paciência* allows us to grasp what may not be readily apparent or obvious, as it demands an extra moment of being there. By allowing a situation to unfold *paciência* makes us remain open and receptive, this not only puts the others at ease, but also gives them space. Such non-doing (in a non-interventionist sense) is guided by the refined skills of tuning in with the senses. *Paciência*

[93] A radical branch of Protestantism characterized by its rigid dogmatic views and religious intolerance. For a brief introduction to Pentecostalism in Brazil see https://rlp.hds.harvard.edu/faq/pentecostalism-brazil

[94] *Samba de Roda* is a celebration with drums and dancing in a circle; it is common for people to 'receive' spiritual entities in their bodies in these celebrations.

involves a kind of wait that is vigilant and accepting of what is happening in the present moment.

(iii) To know how with caring attention

Mutually constitutive of each other, *paciência* and *carinho* are the core guiding references in these women's lives. They create an interaction with the world, which is based on their way of 'doing' things in search of a good outcome. My intention here is not to reify a particular type of care, be it that of *parteiras* or of rural women. Instead, I want to bring to the fore these moments as reflective possibilities, even though I am aware that this risks falling into the common trap in anthropology of "reading the other as a corrective to the Self" (Stevenson 2014, 147).

In her ethnographic exploration of 'care' in a context of addiction and dispossession along the Rio Grande in New Mexico, Angela Garcia (2010) narrates her first night shift in a detox clinic. Working during a power cut, Angela is the only attendant to the group of detoxing patients. She hands out medications at the regulated hours and tries to ease the agonising pains of Peter, a patient not responding to drugs and in severe withdrawal. As they spend the night sleepless under a common blanket, "remaining [in] each other's presence from within such radically different sites of experience … tempo and feeling" she questions "whether singularity and difference can be productive of care, even commensuration" (Garcia 2010, 50). This 'difference' in experience is expressed in 'singularity' as aloneness, existing at many levels, but mainly present in the inconsolable solitude of bodily pain.

Angela Garcia (2010, 51) states that these moments of rupture and shared singularity are the instances where she can begin imagining "the possibility of a new kind of care" in institutionalized settings: a 'care' that can "bridge the distance of one to the other," overcoming the precarious relation between different subjective positionings (Garcia 2010, 51). Similarly, I envision *carinho* and *paciência* as possible bridges between these sites (singularity and difference), where a particular type of attention can unfold, allowing 'the care with presence' people spoke about in Jaboticaba. This care with presence, emerges from a 'doing' guided by *carinho* and *paciência.* It is as a form of knowledge that informs the ways in which to interact with the world. This care is a form of local knowledge. As circumstances shifted, *carinho* and *paciência* also morphed, were eroded and became limited in their expression. In some cases, they were cancelled altogether, giving way to other forms of care that in some of its expressions people resented.

Medicalisation and *Epistemicio*

In Jaboticaba, diverse modes of caring (with a particular type of attention) persistently challenged one another in creative, tense and productive ways. At times, this advanced well-being, while at other times, it deepened vulnerabilities. Although this is explored in detail in Chapters Six, Seven and Eight of this thesis, this sub-section focuses on medicalisation and *epistemicio* to show some of the factors involved in the arrival of the biomedical model to the region. Such model had consequences in the way local knowledge was valued and in the ways in which people came to interact with one another when practicing care under certain constraints. As those, for instance, driven by the obligation to keep record of the specific actions and services delivered to the population.

The arrival of the SUS to the region during the late 1990s was full of shortcomings and contradictions. The much-celebrated universal right to health care was accompanied by the requirement to record and organise, measure and calculate. During the decades that followed as nurses, doctors and technicians began populating the region, pharmacies also proliferated and private laboratories and clinics sprang up and multiplied. The process of 'medicalisation' swept over the region and its inhabitants. Dona Maria, from the quilombola community of Santa Anna, an elderly woman and knowledgeable herbalist, complained about how these days everyone was going to the doctor for the simplest thing: "*the kid has a bit of cough or fever and rapidly they are knocking on the doctor's door …"* This process brought different dynamics and procedures that profoundly shaped ways of doing and knowing, ultimately affecting the way people came to matter. In conversations, community health workers, key figures who occupy an ambivalent position in the development of these changes, expressed their concerns over the process. For instance, Nene, a community health worker, reflected:

> *"I envisioned my work as something emerging from 'um sentido social'* (a social awareness) *… approaching the families with 'carinho' … this is something I learnt with the Pastoral da Criança,*[95] *now with the SUS we have a wage, this is good, but we lost so much autonomy and 'conhecimento'* (knowledge). *Before, we used to make all sorts of herbal medicines, together, we would gather and make large quantities of different stuff like soap for scabies, lotions against lice, a seed mixture against malnutrition, syrup for flu and so on, then we would distribute these amongst the*

[95] *Pastoral da Criança* is an NGO, founded in 1982 by Dr. Zilda Arns and the Confederation of Catholic Bishops in Brazil. It works towards the holistic development of children by also promoting the development of families and communities. Their programme trains volunteer community representatives, who then each supervise the nutrition of 10 to 15 children. For more info see: https://healthmarketinnovations.org/program/pastoral-da-crian%C3%A7a

families. The results were excellent … but then the Municipal Health Secretary stopped with this scheme … the pharmacies needed to make money…"

It was not only the use and abuse of pharmaceuticals and the abrupt process of medicalisation that the population was subjected to, but also the negation and annihilation of local knowledge and the constrictions of bureaucracy that some community health workers lamented. Another active member put it this way:

"Everything we used to make … all the syrups … all gone!! ... now more than 10 years that it was stopped … and now we have nothing, nothing, nothing … Today what we have is paper … registering … keeping records. Every time people come and see me I have to write 'so and so was here'… what is the point?? ... just so in Brasilia it looks like things are being done, like something is happening, but in reality, nothing, nothing, nothing ..."

Within the logics of a 'type of attention' ruled by the clock and the registration paper, *carinho* and *paciência* fade and can become impaired. In parallel with the disappearance of other more tangible knowledge, such as ways of making herbal soaps, syrups, and herbal baths, 'a care with presence' guided by *carinho* and *paciência* not only evokes a different mode of know-how but a different mode of life outside of the univocal official development discourse of inescapable modernity that encompasses the processes of *epistemicidio.*

8. A community health worker registers. Photo by the author

Epistemicidio involves a process of subalternisation, where non-hegemonic knowledges and practices are made invisible and silenced. The Afro-feminist Brazilian philosopher Sueli Carneiro (2005, 97) explains that *epistemicidio* not only entails the cancellation and disqualification of the knowledge and practices of subjugated peoples, but that correspondingly by "denying them the condition for attaining 'legitimate knowledge' deprives them of 'reason'." That is, "*epistemicidio* kills or abducts the rationality of the subjugate; mutilates their capacity to learn. It is a form of kidnapping reason in a double sense: it denies the rationality of the 'other' while imposing cultural assimilation" (2005, 97). In Jaboticaba, local healing practices were often ridiculed in health posts by health professionals, *parteiras* were told that they "*knew nothing*" by some doctors, and black rural women were deemed ignorant and backward. Still, these processes of destruction are not accepted passively. In the following section I draw on the Afro-Brazilian concept of *encrucilhada* (crossroad) to elucidate the multiple and creative ways in which 'care' and 'healing' are made manifest in Jaboticaba.

The *encrucilhada*: "*Some things are not for doctors"*

In Brazil, the *encruzilhada*, which refers equally to a physical fork in the road and to a cosmological principle, is a place of unease and possibility alike. Some people avoid these spaces at certain times of the day and night; others place ritual offerings in them. In the *encruzilhada,* diverse pathways open and close at times finding each other. It is a space charged with force and potency. In Afro-Brazilian cosmology, the Orisha-divinity *Exu,* besides ruling *encrucilhadas,* is the 'dynamic principle' of the *Ioruba* cosmovision. *Exu* is paradoxical, breaks the rules to keep the rule, transits the margins to confirm the centre, innovates so it can conserve, and in this way "maintains a dynamic balance based on the imbalance of structures" (Freitas Santos 2011, 176). Catalyst of change, a messenger and trickster, *Exu,* as the master of possibility, transgression and unfinished business, transforms and communicates. Most importantly *Exu* and its domains, 'the crossroad,' "point to multiple paths that are understood as possibility and not certainty. The crossroad comprises the coexistence of different directions [where], unlike in western logic, one path is not credible in detriment of others" (Rufino 2016, n.d).

Maria de Jesus and Dona Jeje often have visitors with small children. It took me a while to appreciate that there was something more to these neighbourly visits in the peripheral neighbourhood of Engenho Velho in urban Jaboticaba. With time, I learned that women bring their young children to be 'blessed' or 'prayed on' to expel *mau olhado* (the evil eye) by these

two respected women. When I inquired with Jeje and Maria about their expertise in these practices, both replied equally, "*I only know a few words."* Words in Jaboticaba should not be taken lightly. The manifestation of their power became rapidly obvious to me when before my numerous journeys through the dirt road tracks into the thick bush, Dona Cosmiana would place garlic and the herb *arruda* (rue) in my pocket and in a solemn tone would decree "*protect this girl in her journey, in the name of Jesus!!*."

There are diverse signs that identify *mau olhado*. Children may cry, yawn too much or be too clingy. This not only happens to young people; adults can also be subject to this force. One day for example, I was feeling lightheaded and tired, so Dona Jeje's *filho de criação,*[96] suggested I should have a herbal bath, using some of the powerful herbs[97] Dona Jeje has in her herbal garden. "*You call a lot of attention in the 'rua' … the 'big eye' hits you strongly … People may have 'big eye' without knowing and looking at you they deplete your energy, attract to you 'coisa ruim'* (bad things) *…"*

There are energies and forces *porcaria* (dirt), *coisa ruim* (bad things) in places and people and they are also in the air. When explaining this, Dona Jeje tells me "*because we do not know what comes from 'there,'"* pointing her hand towards something, somewhere, far beyond. Interestingly doorways, as thresholds between the outside world and the house, are particularly dangerous, one should not sit on them, especially when eating or while pregnant. When looking at households in a peripheral neighbourhood in Salvador, McCallum (1999, 286) notes that: "The house itself is daily revitalised by female labour and protected from the ills and illnesses that might penetrate from the street (*olhado* (big eye), and evil eye, bad spirits, microbes) by female magic, prayers and medicine."

In Jaboticaba, magic and biomedicine, prayers and pharmaceuticals are not mutually exclusive. Patients, ill people, and those subjected to whatever sort of *infortunio* (woe) will combine in a creative way prayer, medicines, herbs and whatever other therapeutic practices are available in search of healing. Consequently, it is not a coincidence that the word *remedio* is used equally for pharmaceutical drugs (including poison), herbal remedies, and magic spells, whether formed by words – prayers and blessings – or something more material.

[96] This is the term used for children who are not biological but are treated like one. *Criação* derives from the word *criar* – to raise.

[97] *Arruda* (rue), *manjericão* (bay), *alfacema* (lavender), *alecrim* (rosemary).

This is the *encrucilhada,* "where fields of possibilities, time/space of potentiality, where all options intersect, dialogue, merge and contaminate each other" (Rufino 2016). These other ways of knowing, this *ciencia encantada* (enchanted science) as Rufino and Simas call it, is not a subaltern proposition, nor a form of subversion (Nascimento 2018). Dona Ca'u searches simultaneously for the cure of *doença do ar* (air sickness) and *derrame* (stroke) and mothers feed paracetamol to their children while they call for a prayer to heal the *mau de olhado* (evil eye). It is from the 'multiplicity of the real' that what is at stake in the healing process is established. The idea of the *encrucilhada* brings with it precisely the capacity to be "pluri-rational, pluri-versal and pluri-linguistic" (Rufino 2016). In this, I want to emphasize not so much the fact that this may present a form of medical pluralism,[98] but rather my intention is to bring to the fore the ways in which by negotiating positions (Bhaba, 2011), 'epistemic survival' takes place. This survival occurs in contexts where relations have been historically conditioned by violence and inequality and where subaltern knowledge has been targeted for extermination (Rufino 2016). Under such conditions the *encrucilhada* in Jaboticaba is the existential realm not absorbed by colonialism.

So far, through the story of Dona Ca'u, a *parteira,* I have explored the two most important factors which embody the type of care developed by rural figures: *carinho* and *paciência*. They signify broader local ways of knowing, and are, as such, also affected by processes of medicalization and *epistemicidio. Epistemicidio* exposes the past and current underlying violent power dynamics that silence and disqualify the practices and knowledges of historically subjugated people, in this case black rural populations. These eradicating procedures are not absolute, nor are they passively accepted. Drawing on the Afro-Brazilian concept of *encruzilhada*, where the potency of every possibility remains, I illustrate the ways in which in Jaboticaba the interaction with the world is multivocal, cancelling the totalizing forces of colonialism and its legacies.

[98] The concept of medical pluralism means that in any one community, patients and their carers may resort to different kinds of therapies, even where these have mutually incompatible explanations for the disorder. However, since its inception, the notion of medical pluralism has been criticised for being grounded in an overly simplistic concept of culture; for conceptualising health care from the professional's rather than patient's perspective; for engendering an overly behaviourist account of health seeking; for generating a false consciousness of choice; for underplaying the importance of financial, structural and other political economic considerations; for insufficiently attending to issues of power, authority, and policy, or working with naïve notions of them, and for implicitly reproducing a monolithic concept of (bio)medicine (Hsu 2008). The strongest criticism came from critical medical anthropology, whose proponents stressed patterns of hierarchy and the dominance of biomedicine in the modern world, calling into question the notion of 'pluralism' itself (Penkala-Gawecka and Rajtar 2016, 129).

In the following story about Dona Cosmiana, a rural worker, I turn to some key issues I have briefly discussed in the life of Dona Ca'u, land and autonomy.

A rural worker: *Dona Cosmiana*

Every Saturday, a section of Jaboticaba's waterfront is filled with stalls selling local products. This is a time and place to not only make some money, but to socialize outside of the *comunidade*. People compare their produce, exchange goods, shake hands. This is also where rumours are confirmed, and gossip spread. Dona Cosmiana, in common with many other rural women, has been bringing her products to the local market for most of her adult life.

On several occasions, I helped Dona Cosmiana (who is in her early fifties) to prepare for the market. This usually takes a whole day, although if the harvest is good it may stretch to two. The main produce reaching the market comes from the *quintais* (vegetable gardens) she has planted and tended to around her house. Collecting and picking, sorting, washing and packing fruit, vegetables and herbs entails a lot of work and Dona Cosmiana usually counts on younger members from her *comunidade* to aid her in these tasks. They follow her instructions dutifully as part of their play.

Dona Cosmiana's husband, Seu Felipe, is in charge of packing the load of goods in their very run-down Fiat 1, (one of the few cars in the *comunidade*). He skilfully drives it to its destination through the deep Atlantic Forest, which is cut by twisting reddish dirt roads. When there is rain, these tracks can turn into lethal, muddy slopes. Dona Cosmiana's prayers provide a soothing hum in the background.

Going to the market means an early journey to town, starting at 3:30 am. Although it is pitch black, there are always a few figures waving here and there by the side of the road, handing out some cash. *Can you bring milk powder? …. Can you hand this to so and so…* always followed by the same phrase: *Deus acompanhe vocês!* (God be with you!).

Cosmiana's and Seu Felipe's lives revolve around attending to their agricultural tasks. Seu Felipe wakes very early and quickly gets lost in the dense *mata*. Sometimes you can hear his voice singing from very far and Dona Cosmiana locates him quickly: *he is over there*, and she points to the thick over layered forest. I look, disorientated, towards what seems an immense mass of homogenous green spread out in front of me. Dona Cosmiana's ear is finely tuned to the sounds around her. She recognises footsteps, fruits dropping, people talking from afar, and animals moving. She can tell who is doing what and where; she will stop her activity, stand still, focus her listening and then continue moving as she reports what she has heard. For instance, *the girl is doing the washing*, or *Tia Tata is picking guarana* or *down there, they have already started drinking sugar cane*. Silence seems to be talking to her.

Seu Felipe attends daily to their plantations of *seringueira* (rubber), *cacao* (cocoa) and *banana da terra* (plantain), among other crops such as *mandioca* (manioc). One day a week he works in a men's *Mutirão* (collective work event), a roster scheme[99] in the *comunidade* where

[99] This is a similar scheme to that described by Acevedo and Castro (1998, 12) under the name of *Puxirum* in the Amazon region of Trombetas. He describes these collective efforts as: "a social technique for the maximization of individual energies, the exercise of collective work in the form of mutual help." This common activity is

men help in each other's gardens. There is also a similar scheme amongst women, where women work each other's plots together, *It's good to work together, to be together,* Dona Cosmiana says.

The *comunidade* quilombola of Onça Vermelha, located in the inland valleys of Jaboticaba, is her home. The process of demarcating the land started several years ago, after the quilombola community was first recognised by the Bahia Federal government in 2007. This process was not without confusion and internal disputes. Nowdays they are still waiting for the official land title. Through the *comunidade's* association, Dona Cosmiana has been appointed to oversee women's issues. This means coordinating meetings, liaising with bodies such as the Rural Workers Union, NGOs and whatever else may be of interest or need to women in the community. Despite being illiterate, I have seen Dona Cosmiana accompany and help people with issues related to doctors, the hospital, social services and the court, and prepare a *Cesta Básica* (Basic Food Basket) and clothing for those in difficult situations. She has also assisted home births and is *madrinha* (godmother) of more than a dozen children. Siblings, half-siblings, cousins and elderly members, from the darkest ebony to the lightest golden-brown skin, constantly orbit around her household like loyal satellites.

She learnt to take care of others with her *vó* (grandmother), who was a *parteira*. For Dona Cosmiana the most important lessons she learnt from her *vó* were how to live together and how to respect. *We are all from around here* she says, pointing to the *mato.* Her mother died leaving eight children behind, and as she was the eldest at the time (about ten years old) she became her grandmother's right hand. They settled in different camps, occupying the land for a while, where they would plant *madioca,* and fish and hunt. *We would also gather, drum and sing … it was very rare to come across Pentecostals in those days*. Once, as we passed a certain area while driving, she pointed and said: *Look Laura, there we used to camp with my vó!*

After marriage she laboured in several *fazendas*, where she lived and worked with her husband. Her children, she says, were raised differently to her. *They would come with us to far away plantations.* After much hardship and many seasons in Espiritu Santo collecting coffee, Dona Cosmiana and Seu Felipe had saved enough money to buy a piece of land in the region. They started with a small mud house and later upgraded to a wooden shack. Currently they enjoy a brick house with untreated running water and electricity.

Now I live here in my house and work my own land … Everything you see here, was us who planted it, she tells me with satisfaction.

important not only because of its "societal purpose," but also because "it potentiates physical and psychological energies," thus producing an "individual collateral potentiation" ultimately serving the utilitarian and integrative needs of society (Frajtag 2013, 176).

9. Young girls help in market preparations. Photo by the author

Collective landscape and *memória*

In rural communities, one of the most common topics in heated discussions revolves around what the price intermediaries in Jaboticaba's urban centre give to rural workers for *cacao*, *guarana*, *cupuaçu*, *cravo* and other local produce. Despite the importance of this issue in everyday life, it would be misleading to reduce the relevance of access, occupation and use of land[100] to its productive dimensions. Such a reduction would entail omitting the lands' fundamental role as part and parcel of larger aspects in the reproduction of life in the rural communities of Jaboticaba.

In the context of black rural communities in Baixo Sul da Bahia, the territory as the 'lived space' of the collective[101] also encompasses socio-economic and cultural aspects, in which cultural ancestry and present identities are part of day to day activities. This can be illustrated, for instance, by the production of manioc. This staple is essential in people's diets and provides their key source of carbohydrates. Every meal is religiously accompanied by quantities of

[100] Matos Viegas (2012, 132) discusses this aspect in depth in her work with the indigenous *Tupinamba* in South of Bahia.

[101] By the term 'community' I refer to the expression locally used to indicate a group or unit attached to a defined territory, usually recognised as well by the local administrative powers. This is not a closed concept and people who live, have lived, or are attached to the territory through kinship may be referred also as being from the 'community.' By 'collective,' I mean the broader set of sociocultural experiences and the common history shared amongst the black rural populations of the region of Baixo Sul.

manioc flour. In the '*casa da farinha'* (manioc flour mill) of the quilombola community in Onça Vermelha, families bring their own manioc from the household gardens, though the whole procedure of peeling, grinding and processing is done collectively. This is a time and space to banter, give each other new nicknames, laugh at past events and drink small shots of *cachaça*. Manioc flour is a source of identification involving the history of the territory and the people who occupy it. It recalls memories and traditions, identity and customs, often linked to food and to the everyday actions necessary to care for the land.

The land is not only about immediate survival, it is also a map of the community's history, it encompasses the *communidade's memória* (memory). Markers in the landscape guide members of the community to events that include the past and the future. Seu Miguel, an older member from the quilombola community of Santa Ana, has patches of gardens (recognizable from a distance) where he is planting important endangered species for reforestation. The community knows about it and admire his *responsabilidade pela vida* (responsibility towards life) based on his experience and *conhecimento* (knowledge). The dangers posed by deforestation in the municipality of Jaboticaba are a real threat. In the quilombola community of Guaiaiba on one of the mountain hillsides, the vast green suddenly turns into dotted dull-brown squares surrounded by barren land. This is a commercial plantation of plantain. Pointing to a small stream, a community member tells me how they can no longer use the water. The flow has been considerably reduced and it is polluted with pesticides. Despite this, people are silent. Nobody dares to complain. The plantation owner is a dangerous man, and some community members are working in his plantation.

Dwelling and working locations are infused with emotions. Usually, places and activities associated with collective action – whether in *casa da farinha, quebrando cacau* (breaking cacao pods) or fishing with a group in the river – are charged with notions of *alegria* (joy). Other places are testimony to a past of abuse and exploitation, which is also part of the *memória*, such as a few wooden planks covered now by weeds and bush. This is what is left of Seu Aurelino's shack. One of the first residents of the community much of his land was taken through trickery by *grileiros* (land grabbers). Others, like Seu Miguel's father lost their small plots of land to plantation owners by becoming chronically indebted in the *fazenda's* store. Places where assassinations took place are also charged with *tristeza* (sadness). "*We still cry"* Benedita says, remembering while looking at the place where a community member was murdered by her husband. *"Killed with her child in her arms, the toddler would not let go of the dead mother's body.*"

As an "organic ancestral archive" (Frajtag 2013, 59) trees and paths evoke memories that prompt ancestral narratives of belonging. The serpentine trail that leads to a *roça de cacau* (cocoa plantation), so many times walked as a child, planted with much hardship hand in hand with other family members. There are the *cravos* (clove trees) that a mother migrating to São Paulo left for the small daughter she was leaving behind. They are all links rooting people to the land, encompassing traditions, uses and customs, comprising a *memória* that links the past to the present while also projecting into the future. As Dona Cosmiana walks around her gardens, a sharp machete in hand, she points to the trees she has planted for her grandchildren explaining that she only *"became a whole person when I had my own land."*

Pride, care and work: *A gente não bota remedio*

The lives of black rural communities are entangled and rooted in the lands they inhabit and cultivate. The importance of land and labour is a symbol of their ancestry and, as in Jaboticaba, access to land is also directly linked to autonomy[102] and dignity, and consequently pride.

During my stays in the rural *comunidades*, members always insisted on showing me their *roças* (plantations), fruit trees and *quintais* (vegetable and herb gardens). They would describe in detail what they had planted and how, through their labour, the landscape was transformed into a better place, a place where life was possible. Dona Ca'u, refused to live in "*a terra dos outros"* as a statement of her sense of dignity. As indicated above, Dona Cosmiana also stated that she gained a more complete sense of self when she had the security of owning her land, a place where she could live and cultivate life. Statements like this were not uncommon. This sense of dignity came not only from occupying land and cultivating it, but it was also connected to the way in which this was done. Often women would stress the fact that *"A gente não bota remedio"* (we do not use poison).

This became particularly noticeable during the *cravo* season. Collecting *cravo* is a difficult and dangerous task as the trees are very tall. To reach the top of the tree women tie with rope thick sticks to the branches This strategy ensures a form of scaffolding, the scaffold grows as the women remove sticks and retie them higher up. They balance skilfully on top of the sticks, both hands then free to pick the cloves. There are stories of people falling, injuring themselves

[102] For instance, De Vore (2016), who, since 2002, has worked extensively in several squatter and land reform communities in Bahia's cacao lands and has drawn attention "to the resilience that land can provide to people when all else seems to fail." He argues that the recent crisis in Brazil has hit the cacao region hard, with many plantation workers being laid off. Those who became smallholding farmers can creatively allocate land and labour in response to the crisis.

for life. Small children (and anthropologists feeling vertigo) stay on the ground and collect the cloves that fall. Sometimes whole branches will be cut off so they can keep busy picking through them while adults work their way through the trees. However, not everybody follows this crafty procedure and some *botam remedio* (use poison), a form of hormone that is sprayed on the tree, making the *cravo* fall directly off the tree on to spread out nets. These practices were frowned upon and those who practiced them were regarded as *sem juizio* (having no common sense) and 'selfish' "*because that poison is bad for the whole of the community.*"

Methods for cultivating without pesticides in an organic way were practiced in the region long before the word agroecology was coined, initially prompted by the *Pastoral da Criança,* who fostered food self-sufficiency and a healthy diet. This approach in the region of Baixo Sul was later encouraged by local NGOs and government programmes during the early 1990s. The principles of *agroecologia*[103] have been linked to gender equality and the movement of black rural women, making it a solid space in which to cultivate autonomy. In Jaboticaba this is reflected in the annual festivity of *Feira Agroecológica de Mulheres do Baixo Sul da Bahia Contra a Violência* (Womens' Agroecology Fair Against Gender Violence in Baixo Sul), organised to confront violence against black rural women and give visibility to the things women produce. It is a joyful occasion during which, since 2012, agricultural products cultivated by women from the communities and cultural manifestations such as *Samba de Roda* are celebrated. Thus, the fair is an important political space where territorial identity and rural women's rights come together under the same banner. To conquer this space has been a slow process and for many women attending the fair has entailed a series of negotiations with their families and partners.

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After a long day of meetings to organise the upcoming agroecological fair, Dona Cosmiana and I finally reach her home in the quilombola community of Onça Vermelha. We sit on the rammed earth floor in her kitchen and eat dinner: *caranguejo* (crab) and *pirão* (a paste made with *manioc* flour and the gravy from the stew). She is telling me about the difficulties of being a community leader. As she forcefully cracks the leg of a crab with her teeth, she says:

> *You know some men here were telling my husband that I deserved to receive 'uma boa zurra'* (a good beating) [her voice takes on a raspy tone]. *They said: 'Essa besta'* (that idiot) *all day calling for women's meetings while her gardens are being eaten by the bush. But I don't care, we continue even with the challenges …*

[103] See: http://agroecologia.gov.br/

She then unexpectedly breaks into singing, as if her sentiment could only be expressed with a song.

> *Companheira me ajuda ... Que eu não posso andar só ... Eu sozinha ando bem ... Mas com você ando melhor*
>
> (My comrade support me … I cannot walk alone … on my own I walk OK but by your side I walk much more).

She finishes with the motto: *A woman's place is wherever she wants … wherever she wants, that is!!* – which she accentuates by heartily directing her hand to me, the crab leg swinging back and forth in her *dendê* (palm oil) stained greasy hand. After this, everything goes quiet. I can only hear her cracking and sucking the crab's leg, now and again. I am left with the song's lyrics lingering in my head as I finish my dinner. That night as I lie in bed, I recall the lyrics of the song again and again …

R(ex)istence: *ancestralidade*

In previous sections I have shown how these women actively carve themselves a space to self-define and affirm their rural black womanhood on their own terms. They collectively challenge gendered oppressive structures and redefine their place through action, supported and inspired by their collective networks. Fuelling this project of social transformation entails overcoming many barriers and layers of oppression. Living in isolated communities, working in local plantations as day labourers, assisting in the family *roça*, cooking, cleaning and collecting water, washing clothes by hand in the river, rearing children and tending to their *quintais* and small animals are some of their daily challenges, and they leave little spare time. Many women also face their partner's opposition, who overtly resent their engagement with other women. Stories of women not being able to join gatherings, meetings and activities because their partners did not allow them to leave the house were widespread.

Women's narratives over their processes of *conscientização* (becoming conscious) followed similar patterns. For some, external agents such as NGO workshops were the catalyst in this process; for others, *companheiras* (fellow females) led them to the call and finally, for many, the path was linked to struggles over land and the example of the female elders around them. Dona Benedita elucidated further:

> *"Yes, the NGO's workshops brought a framework to think with, provided also spaces, but we already had the examples of our 'ancestrais'* (ancestors). *For instance, the sister of my grandmother, she lived alone with her children, she was tough. She would always have her machete with her, suspended from her hip, to defend herself, because in those days if you had no man by your side, you were not respected … and still today!*

... Those are the women we look up to because you see … she was not a 'coitadinha' (someone to be pitied) …*!!"*

Black rural women find in female *ancestralidade*[104] (origin) a source of inspiration and guidance, ideas that are directly linked to notions of *memória*. This past history of female resistance and creativity in guaranteeing 'existence' now helps them to imagine and rethink their place in black rural communities. It provides them with a sense of continuity, even though sometimes these narratives of the past are simultaneously imbued with affliction, and pride, creativity and tragedy. Nene, who had travelled to Senegal in an exchange programme led by an NGO, visited the port where former enslaved Africans waited till it was their time to cross the Middle Passage, said *"When I saw that place, the shackles, the inscribed numbers on the rocks. I cried and cried … from that trip I brought something very special to me, this doll,"* and she shows me a doll made from cloth, with African phenotypic features, who has in her belly a space where a tiny baby made also of cloth fits perfectly *"I use it in my educational work with the mothers. I love this doll. This doll is US!!"*

Here, I want to highlight how past strengths inspire black rural women in the present to become stronger. By valuing the resilience and power in their roots, they place value on themselves and their future projects.

The Brazilian black feminist Joyce Berth, following other key black feminist thinkers such as Brazilian Leila Gonzalez (1983), and the North Americans Patricia Hill Collins (1990) and bell hooks (1989), writes about the empowerment of black women. She states that looking back to the past is critical in order to "not lose historical perspective on resistance and the possibilities to re-exist within frameworks of self-definition" (Berth 2019, 94). Anthropologist and black feminist Lélia Gonzalez (1988) contends that ideologies and actions of liberation need to be anchored and committed to historical experiences defined by their protagonists, rather than imposed from the outside. It is within this cultural universe of resistance that the figure of the *Ialodê* emerges as a possible metaphor of leadership and self-government (Werneck 2007,1). I became interested in this ancestral figure because of the positive

[104] During the XX century in Brazil diverse black groups resisted Eurocentric initiatives aimed at assimilating them, under specific conditions. These self-affirmative responses opposed not only whites and their privileges but also the models of blackness proposed by them. In this sense, the racial affirmative movements "will be in charge of translating and reinterpreting the culture originated in the African continent as a fundamental action, in a process that was described by Hobsbawm as social use of the past" (cited in Werneck 2007, 7). Werneck states (2007, 8) how this reinterpreted translation and incorporation of tradition allowed a new form of belonging by conferring validity and modernity to ancestral characteristics.

affirmation of blackness and black womanhood it invokes in the Brazilian context, and because it captures the disposition, attitude and temperament I encountered in the women *lideranças* in the black rural *comunidades* of Jaboticaba.

Ialodês: breaking the order of silence

Jurema Werneck, Executive Director of Amnesty International Brazil since 2017, is a black feminist and a physician. In her doctoral thesis in the field of Communication and Culture, she explores the ways in which black women are stereotyped and under-appreciated in the historiography of Samba. In order to displace this for a better rereading of history, she proposes the figure of the *Ialodê.* For Werneck (2007, 79) "the return to 'our past' allows us […] to construct ourselves new, as new subjects." By reclaiming the figure of the *Ialodê,* Werneck aims to establish a dialogue with the Afro-Brazilian tradition, where the *Ialodê* symbolizes the affirmation of female autonomy. She proposes the *Ialodê* as a tentative answer to recognising the black experience beyond eurocentrism. However, Werneck clarifies that the *Ialodê* in the Afro-Brazilian tradition is not a concept; instead she explains it as a (re) invention that proposes *Ialodê*[105] as an analytical tool which, when detached from its original context, adapts itself according to the need "to make visible and analyse the strategies of self-definition and struggle undertaken by black women" (Werneck 2007, 79).

Although "provisory and unstable," the objective is to define black women beyond generic reductionist approaches conceived under "the empires of violence and force that are race (and its phenotypical attributes) and sex in a racialised and patriarchal society" (Werneck 2007, 80).

[105] *Ialodê* is one of the titles given to the female *Orixas Nanã* and *Oxum. Orixas* are analysable but difficult to translate (Johnson 2002, 171). They are part of the cosmological order in Afro-Brazilian religions (*Candomblé* and *Umbanda*). *Orixas* play the important role of being an intermediary figure in communications between humans and greater spiritual forces. These are mostly natural forces, spiritual guardian angels, and divine masters (Johnson 2002, 171). *Oxum* is identified by sweet waters and waterfalls; fertility and the capacity to see the future, and with richness and gold and the colour yellow. Through work and respect for traditions *Oxum* reversed power structures in mythological tales (Werneck 2007, 67). *Nanã* is also linked to water, but to stagnant water and mud. She is an older woman and her power is associated with the beginning of existence, and birth and death (Werneck 2007, 68). Both *Oxum* and *Nanã* are known for their actions when confronting male power and for their reaffirmation of equality. *Ialodê*, beyond spiritual realms, is a political position conferred to representative women in the public sphere and in government. The title refers to emblematic females who bring women together for public discussions, while patriarchy aims to confine them to the domestic sphere (Werneck 2007, 69). It is in all these discussions that the figure of *Ialodê* is being used: a necessary clarification is that this African past must be understood as a construction external to the African world, that is, it responds to the tensions and instabilities caused by the processes of colonization in a Eurocentric context. They need to be understood as initiatives of reinterpretation of a common African past for identity production and resistance (Werneck 2007, 72).

Ialodê is the Brazilian form for the Yoruba[106] word *Ìyálóòde or Iyálóde*. Werneck argues that in Brazil, *Ialodês* are to be found in any black community where women assume leadership roles and collective responsibility in the fight for the betterment of social and material conditions (Werneck 2005). She says that exploring the figure of the *Ialodê* involves looking at black women's "actions, their differentiated contexts and their individual and collective trajectories," focusing on those women who "have broken the order of silence" and have developed strategies to move beyond the limits imposed on them (Werneck 2007, 74).

In the following section I turn to this Afro-Brazilian figure to explore the networks of care and solidarity that black rural women develop to confront a racist and gender-biased system. These women, informed by their historical experiences and their social conditions, advance creative strategies in which land plays a key role in their pursuit of autonomy.

Ialodês at work: networks of care

I am sitting on the floor and Dona Vladicir is looking down at me with her big brown eyes. A smirk in her face allows her few teeth to timidly show her contentment. I move my hands profusely as I massage her worn out feet. Decades of being a rural worker have made the skin turn into ragged old leather, her toenails are sickly brown and chipped, the heels deeply cracked. She tells me it is the first time she has had a massage like this, and then confirms that she is liking it. We are sitting in a circle in pairs at the Rural Workers Union building in Jaboticaba. The idea is to offer each other some pampering. *Because we are always caring for others and we forget about ourselves*, the female president of the Rural Workers Union exhorts. Some of the women make jokes: *Oh yes… do not stop …*, *... keep going … move up, up, up …* There are bursts of general laughter.

After this comforting icebreaker, the discussion moves on to serious issues. The aim for this meeting is to coordinate the upcoming actions for this year, 2018. The turnout for the activity has been low and the convening capacity for events is falling. Women's faces become sober and thoughtful. The circle starts to move around and each woman intervenes with her ideas and reflections. They unanimously agree that *lideranças* need to be stronger and must improve their coordination. They are aware this is an especially challenging task. This year the focus needs to be on 'paperwork,' as they need to map the ways in which women are hidden and unprotected. The president of the Union goes on to say:

We have cases comrades where everything is in the name of the husband. We need to go and find these 'unprotected' women.

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[106] Yoruba is a language brought to Brazil in the late eighteen century by enslaved African peoples from the Niger river zone. Yoruba remains an active language in Brazil many centuries later, spoken in the ritual domains of African-based religious communities like those linked to Candomblé (Werneck 2007, 66).

In Jaboticaba, there are many instances of collective arrangements to confront situations of abuse and abandonment. In the case of domestic matters, *liderança* women often discussed and questioned how much they should interfere with family affairs. The common Brazilian saying *'Em briga de marido e mulher não se mete a colher'* (in fights between husband and wife one should not get involved) was frequently used as an example of a widespread idea that needed to be challenged. Women explained that besides physical and sexual violence, abuse related to patrimony was rife and many women also suffered economic violence. There had been cases of forced pregnancies so men could access the money the government granted female rural workers for maternity leave. In such instances, various forms of violence overlap creating situations of extreme vulnerability. It was known that some women were secretly taking oral contraceptives to protect themselves. Nene, a community health worker active in the defence of women's rights, described the following situation:

> *"I go to some houses where I do not cry to not show my weakness. The woman is 'cheia de filhos'* (full of children) *and has nothing, not even clothing to wear. I wonder: where has the maternity leave pay gone? Then you see a new motorbike … there was a case where the man got a car and he could not even drive!!"*

Julia, the president of the Rural Workers Union, explained how men repeatedly reached her office asking for information on how much the woman was going to receive for the *Licencia de Maternidade* (maternity leave), "*I tell them: Is it men who give birth? uh?"* – she gives a robust look of rejection – "*I will only give the information to her."*

The main problem for women in accessing this benefit is having all the documents to guarantee their rights, and most importantly being aware that these rights belong to them. *Lideranças* make efforts to bring this information to the women in the belief that empowering women also entails empowering families and communities, and this involves talking to men so that they understand that "*women also need to be happy,"* Julia says. One of the key strategies in protecting women was suggesting they invest the money received through maternity leave pay to buying land. The land could be registered under their name. The story of Nair illustrates this process of intervention (and I observed several cases). Nair, a twenty-six-year-old and mother of six children, is a close neighbour to Dona Cosmiana. She expresses a great deal of respect to Dona Cosmiana who, in Nair's own words, has aided her on many occasions, such as providing her with a basic food basket in difficult times, assisting with the birth of one of her children, and always being present in the periods of *resguardo* (postpartum care). When I

asked Nair about her land, she told me that it was all thanks to Dona Cosmiana, who helped her to understand how important it was to have her own piece of land. Dona Cosmiana had given her clear instructions on all the documentation she needed to complete so that she could use the money she received from the births of her last three children in this way. Having land, Nair explained, has brought great peace of mind to her life – *"The biggest happiness after my children,"* she says smiling.

This sub-section illustrates how a 'right' such as maternity leave can paradoxically turn women, who have no control over their reproductive capacities under violent gender relations, into exploited resources. Some women based on a sense of solidarity and cooperation are ready to organise themselves in a way which enables them to overcome experiences of abuse through formal (community association, rural union, women's groups) and informal groups (kinship and neighbour relations), creating strategies within various systems of provision. These women, informed by their historical experiences, also generate networks of care in which land is directly linked to notions of autonomy, and in which land becomes the catalyst where belonging and care are simultaneously performed in their collective initiatives to protect women.

The story of Dona Cosmiana demonstrates the importance of land for black rural communities in a variety of ways. Primarily, local accounts confirm the ways in which land encompasses broader aspects in the reproduction of life, beyond the mere production of a livelihood. Socio-economical features, such as, for instance, the production of *manioc* and *cocoa,* are closely intertwined with cultural ancestry and current identity. Likewise, markers in the landscape are intimately connected to *memória* (memory) and the history of the community capturing the past, as well as a responsibility to the future.

Second, I have shown how access to land fosters a sense of autonomy and dignity. As the case of collecting cloves illustrates, pride emerges when tending to land following the principles of agroecology which involve avoiding contaminating, not only the land but the *comunidade* with agrochemicals. These ideas and practices about caring for the land in an agroecological way are generative of political subjectivities as they provide spaces where women can collectively question patriarchal and racist orders, as seen in the celebration of the agroecological fair. I further borrowed the figure of the *Ialodê* to present the affirmation of female autonomy and leadership in the communities and show how they create networks of solidarity and care where the ownership of land is critical in their definitions of autonomy.

In the following story of Dona Anna, I explore the role of autonomy in the domestic realm in two separate social spheres occupied by black rural women. On the one side, I scrutinise the exploitative Brazilian racial and class hierarchies in which these women have historically been embedded in domestic labour, and on the other side, I unpack how households are created and how systems of kinship emerge within local gender dynamics.

A (grand) mother: Dona Anna

A disquieting and high-pitched voice pierces the darkness like a shooting arrow. It is the broadcaster from Radio Litoral wishing the audience *Booooom diiiaaaa!!!* (good morning!!!). As usual, he announces the phone callers' messages. I hear Dona Anna's name, fondly known as *Anna Preta* (the black one) … *from Comunidade de Caguaiba!!!*, mentioned several times. Friends and family have called to compliment and congratulate her on her 50th birthday: *Oooh, good people!!,* she says from her bed.

It does not take long for her to get up and start her morning routine. Her daughter Carol, a casual day-labourer on the neighbouring plantain plantation, is already up and preparing to leave. Dona Anna's husband, Seu Matheus, is also up. He is about to go and cultivate their land as he does everyday.

The house is an open sound vessel and I can hear her grandson and granddaughter giggle next to each other in the bed they share with their mum Carol. The rattle of the radio accompanies the start of the day: prayers to God and news about the mayor of a nearby city being kidnapped follow. The girl, Gorete, affectionately nicknamed Tete, goes to the community's school. Every morning, Dona Anna runs around to get her ready. Small Arthur moves around them, making tiny demands here and there.

In the morning the kids are already clean. The routine for showers is to have them at night before having dinner and going to bed. This is done at the back of the house in a basic wooden structure amongst the cocoa trees. In this way, Dona Anna only has to focus on providing breakfast, usually *beiju* (tapioca) and some fruit, putting clothes on them and combing Tete's hair into two shiny buns.

Scattered in clusters around the bush, community houses are usually far from each other. The school is situated in a valley further down and a pickup truck driven by a community dweller employed by the municipal council collects the children. Before the truck arrives, Tete likes to run to the next-door neighbour's house. Every day she says good morning to Dona Marcelina, who lives across the dirt track with her husband and the granddaughter she has been raising since her birth.

Once Tete is gone the movement around the house accelerates, only to be interrupted and tweaked by three-year-old Arthur's pace. Dishes are cleaned on an outside wooden bench. Big metal buckets with leads on them hold the water brought from the 'fountain.'

Throughout the day, constant trips are made to refill these buckets. To do this, we walk out the back door along the little path that borders the house, past the *secadero de cacau* (cocoa drier), past the palms of coconut trees and *assai*, past some cultivated patches with *mandioca*.

The terrain then turns into a gentle slope surrounded by fruit trees, at the bottom of the slope stands a deposit of water, fed by a hose. This is the fountain. We collect buckets of water and bring them back to the house. Dona Anna organises lunch right away. Seu Matheus has high blood pressure and some other medical issues, and he needs to have a separate diet. Dona Anna cooks on an outside fire; her husband is in charge of providing a good stock of wood. She collects, peels, cuts and boils vegetables, picking the beans carefully then preparing them in the pressure cooker. The inside of the house and the front house courtyard have already been swept.

The next task means a trip back to the fountain as the clothing needs to be washed. Arthur plays with the water and Dona Anna scrubs and rubs the pieces of clothing between her hands, using a hard brush on tough stains. To finish, she skilfully squeezes all the soap out of the clothes. Twisted in bundles she transports them in a metal bowl suspended on her head to the *secadeiro de cacao* where they are left to dry, protected from unexpected rain showers. Arthur sometimes disappears into their neighbour's house, and at other times follows his *vó* loyally. There are also moments when, untuning from each other's pace, grandmother and grandchild break into small arguments.

Later in the afternoon, we sit by the front courtyard, nicely painted in a greenish blue. Dona Ana cuts pieces of colourful paper to make into decorations for the ceiling in preparation for the upcoming Catholic mass she plans to hold at her place. As she cuts the threaded paper, she tells me about the years she lived as an *empregada* (domestic worker) in Salvador:

> *"I was so happy when I returned back to the 'roça.' Salvador was fine, and they treated me well but it was hard to be there. Sometimes when I would see all of 'that' ... I would hide in the toilet and cry ... I would think: Oh God! I am here with all of this and I don't know if my family has enough there ... I would look at myself and I would think: Oh God! look at me with this white baby in my arms."*

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10. Dona Anna cooking. Photo by the author

A visceral rejection of dispossession

In *Death Without Weeping*, Nancy Scheper-Hughes describes the multiple ways in which the people of the Alto, a Brazilian northeastern rural shantytown, are "invisible and discounted" (1992, 231). In her analysis she includes the words of a Salvadorian peasant, who questions an American visitor in the following way:

> You gringos are always worried about violence done with machine guns and machetes. But there is another kind of violence that you should be aware of, too. I used to work on a hacienda. My job was to take care of the *dueño's* (owner) dogs. I gave them meat and bowls of milk, food that I couldn't give my own family. When the dogs were sick, I took them to the veterinarian […]. When my children were sick, the *dueño* (owner) gave me his sympathy, but no medicine as they died.
> (Scheper-Hugues 1992, 230 cited in Chomsky 1985, 16)

The image of Dona Anna's tears and anguish when hiding her 'dispossession' in the toilet of a white comfortable Brazilian family conveys a perverse and quiet brutality. As with the case of the Salvadorian peasant *dueño's* sympathy, below the surface of seemingly being *"treated well,"* lay brutal social disparities and deprivation. These scenarios portray the bare crudeness of power and privilege and their consequential assaults on human dignity.

As Edmonds (2010, 200) states "the pervasiveness of this type of domestic work is a highly charged political question, though one that often remains invisible within the daily cordial, and sometimes intimate, relationships between masters and servants." Little about Dona Anna's story is unique, although less common these days due to Brazilian[107] domestic workers' fierce fight for rights. In these accounts, women as young as their early thirties reported similar stories during the time of my research in 2017-2018. White middle and upper-class women searched for rural girls to take to the cities with them always eliciting the same demand: "*Você tem uma menina para dar?"* (Have you got a girl to give?). These words, reflecting a colonial ideology, crystallize a form of domination where 'white' are in the centre and 'black' at the margins. The latter appear as disposable or spare, while at service to the dominant, as it is manifested in the expression '*para dar'* (to give). Sometimes the promise was to educate the young girls while they 'helped' with the house tasks; in other cases, families living in poverty envisioned

[107] For instance, see the PhD thesis of Accaraci L. 2018. *Paradoxes of Subaltern Politics: Brazilian Domestic Workers' Mobilisations to Become Workers and Decolonise Labour*. Department of Gender Studies of the London School of Economics. Also see the story of activist Creuza Olivera in: https://www.ohchr.org/EN/NewsEvents/Pages/DRCCreuzaOliveira.aspx (United Nations 2009).

this as an opportunity to gain a 'white' godmother in a structure of patronage relationships. This was domestic work with a lack of formalization and was performed many times for free in exchange for food and a place to stay. This meant a tiny room at the back of the house. In one case, a woman told me how she "*slept on top of the dirty clothing"* or "*on a mat on the floor."* Narratives of the experience varied, but they all shared the reaffirmation of Brazilian racial hierarchies through the reproduction of strict race boundaries. The reproduction of these boundaries were the mechanisms that transformed these rural girls into an overt legacy of slavery. Placed in a matrix of racial and gendered power relations, young girls occupied spaces of great vulnerability. Some of the women described how under situations of exploitation and sexual assault they ran away from these houses, making their way back to their own homes in the rural communities by whatever means available. On their arrival at home, they were often reprimanded by their own families.

Scheper-Hughes (1992, 231) goes on to say that people from the Alto "inhabit a world with an uncomfortable human shape, a world that is intimately embodied […] they 'think' the world with their bodies within a somatic culture." At one of the last gatherings I attended during fieldwork, black rural women had been summoned by NGOs to discuss among other issues (such as agroecology, racism, black feminism and gender violence) the much-dreaded upcoming 2018 elections. Narratives in the *rodas* (talking circles) mixed politics with life experiences. A very talkative woman whom I had never met before, explained how she had worked for many years as an *empregada* (domestic worker) in a local politician's house. She described the following:

> *"One time I came across all this money. My boss's cupboards drawers were full of banknotes, full!! ... and we know where that money comes from ... so much money!! ... I felt so bad, so sickened, I had to literally go to the toilet and vomit."*

Historically, in the domestic sphere of the white middle classes, black rural women have found their bodies captive and deemed fundamentally unequal. Experienced physically, this visceral moral sensibility is the affect of inequality. Her vomit is the subjective embodied response of those who have been historically despised and denied. Through nausea and revulsion, her body finds a way to express the rage and anger emerging from inhabiting spaces of exclusion and disinheritance.

In the role of blackness as a signifier of difference, Beatriz Nascimento – a critical figure in Brazilian black movement and considered by many a visionary – points to the centrality of the

body in the black experience. She contends that the body is the terrain in which racialisation and power relations are anchored (Ratts 2006, 69). In the following section I borrow the Afro-Brazilian concept of *Ori* to explore (metaphorically) the process of liberation from these domestic spheres of exploitation, while showing the ways in which these arrangements are part of larger historical racial power relations in Brazil.

ORI: '*Eu ja não sou governada'* (I am not ruled anymore)

Dona Jeje is Anna's '*tia de criação.'*[108] She lives in Engenho Velho in urban Jaboticaba. Many people from the rural communities have small houses in this neighbourhood and Dona Jeje is in constant movement between Onça Vermelha's quilombola community and her place in the *rua* – this is how locals call anything slightly urbanised. She is a figure of reference in Jaboticaba because of her involvement in the first struggle for land in the area, which took place in the isolated quilombola community of Terra Brava.

She is outspoken and engaged with black women's rights and a strong Afro-religious leader. A vibrant seventy-year-old, she is tiny and still so much bigger than me; my 1.80 cm shrink to nothing in her presence. When at home she loves to dance across her kitchen, smokes tobacco in her pipe, cooks (in my opinion) the best *moqueca de peixe* (Bahian fish stew) and adores mocking my accent. Today, she is annoyed. She was made to wait for a long time at the doctor. Just as her turn came up, a white woman arrived who was given preference without explanation or clear reason. She was infuriated at this injustice and in a sarcastic tone told the girl at the front desk *What is this??!! Oh, yeah … is because the' negro' is only good for a 'penico'* (urinal). She then says to me that her stance was not always like this. She did not always feel that she had the '*direito'* (right). *That was a long journey, minha filha* (my dear).

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In the description that follows about Dona Jeje's process of liberation from captivity and oppression to political consciousness, I use the Afro-Brazilian concept of *Ori*,[109] as seen in the documentary film of the same name. In this fascinating work, Beatriz Nascimento[110] explores black subjectivity, agency and autonomy. Through her personal narrative, she unpacks the awakening of black consciousness in Brazil at both an individual and a collective level.

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[108] This is the term used for aunties who are not biological but are treated like one. *Criação* derives from the word 'criar'– to 'raise.'

[109] Ori (1989), was directed by sociologist Raquel Gerber. The film documents black Brazilian movements during the 1970s and 1980s. With Beatriz Nascimentos personal history as the narrative thread, the documentary explores black Brazilian subjectivity and "articulates spaces such as the quilombo, Afro-Brazilian religions and samba schools as elements capable of restoring the humanity denied during slavery, and as key sites for the reconstruction of black identities" (Ratts 2006, 63).

[110] For a clear exposition of her contributions to Brazilian and transnational black feminism see: Smith C.A. 2016. "Towards a Black Feminist Model of Black Atlantic Liberation: Remembering Beatriz Nascimento." *Meridians: feminism, race, transnationalism,* 14 (2);71-87.

A Yoruba word, *Ori* means head or centre. In Brazilian Afro-religious contexts *Ori* is the key link between humans and the spiritual world (Ratts 2006, 63) and the vessel of consciousness. When a person is initiated into Candomblé it is said to *fazer cabeça*, literally, 'do the head', do the *Ori*. According to Nascimento (1989), "*Ori* means the insertion into a new stage of life, it's a new life." Thus, *Ori* can be a metaphor to illustrate the journey undertaken to rethink personal and collective identity. *Ori* can capture the culmination on a exercise of recognition where definitions of blackness are established under one's own terms. This process includes the destabilization of hegemonic narratives about the place of the black population in the history of Brazil (Ratts 2006, 63).

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In our conversations, Dona Jeje always emphasized how collective political awareness in the black rural communities was linked to land conflicts and how this collective 'awakening' played a critical role in her personal political construction as a subject of rights: *It was in Terra Brava with the land movement that I began to understand myself. In the meetings we would discuss things together, not only with the Pastoral da Terra but also amongst ourselves, we were "andando junto* (walking together).

In the description of this process, Dona Jeje often highlighted how this was a long journey, made up of many experiences which gradually facilitated the unfolding of this sense of 'understanding herself.' Daughter of a single mother, Dona Jeje had many brothers and sisters. They all died before they reached two or three years old. From a very young age Jeje moved between working in the *fazendas* (plantations) and in *casa de familia* (white families) as an *empregada* (domestic worker). In the latter she was always treated "*with difference."* In order to make me understand the multi layers and nuances of 'this difference,' Dona Jeje tells me how one day after being well integrated into the quilombola movement she participated in a discussion panel with some regional politicians. Once the talk had concluded, a woman – whom she quickly recognised – approached her. She was the sister of one of her past *patroa* (bosses) when she worked in a *casa de familia*. Jeje, slowly repeats and emphasizes with her voice the sentence the woman said, mimicking an *echo*:

A sua patroa morreu mas deixou marca em você, não foi?

(Your boss died but she left some traits in you, didn't she?)

Jeje then explains, in case I have lost her train of thought:

Does she think that 'this right' [the right to be there, occupying a political space, talking publicly, belonging] *was her sister who granted it to me???!! Sera??* (Can that be?).

She asks this rhetorically several times while she looks at me with inquisitive eyes.

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In the documentary *Ori*, there is a moment when the camera places the audience as a subject that runs into the forest. Running, moving fast, an overwhelming sense of escape, a strong desire for a new destination invades the screen. This desperate urge searches for "a new social place other than that of an enslaved worker" (Ratts 2006, 66). Beatriz Nascimento describes *Ori* as a form of self-awareness and realization … "established as a ritual by those capable of making a 'head' complete: a head integrated with its past, its present and the future, linking origin and current moment" (Nascimento 1989).

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Dona Jeje, returns to her pipe again reflectively, and pauses a few seconds, before she states:

> *Before I did not know what was a 'right,' before I was enslaved. But not anymore … 'Agora, eu já não sou governada!!'* (Now, I am not ruled!!)

Jeje has her own voice, her own self-definition, she ultimately perceives herself as a subject of rights. Breaking the process of invisibility, she subverts social expectations and impositions. She destabilizes hegemonic narratives about the participation and exclusion of the black population (in general) and rural women (in particular). Jeje's personal experience through realising her own voice and her sense of autonomy and freedom illustrates the difficult path and the punishing structural and symbolic barriers to be overcome by black rural women in the Brazilian racial (read class) economy. Immersed in a personal and collective struggle these women have to construct their identities on their own terms in a violent context that sees their possible contributions and humanity reduced to a docile and silenced labour force. In this setting, *Ori* "can be the reworking of personal and collective identity, of blackness and black territory" (Ratts 2006, 63). *Ori* is about the awakening of black consciousness, the making of a symbolic and physical space away from hegemonic patterns that negate black existence. *Ori* condenses the processes of emancipation, self-definition, autonomy and freedom that many women in Jaboticaba navigated in their construction as subject of rights.

In the following section I continue to pose questions around the struggles involved in achieving a sense of autonomy, although my focus shifts to the realm of gender dynamics and kinship relations in the context of local forms of patriarchy. For this, I examine the conditions and experiences under which rural women in Jaboticaba fall pregnant, become mothers and create households.

Are you pregnant and ... *'asumida'*?

Dona Anna is worried about her daughter Carol. At the plantain plantation a fellow worker keeps approaching her. Carol has brought home presents from him, like shoes and a pair of leggings. For many years Dona Anna had a small shop and people in the *comunidade* still hang around her front courtyard. The worker often comes with other men and lingers around drinking coffee and looking slyly into the house. This man comes from a far way municipality and no one really knows him; later we will discover that he is actually married and has two children. Dona Anna cannot keep hold of her frustration. *"I do not want anymore children in this house. If she is pregnant from this man, she better tell me now and she can leave the house. We already have two kids in here without a father ..."* Dona Anna's sister, Dona Jeje, also expressed this form of frustration as she told me how she had stopped talking to one of her daughters for almost a year on a number of occasions when she had found out about new pregnancies (her daughter had 12 children with five different men) …*"when I asked her 'tu ta gravida?'* (are you pregnant?), *she told me it was a 'mioma'* (uterine fibroid). *Well, look at the 'mioma' right here!!"* pointing to one of her grandsons while chuckling lightly. Every Monday in one of the health posts before the prenatal sessions begin, a community health worker gives an educational talk that always includes the following statement, *"we are too used to the fact that men are only present to make the child."*

With the hardships of single motherhood as a well-known reality, in Jaboticaba attitudes towards pregnancy were highly ambivalent. The consumption of herbs and other medicines such as cycotec are broadly used to perform home abortions. Abortion[111] in Brazil is illegal (although in practice allowed under certain circumstances), which means many unwanted pregnancies reach full term. Contraceptives methods (see Part II for details on this) are also commonly used; however women repeatedly reported falling pregnant while using them: "*the 'remedio'* (contraceptive medicine) *was too weak for me,*" was the common explanation.

In Jaboticaba, the trend is for women to get pregnant at a young age, though that first pregnancy rarely leads to a lifelong lasting partnership with the father. This confirms what other anthropologists studying the Baixo Sul have concluded. In the region there is "a delay or time gap between the fertility cycle and the cycle for what the authors coin "domestic

[111] Abortion is permitted in Brazil in cases of rape or when the mother's life is in danger, and since 2012 in cases of anencephaly (Leal et al. 2018).

constitutions"[112] (Pina Cabral and da Silva 2013, 87). This means that often, heterosexual couples will establish *conjugalidade* (conjugality) households at a later stage in lives, to which children from both sides will adhere. However, there is an element of instability in these relationships, and many women will go through several of these partnerships throughout their lives.

Early pregnancy in Jaboticaba may not be a novelty but it is generally spoken about as an event detrimental to the life trajectories of the young girls. All the young women I met stopped studying when they fell pregnant and this generated discord within their families. Many of these young girls' mothers gave birth at a young age themselves and became grandmothers early, which substantially increased their domestic load, as the cases of Dona Ca'u and Dona Anna have illustrated. Still, while generally perceived as a social disorder, young pregnancy and parenthood retain "strong continuities with core Brazilian values and norms of sexual culture" (Heilborn et al. 2007, 412).

Authors working in Baixo Sul (Pino-Cabral and Silva 2013, Martins Gualberto 2018, Rezende 2015) and in the Bahia context at large (Landes 1947 [1994], Woortman 1987, McCallum 1999, Hautzinger 2007,) have pointed to the centrality of women in the making of households. As McCallum (1999, 278) states, "women provide the stable element in a context that may shift constantly due to socioeconomic pressures."

In Baixo Sul, although matrifocal families are the usual pattern (Pina-Cabral and Silva 2013), local perspectives and narratives place great importance on having paternity recognised. This is known as having the pregnancy *asumida* (recognised). Iracema, a young quilombola girl, described her anguish in this way: *"I thought if this man does not 'asumir'* (recognise) *my pregnancy, Oh God, what will happen to me?"* Dona Anna expressed to me on numerous occasions the fact that her grandchildren had no dad, and this made her *triste* (sad). Some women opted for taking men to court, where paternity payment could be established. Giseli had done this with the dad of her last child, however for her

he had still left her *largada* (abandoned): *"It is not only the material difficulties, but also the emotional. To raise a child alone, the child may become rebellious without a dad … and then what can you do?"* In one of her interviews she explained how out of her eight pregnancies, none of the fathers were present, which drove her to tears: *"They were born like*

[112] This, they argue, is due to the different interests between genders. For men, 'recognizing' children at a young age will impair their mobility in a region where "geographical mobility equals access to socioeconomic mobility" as the established local social structures close the possibilities of class mobility. Contrarily for women, fertility is a valued resource as "through having children they may conquer a desirable partner" (Pina- Cabral and Da Silva 2013, 91).

'cachorros' (dogs)." Still, Giseli, a hard-working woman, was far from pitying herself, as these words may have suggested. In our many conversations Giseli displayed personal pride in her capacity to always *se virar* (cope/manage). At the time, Giseli was living with a man she had recently met through her cousin. They shared a house together and her children were brought back to her from their grandmother, Dona Ca'u's, house. This new partner had *asumido* (recognised) her last two children and Giseli referred to him as *meu marido* (my husband). Rezende (2015, 96) in her study about reproduction in a village of Baixo Sul asserts "that it is not enough for a man to officially recognise the child. *Asumir* entails more than a 'formal/official recognition.' *Asumir* entails *consideração* (attention/respect/esteem)."

Thus, from a vernacular viewpoint the term *asumir* (recognition) is not only important in the acknowledgement of an offspring, but also in all other forms of social relationship. A partnership in which you are *asumida* entails a form of marriage. This form of matrimony does not involve something fixed and stable; instead it is a process always in the making through acts of *consideração* (attention/respect/esteem). It is through this process of recognition (*asumir*), based on acts of attention and respect (*consideração*), that social ties become 'affectively constituent': that is to say, "the relationship is given existence because the person is ready to apply a co-responsibility" (Pina-Cabral and da Silva 2013, 26) within a constant process of actualization and renewal.

Although women navigate their way through the intricacies of *asumir* (recognition) and *consideração* (attention/respect/esteem) in social relationships, these dynamics take place in the context of unequal gender relations. This presents a clear tension between women's expressed desire to have an ideal monogamous male partner, and the real experience of polygyny,[113] or multiple paternities (frequently without support) as the common trend. Pina-Cabral and da Silva (2013, 95) have stated that this should not be misread as there being a lack of men present in Baixo Sul households, but rather that this usually, as mentioned earlier, can take place at a later stage in a women's life, or in numerous stages throughout it.

Furthermore, while women generally may worry about the number of children the household begins to accumulate, as shown in the attitudes displayed by Dona Jeje and Dona Anna towards the pregnancies of their daughters, men draw pride from the number of children they have. On one occasion, as Tia Tata was telling me how many children her *velho* (old man,

[113] Current matrifocal kinship patterns are the result partly of slavery, given that the paternity of enslaved men never received juridical recognition. Simultaneously, on an ideological level the continuation of models of African-influenced kinship is probable (Hautzinger 2007, 24).

also her current partner) had had (a total count of twenty-six with three different women), he stood up looked to the sky with open arms and stated: *Graças a Deus!!* (Thanks to God), and then, walked away defiantly, illustrating a common attitude among men in the region, that procreating is part of their masculinity and a source of joy.

In following the story of Dona Anna's activities in the domestic sphere, I have shown how reproduction in the domestic realm requires a choreography of tasks that absorbs time. These activities are fundamental in maintaining daily life. I have also demonstrated how the social relationships which shape work in Brazilian socioeconomic hierarchies are deeply gendered and racialised. I have evoked too, through the metaphorical use of *Ori* and the narration of Dona Jeje's journey to liberation, the process through which the dawning of black consciousness can take place. *Ori* encapsulates the process of emancipation, self-definition, autonomy and freedom, bringing with it the perception of oneself as a subject of rights. I have suggested how this force challenges hegemonic narratives of black women's place in Brazilian society and breaks symbolic historical bondages.

Finally, foregrounding the dynamics of kinship I have explored the making of households in Jaboticaba. I have discussed the ways in which women navigate the intricacies of *asumir* (recognition) and *consideração* (attention/respect/esteem) in the formation of vernacular social relationships in a context of unequal gender relations. I have done so by illustrating and highlighting the tensions and contradictions that emerge, between women's desires for partnership and autonomy and the actual constraints in self-defining their social spaces for reproduction within local forms of patriarchy.

Conclusion

Overall, in this chapter I have attended ethnographically to the daily maintenance and reproduction of life by black rural women. I have described the ways in which these women carve unique spaces to foster well-being, autonomy and self-definition. I have illustrated how, through diverse networks of care, organisation and leadership, they engage in creating projects to nurture and imagine a liveable future. These liberatory practices are based on their historical experience and defy violent historical, racialised, and gendered agendas. They evidence these women's sturdy resistance to oppression as they craft possibilities for social transformation emerging from a vigorous sense of belonging.

In Part One I have explored the many expressions of violence and death in Brazil as they manifest at national and local levels. My focus has been to illustrate how the extension of 'death worlds' (Mbembe 2004) impacts processes of reproduction, as they foreclose a sense of futurity and belonging, captured in the troubling expression of the impossibility to 'raise a child.'

Equally, I have emphasized how alternative projects that foster life and possibility are also present in Jaboticaba. By focusing on black rural women's participation and struggles, I have shown some of the political manifestations of care practices, also highlighting the ways in which reproduction can be a site for social transformation.

In Part Two of the thesis I explore a different dimension of reproduction. By following the pregnancy journeys of black rural women, I investigate other manifestations of care as they emerge in these women's interactions with health care facilities, where they officially receive maternal health care.

PART II

BIRTHING

A noite não adormece
nos olhos das mulheres
vaginas abertas
retêm e expulsam a vida

donde Ainás, Nzingas, Ngambeles
e outras meninas luas
afastam delas e de nós
os nossos cálices de lágrimas.[114]

Conceição Evaristo (2008)

[114] Translation: The night does not fall asleep in women's eyes, open vaginas retain and expel life, where Ainas, Nzingas, Ngamelas and other moon girls, push away, from them and us, the chalices of our tears.

Chapter Six

PRENATAL: BUREAUCRATIC CARE

... As estatísticas não sabem, por isso não divulgam
Ando triste, confusa e ruim da memória.

E no posto de saúde.
Onde sou apenas mais um número no SUS
Não tem psicológicos para sequer uma consulta.
Desconfio que psicológicos devam atender
Apenas números inteiros e não os fracionados como eu[115] *...*

Jennifer Nascimento (2014, 18)

Beautiful prenatal care registrations

It is around 7:30 a.m., and I am in the town centre of Jaboticaba catching a *lotação* van (a form of informal public transport) so I can attend a weekly prenatal session in Jacami, one of the district health posts to which several quilombola communities are attached. The ride is a few kilometres long and it costs around 4 *Reais* (approximately 80 pence). The health post building in Jacami is small and run-down. It stands at the top of a small slope, surrounded by houses, some are wooden shacks, while others are made of solid bare brick with protection bars in the doors and windows. On the nearby pathways, many sheets of cloth are spread out so the cocoa seeds can dry under the sun. The health post is made up of blocks and has three rooms, a toilet and a small front desk where an old table recycled from the local school does the job. Behind this table, facing the two benches, carefully handcrafted decorations make the place more inviting. This month's health theme is STDs (Sexually Transmitted Disease) and numerous red blood drops cut out of cardboard combine with brighter red tiny shreds glued in the centre. They hang from the ceiling, giving the health post a festive atmosphere.

Today I have arrived early and I meet some of the pregnant women waiting outside. Some have walked an hour or more to reach the health post. They are chatting and resting. As I approach the group, I am offered Coke in a disposable plastic glass and some commercial pop-corn. Breaking through the conversation I hear an alarmed voice from within the group, a grandmother is asking her pregnant teenage granddaughter – *Did you bring the folder?!!* The grandmother's eyes open wide. *–Yes, vovó ... here it is!!* Rosieni replies slightly grumpy while continuing to eat her pop-corn. Her gaze is adolescently absent as she chews and rubs her big belly simultaneously. The pink varnish on her nails is cracked, and almost completely worn off.

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This grandmother (*vovó* in Portuguese) is referring to the folder that the nurse urges them to buy to compile all the documents about the different tests they will undergo throughout the

[115] Translation: … Statistics do not know so they cannot disclose, that I am sad, confused and with a frail memory. In the health post, where I am just a SUS number. They do not have psychologists to consult, I suspect psychologists only attend whole numbers. And not fractioned ones, like me …

pregnancy. Usually the folder will have the *Caderneta da Gestante* (pregnant woman's registration booklet), and reports of scans and lab tests. Ideally, these tests should be done through the national health system (SUS); however, in reality they are almost always done privately. "*This folder is your treasure and you must bring it every time*," I hear the nurse repeatedly state in the first prenatal session. "*E tem que ficar tudo bonitinho*," it must be all beautiful, that is: all the information has to be clearly organised. A *bonitinho* (beautiful) prenatal care plan is one where all the sessions have been completed and the information is 'beautifully' registered.

In Brazil, the Ministry of Health has identified prenatal care as a key strategy in reducing maternal and infant morbidity and mortality. Since the 1990s, prenatal coverage has been reinforced by government programmes such as the Prenatal and Birth Humanisation[116] Programme[117] (PHPN) in 2000, later complemented by the Stork Network,[118] in 2011.[119] Following recommendations from the Ministry of Health (2006), prenatal care includes a welcoming reception, educational and preventive actions, identification of gestational risk, early detection of diseases and it is meant to establish the linkage with the facility where the woman will give birth. It is also meant to include quality health services (primary care and hospital care) for high risk women. To be satisfactorily delivered, this assistance requires a series of resources and mechanisms, such as qualified professionals, adequate physical structure, essential equipment, registration documents, processing and the analysis of data and medication. An essential aspect of this policy involves taking responsibility for the arriving women, "listening to their complaints, allowing them to express their worries, anguishes, and guarantee resolutive attention and links with the other services" (Ministry of Health 2006).

[116] The word humanisation in healthcare in Brazil focuses on patients' autonomy and rights (Serruya, Lago and Cecatti 2004, 275).

[117] Created in 2000, *Programa de Humanização do Pré-Natal e Nascimento* (PHPN), the Program for the Humanisation of Birth and Prenatal Care, was conceived with the intention to reduce the high number of maternal and infant deaths and morbidities. Among its main objectives were to improve access, coverage and the quality of pre-natal care. It established that satisfactory pre-natal care should be initiated before the fourth month of gestation, have a minimum of six consultations, and include blood and urine tests. In this way, state and municipal departments of health could be organised under some orientation of the minimum requirements for an optimal prenatal assistance.

[118] The other three key strategies in the Stork Network 2011 are: assistance to birth; postnatal and comprehensive health care for the child and logistic systems (transport and referral) (Brasil, Stork Network 2011).

[119] In 2013, the Ministry of Health launched the *Cadernos de Atenção Básica Primária número 32,* which was directed to the healthcare teams as part of the Stork Network assisting low risk pre-natal women.

Despite this thoroughly conceived holistic approach to prenatal care, the "*reality is very different,*" as one health manager told me at a regional centre for normal birth. "*The prenatal care that we get at the other end in the hospital is not as 'bonitinho' as it appears in the books.*[120]"

This chapter describes the tension between programmes and policies, and their planned and unplanned outcomes, by following two main aspects in the delivery of care. First, I examine the effects derived from the imposition of the production of metrics through registration, and next, the consequences of material scarcity and the lack of medical resources.[121] I then focus on the delivery of prenatal care in the rural town of Jaboticaba and examine the dynamics resulting from the consultation procedure. By isolating and identifying the specific practices taking place, I probe the limits of quantification and numbers and expose the complex ways in which these alter how people come to matter.

To describe this process, I focus on the techniques that are applied when complying with bureaucratic concerns in the delivery of prenatal care, such as monitoring through strict measuring. This raises the questions: how do the mechanics of surveillance and care for the bodies of black pregnant rural women unfold? Who or what comes to matter in this process? What alternative ways of knowing are foreclosed as a result?

By addressing these questions, I show the complex ways in which technology emerges as a fundamental tool in the delivery of care, while simultaneously scrutinising the ambivalent role it plays in a context of material scarcity and a lack of medical resources. In addition, I reveal some of the ways in which the uncertain availability of technology exacerbates and reinforces harmful stereotypes in black rural populations, where the language of risk and danger also fosters specific subjectivities while under current neoliberal forms of governance.[122]

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[120] She refers to 'the prenatal' as the outcome of the prenatal care process personified in the figure of the woman arriving to give birth, including not only the 'folder' she will bring but also the type of preparation and information she will have received. By 'books' she connotes all the Ministry of Health prenatal care guides and programmes.

[121] By material scarcity I mean conditions of material poverty where the population lack the resources necessary to meet specific needs. By lack of medical resources, I am referring to anything critical to providing health care services such medical staff or equipment.

[122] I understand 'neoliberal governance as "the rationalities, technologies and ethical problematizations, through which governance and rule (often by the State) can be exercised remotely, indirectly and via a specific mode of 'subjectification.'" In this form of subjectivity or self-hood the autonomous and free individual shifts explanations for problems from external forces to the self, calling on personal responsibility. (Pyysiäinen, Halpin and Guilfoyle 2017).

Ultimately, this chapter exposes the contradictions in the Brazilian recognition of the right to health by revealing how it is deployed 'in practice' in the delivery of prenatal care and the ways in which it is lived and experienced by some of the most disenfranchised populations of Brazil: black rural women.

At the Health Post

The municipality of Jaboticaba has several local Health Posts[123] where basic health care is delivered to the population from each ascribed area (seven in the diverse rural areas and two in the municipal urban centre). Rural health posts are located in the *povados* (small villages), where a cluster of houses gather together, usually consisting of a few shops and a local *boteco* (bar). Surrounding these rural centres, the population spreads out into the dense *Mata Atlântica,* with road infrastructure becoming extremely hazardous the further one plunges into the woods. *Posto* (health posts, from now without translation) buildings vary in comfort and resources, from very precarious sites where almost everything is lacking, to newer buildings with air-conditioning where basic materials are available. The Family Health Strategy (*Estratégia Saúde da Família*, ESF[124]), is the key model for the assistance and implementation of prenatal care. Every *posto* is comprised of a multidisciplinary medical team (*Equipe de Saúde da Família,* ESF), each containing a doctor, a nurse, a nurse assistant, a variable number (from four to six) of community health workers, and a dentist with an appropriate assistant. These medical teams, known as *Equipe Médica* or just *equipe* (medical team, from now on without translation), have their own ways of working and their unique dynamics, lending each *posto* a very specific character. It is not uncommon for *postos* to not have a complete *equipe.* For instance, none of the pregnant women I met during my field research had appointments with the dentist. I only once came across a dental assistant at a *posto* I visited, who explained that, "*due to lack of equipment, we cannot deliver any services beyond diagnosis."* As one nurse told me when I asked for these services, "*We are waiting…*" *Postos* are also supported by the

[123] Locally known as '*Postos de Saude'* or '*Postos'* and referred to in the literature and policy documents as *Unidade Saúde Família* (USF). They are responsible for the registration and monitoring of the population linked to their area, taking care of a maximum of 4,500 people, or 1,200 families.

[124] Emerging out of the Family Health Program initiated in 1994, the *Estratégia Saúde da Família* was created in 1997. Envisioned as a new model of assistance, it brought innovation and profound changes on basic care organization, due to its community and family centred approach by the inclusion of Community Health Agents, among other measures (Silva, Casotti, Chaves 2013).

Núcleo de Apoio à Saúde da Família, NASF[125] (Support Centre for Family Health). As part of this scheme, there were several occasions when I met a nutritionist who travelled between the *postos* of the municipal area attending to the population. Each *equipe* tries to provide routine health care for the population that is ascribed to their *posto*, and they are responsible for the well-being of pregnant women and their babies. *Equipes* also visit the more isolated rural areas once a month, although this depends on the state of roads and the availability of transport. At the time of my stay, this scheme was taking place on a regular basis, although there were some communities that had not been visited for several months.

At the *postos*, doctors, nurses, auxiliaries and community agents took pride in the care they delivered to the population. Overall, I witnessed devoted professionals who would go out of their way to ensure that the population received what they needed. Nurses bore the greater brunt of care, and most showed signs of emotional exhaustion. Their personal telephone numbers were available to most patients and they described receiving WhatsApp messages every day until late into the night. They also handled the bulk of the paperwork and completed the most hours of work. As one nurse told me: "*the doctor is always late and never fills in all the forms, so I have to check everything at the end of the day."* Hierarchies within the *posto* were thus clear, although Cuban doctors brought to the region through the programme *Mais Médicos* were the exception to this form of behaviour, that is they were not late and completed all their ascribed tasks. In this area, the turnover of doctors was high. An auxiliary nurse who had worked in the same *posto* for the past five years described how there had been six doctors in the last five years. The longest stayed three years. Another stayed one and a half years. The rest all stayed for intervals of two to three months. Brazilian doctors do not want to work and live in the rural areas. This was confirmed by the notes in the local *Conselho de Saúde's* (Health Council) books, which indicated that there had been a serious shortage of doctors in recent years.

Typically, community health workers identify pregnant women in the communities and direct them to the *posto*. Ideally this take places before the 12th week of gestation. At the first prenatal consultation, the nurse registers the medical history of the expectant mother, the personal and family background and the obstetric-gynaecological history. The woman also has

[125] NASF: This is a team formed by professionals from diverse areas who act in an integrated manner with the family health teams. The composition of each NASF is defined by the municipal managers and based on the territorial needs and the available epidemiological data. For more information see: http://dab.saude.gov.br/portaldab/nasf_perguntas_frequentes.php

the ‘quick test’ done, which includes those for HIV, syphilis, and hepatitis B and C. If the partner accompanies the woman, which is unusual, he also has these tests done. This is followed by a physical examination. Generally, in this consultation, the nurse categorises the pregnancy as ‘low risk’ or ‘high risk.’ The idea of a pregnancy with ‘no risk’ is not contemplated;[126] this is linked to questions about the medicalization of birth in Brazil which follows a rigid medical-centred model. From these categorizations, women’s bodies will be managed accordingly, and as Bridges (2011, 170) reminds us, this will also encourage new identities to be formed. Typically, women leave this first consultation with a few requests from the doctor for further investigations, commonly a blood test and an ultrasound, and the next appointment is arranged. Necessary vaccines, folic acid and *ferroso sulphate* are meant to be covered by the SUS, as well as are any routine and complementary examinations. Women with low risk pregnancies have monthly consultations until the 28th week, then fortnightly between the 28th and 36th weeks, and subsequent visits are weekly until the 41st week. The minimum number of consultations is meant to be six, with follow-up appointments interleaved between a doctor and a nurse. Every woman will also visit the obstetrician, who is located at Jaboticaba’s local hospital, at least once.

Smiling, the local nurse at Jacami, Lucia, explains that she always tells women that the first meeting is going to be “*very chato* (boring), *I say: Look, relax because today I need to register you and put all the information down, so it will be boring.”* She believes it is important to make this clear to patients, so they are not tempted to “*fugir”* (runaway). *“I am thinking …* – she reflects as she looks at her mobile phone – *this is the first contact we have with the women and we don’t want them to get the wrong impression.”* In this first interaction, I did not hear the nurse ask the women how they self-identified in terms of skin colour. The registration of this is critical for the development of appropriate health policies for the black population and I will elaborate on this question in more depth in the following chapter.

In consecutive routine prenatal visits, health professionals are responsible for completing the documentation contained in the *Caderneta* or *Cartão da Gestante* (pregnant woman’s registration booklet), which remains with the pregnant woman and contains data about the pregnancy for referencing and counter-referencing. The health professional must complete also the *Mapa de Registro Diário*, a daily register used as a tool to assess the activities taking place in the health unit, which contains basic quantitative information about each prenatal

[126] Conceptually, Lealle Ruhl (1999) relates this categorization of risk in pregnancy as the by-product of what she coins the ‘risk society.’

appointment, and the *Ficha Perinatal* (perinatal record), a data collection tool for the professionals in the health unit, which contains all the main data from the pregnancy, birth and post-partum period (Brasil 2012, 44). As well as these forms, the health professionals also complete requisitions for examinations and prescriptions.

Most of this information is eventually loaded into the SIMPrenatal, a computerized system developed to enable evaluation and monitoring for prenatal and puerperal assistance (a key element of the PHPN). However, during the consultation, the information is transcribed manually from document to document, from the exam results and technical examinations to the *Caderneta* or *Cartão da Gestante*, then to the *Mapa de Registro Diário*; thus, the same information (such as fundal height, blood pressure, weight and so on) is repeatedly documented.

Later, in Jaboticaba's Department of Health, this data is digitalized by a person appointed to perform this task. Feeding data into this system is the responsibility of local government and it is directly linked to the transfer of funds. This is a strategy designed to increase the achievement of health municipal goals through financial stimulus for each woman who completes the recommended measures[127] (Brasil 2000). This data is considered important, not only to guarantee payment to the municipality and to prove the performance of the actions, but also to protect the user and to establish indicators for future health planning (UNA-SUS 2013). However, this method can create failures in documentation, due to the details involved in the subsequent transcription and typing into the system, with several studies confirming the SISPrenatal system as an unreliable source for evaluating the available information on care during pregnancy (Momaiz et al. 2010; Adreucci et al. 2011; Araújo Souza et al. 2016; Maia et al. 2017). Studies also call attention to the necessity of training health professionals on the importance of registers (Melo Guimarães dos Santos et al. 2017), with research in Brazil already depicting the negative feelings health workers have about these burdensome tasks and the effect they have on their daily work dynamics.

Nurses are outspoken about how they find this exercise tedious and complain about the negative impacts this has on the way they engage with patients. *"You wanna give 'care' and you end up all caught up in this amount of paperwork."* During prenatal sessions, health professionals constantly excuse themselves to me or to the pregnant woman for having to invest so much time in filling out documents. "*This papelada* (paperwork), *can you see? It's too*

[127] Indicators created to monitor implementation steps and the programme's continuity are: onset of prenatal care within 120 days of gestation, a minimum of six prenatal consultations, a puerperal consultation within 42 days of birth, and a tetanus vaccine (Brasil 2000).

much!! It's for the SIS, I don't think it really works, it started a couple of years ago ... and it's not like you can tick-tick-tick quickly, no, no ... you need to focus ... 'Assim que querida tenha paciência!!' (so darling, be patient!!)" In another instance, this same bubbly nurse, while she was completing the forms, in an attempt to make the meeting more dynamic kept asking the pregnant woman: "*Come on woman ... you can tell me how everything is going ... Do you have any questions or concerns? You can talk to me while I do this* …" She repeated this rashly without lifting her eyes from the documents. The pregnant woman remained quiet and eventually responded shyly: "*Tudo bem, graças a Deus*" (All good, thanks to God). The nurse then looked at me and laughed. Lifting her hands up, shrugging her shoulders, and rolling her eyes, she clearly recognised the absurdity of the situation. The volume of paperwork was preventing her from creating a warm and conducive atmosphere for the woman to respond to her personal questions.

National research has stated that access to prenatal care is almost universal in Brazil, reaching close to 90 percent in all of the country's regions[128] (Viellas et al. 2014, S1). Nevertheless, numerous studies (Teixeira et al. 2016; Viellas et al. 2014; Tomasi et al. 2017) have pointed to the lack of quality[129] in the delivery of prenatal care. Health professionals continue to act with a biological and fragmented perception of the human being. In the case of pregnant women, the actions of the health professionals occur entirely through consultations and procedures. The lack of educational activities further confirms that the relationship between health professionals and the users of the system (women attending prenatal care) is centred on procedures (Costa et al. 2009, 1352); and the lack of information women receive during their prenatal appointments points to inadequacies in preparing women for childbirth and breastfeeding (Viellas et al. 2014, S12). Furthermore, studies also signal clear and worrying evidence of race/colour inequalities (Leal et al. 2017; Theophilo et al. 2018).

[128] This information, which is based on the Information System on Live Births (SINASC), demonstrates an increase in prenatal coverage in the country, reaching values close to 100 percent in 2011 (Viellas et al. 2014).

[129] There is a significant reduction in the adequacy of prenatal care when studies compare the quality of care based not only on quantitative variables (such as number of consultations and frequency of basic tests), but also on qualitative variables (such as technical guidelines) (Nunes et al. 2016, 259).

11. View from Jacami's health post. Photo by the author.

Measuring care: technology and scarcity

The nurse seems flustered; she has arrived late. Due to an unforeseeable event, the doctor cannot attend today, so she has to take his prenatal consultations. I am sitting in the corner on a pre-school chair with my notebook, my long-crossed legs my most visible feature. The first woman enters. As she sits down, she manoeuvres her big pregnant belly so that she can fit into the school chair, the kind with an arm-table attached, provided for the patient's use. She opens her folder and waits for the nurse to ask for the *caderneta*. When asked, the pregnant woman hands over a photocopied data sheet folded in three. *Suddenly they stopped supplying the 'cadernetas' a few months ago* – the nurse tells me – *and we are now just waiting …* The nurse asks the pregnant woman for the results from the previously requested ultrasound scan. She sighs and tries to make space in the restricted chair. *I want to do it* – she explains – *but money is lacking, hopefully on Monday…* Next, the nurse examines the woman: her nipples and ankles are checked; fundal height is measured, followed by abdominal palpation. Now the heartbeats of the foetus fill the silence in the room. The woman gets dressed and answers routine questions monosyllabically.

As the nurse completes documents and ticks boxes, fills in gaps, enters numbers and digits, the pregnant woman leans forward, her elbow on the table, her hand supporting her chin, waiting. The pen moves back and forth from the data sheet to other documents. Papers are shuffled about, rearranged in a specific order, re-checked so that all the information matches. All the activity in the room is taking place on the table. The walls do not reach the ceiling and loud voices beyond the room become especially present. A blast of music from a car passing by penetrates the tiny building. We can all hear Manu Brown's lyrics …

> *... me ver pobre, preso ou morto, já é cultural. Histórias, registros, escritos, não é conto, nem fábula, lenda ou mito, não foi sempre dito, que preto não tem vez ...*[130]

[130] Translation: Seeing me poor, incarcerated or dead, it's already cultural. Histories, registers, writings. It's not a tale nor story, legend or myth. It wasn't always said that black don't have a chance (Racionais MC's 2002).

The nurse lifts her head up and asks the woman: *Have you got any questions?* She replies by shaking her head from side to side and collects her documents. As she leaves, she gives a friendly – *Obrigada, viu?* (Thank you, eh?).

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Consultations last around 15 to 20 minutes. Although this can vary, they are never shorter than 10 minutes. As a nurse told me, *"when delivering prenatal care, we are not in a rush."* Usually, the facility is reserved for attending pregnant women one day a week. The number of women attended to fluctuates; for instance, in the rainy season women have more difficulty accessing the health unit, and fewer consultations take place. As a general guide, a prenatal care consultation shift can start at 9:00 am and finish around 13:30.

As described above, in a typical consultation the nurse is focused on the procedures of measuring. To an outside observer, the woman and her pregnancy appear as a vehicle, a means to the objective: registering measurements. The focus is on tasks. Consultations are ordered around a pattern, a ritualistic organised choreography of measuring and registering. This arrangement shapes the attention given, which is driven by the information that needs to be documented in the registers. This type of attention, based on measuring, evaluating and ultimately disciplining the body has profound consequences on the type of healthcare delivered.

The Brazilian birthing landscape is characterized by a 'technocratic model' (Davis-Floyd 1997); that is, it is an interventionist and doctor-centred approach. The prenatal period, as the antechamber for birth, follows the very same logics based on an over reliance on technology and expert knowledge as well as the common traits of a biomedical paradigm based on the standardization of the body and its medicalization. A common phrase that appeared as a mantra in many of my conversations with health workers was: *"Birth: it's not an illness but it requires care."* In these conversations, 'care' appeared to be a form of surveillance. Prenatal consultations are centred in the delivery of this conception of care. A Cuban doctor from the programme *Mais Medicos*[131] summed up the situation when he said: *"Basically our job is to monitor the mother and the foetus in her body so if any risks arise, we can quickly intervene."*

[131] In order to address physician shortages in remote, highly vulnerable areas, the Government of Brazil implemented the *Programa Mais Médicos* (PMM; More Doctors Program) in 2013 through Law 12 871 (9). This programme worked along three main axes: (i) Investment to improve the infrastructure of the network in healthcare, (ii) An increase and expansion of medical courses, and (iii) Supplying doctors to vulnerable municipalities, under the project named *'Projeto Mais Médicos para o Brasil'* (More Physicians for Brazil Project) (PMMB), an emergency physician provision program for vulnerable areas in Brazil. In spite of several previous initiatives to attract professionals to remote areas in Brazil, it was only through PMMB that the recruitment and allocation of physicians was satisfactory. To ensure comprehensive health care, the Ministry of

In prenatal consultations, monitoring, measuring and intervention are performed mainly through the use of technology. In the technocratic model, technology is regarded as the main legitimate source of authoritative knowledge. Several authors (Sanabria 2016; Edmonds 2010) have regarded the fetishist use of biomedical intervention in Brazil as intimately tied to the national project of modernity. Full of aspiration, this modern project is always predicted to happen in a near future, in an almost-there. The Brazilian proverb 'Brazil is always a country of the future' expresses this deliberation: "the modern is not quite now, but rather a goal that is continuously receding" (Edmonds 2010, 66). The tension inherent in this aspirational process is reflected in the contrast between progressive maternal healthcare policies and the factual realities present on the ground. SUS's limited capacity to deliver quality inclusive care, because of the chronic underfunding and mismanagement (Aquino 2014, S8), was revealed on a daily basis in prenatal consultations in Jaboticaba. Access to technology for monitoring was crucial, but not straightforward. An ambivalent tool, technology facilitated some aspects of prenatal care while simultaneously creating anxieties and exacerbating notions of risk in healthcare professionals, because of its uncertain availability. It was also a source of multiple apprehensions as in many cases it did not deliver the accuracy that was expected from it. For instance, a doctor coined the term '*Laboratopatologia'* when referring to the terrible service some of the local labs performed. On numerous occasions, doctors and nurses showed me mistakes and contradictions in lab results and scans, with one doctor angrily stating: *assim não se pode trabalhar!* (One cannot work like this!). At the intersection of bureaucratic regimes and biomedical interventions in a context of scarcity of medical resources, health professionals became extremely frustrated. Another Cuban doctor defined her medical practice in the rural areas of Baixo Sul as "*haciendo medicina a pulmón*" (we are doing medicine with our own means). Several times, I witnessed how health workers had to provide their own resources. For instance, the nurse I usually accompanied had to buy her own doppler to measure the foetus' heartbeats because she said: *"I want to give the gestating mothers good quality care … when they hear the heart beating, you know? Their eyes shine and for me that is so important."* It is interesting to note how in this statement, contrary to what is usually thought, technology creates intimacy in a context overwhelmingly characterised by bureaucratic dynamics, forming a bridge of communication between the health worker and the women who receive care. It also

Health of Brazil established the following PMM priority criteria for eligible municipalities: (i) more than 20% of the population living in extreme poverty; (ii) being one of the 100 municipalities with more than 80,000 inhabitants, low levels of public investment in health per capita, and high social vulnerability; (iii) shelter an Indigenous Health District and (iv) having areas among the 40% of census tracts with the highest percentage of the population living in extreme poverty, among others (da Silva et al. 2018, 1-2).

captures the pervasive tensions in the prenatal consultation between bureaucratic and intimate contact, indifference and concern, discipline and nurture. This brings forth the important question about how and which technology is employed. In other words, it is not technology *per se* as a monolith, but its deployment (e.g. the use or mis-use/mal-use) that creates the distance and disconnection between health workers and the women they meet.

Documents are health! Managing uncertainty

One morning as I was sitting next to the doctor in a *posto,* I could hear the nurse patiently explaining to a pregnant woman the procedure for arranging a visit with the local obstetrician.

> "*You need to be early, very early okay? On Tuesday, right? So they can give you a number for Friday's visit. The queue to get a number builds up quickly and they only give away 15 visits. I think people usually arrive around 4:00 a.m. in the morning and they open the office at 8:00 a.m. Do you think you can make it? This is important, we want the obstetrician to evaluate you …"*

She then goes on to explain the documents she needs to take along and emphasizes: "*and do not forget your folder on Friday nor your health card on Tuesday.* "*Os documentos são saúde!!!"* (Documents are health!!!) I could hear her voice rise.

The nurse is talking about the local system that arranges a consultation with the only obstetrician in the *Municipio* (Municipality). This by now very pregnant woman lives in the rural area, and her difficulties in arranging a trip to the town centre are many. Maybe the queue will begin earlier than usual, and maybe she will not get a number. The nurse clearly wants to make sure that she has all the documents with her to reduce the uncertainty of getting an appointment. If the timing happens to work out well, she ought to get through without any additional problems. *Documents are health!!!* she asserts. Their importance in gaining full access to citizenship cannot be underestimated. This excerpt illustrates the significance of 'the folder' as a means of communication between health teams, especially those of prenatal care and delivery care. The papers provide key information on the complications identified, the procedures adopted and the general care-journey of each woman. Thus, prenatal care notes are crucial for sending information through a fragmented health care system. In addition, documents are the key to unlocking the intricate doorways to citizenship. As well as the obvious need for health cards and registrations to access services, during my observations in the health posts, I witnessed innumerable occasions when health professionals would alter and endorse documents with other meanings beyond their formal ones. Thus, forms, reports, and

exams would appear with side notes highlighted in fluorescent yellow or they would have extra annotations clipped to the original papers. At other times, women would be given detailed notes, with clear instructions. For example, one nurse explained: *"When you get to the hospital, do not talk to anyone, ask directly for the head nurse and hand this note directly to her and show her your folder."* In the note, she also clarified that "*this woman's blood pressure is very high, she has initiated the prenatal care late, the woman needs medication."* On other occasions, after a few phone calls, the doctor would arrange an urgent ultrasound at the private clinic free of charge, with an additional note accompanying the woman's *cartão* (card) specifying "*Utrasom urgente, sem condições*" (urgent ultrasound scan, without means). Health workers use documents as a means to secure their patients' care in a precarious and insecure healthcare structure. At times, they subverted protocols and broke bureaucratic logics, searching for faults lines to insert their care.

However, the information that documents carry is not necessarily clinically neutral data, but instead it is often charged with moral judgements. One day, after a busy morning at the *posto*, the last two women were patiently waiting outside the clinic for their turn. They were a mother and her daughter, both pregnant (which is a common sight in the region), with their pregnancies a few months apart. After examination, it was decided that the young girl should go to the hospital given that she was already at term. There was confusion over her estimated date of delivery because she initiated prenatal care late, with her first scan being done in the second trimester, and she could not remember the date of her last menstruation. Mother and daughter disagreed, as going to the urban centre would cost them time and money. Besides, the mother has already experienced this in previous pregnancies, and they may be sent back home and told to wait for contractions to start. The nurse insisted, and tensions grew. At one point, the nurse pointed towards some writing highlighted in fluorescent yellow in one of the girl's documents and told me something I did not quite understand. I could see the mother becoming furious and protesting: "*isso é mentira!!"* (that is a lie). Eventually, I came to understand what was written and what they were talking about. The highlighted writing stated that the girl, who was only fifteen, had previously been pregnant. Apparently, she had had a spontaneous abortion provoked by a domestic beating. The discussion built up and the nurse finished the conversation with the following remark: "*You are saying this is not true but as a professional I can only believe what's on paper…"* With this observation, the nurse not only reinforced the authority of the document and the written word, but also demonstrated how the health professional's narrative counted for more than the patient's version. Once mother and daughter left, the nurse told me how they are typically non-adherent and trouble, *"barraqueiras …*" (churly women).

During my informal discussions with health workers, I perceived that 'moral judgements' were not only based on what is stated in the documents, but also on which documents a pregnant woman carries in her folder, a reflection of how active she has been in 'caring' for her pregnancy. Many times, the documents missing in the woman's folder had little to do with her non-compliance and moral status and said much more about her socioeconomic circumstances characterised by inequality, discrimination and poverty. Women in the rural communities remarked how they would walk for kilometres with big pregnant bellies to the health post to attend prenatal sessions. They knew that at the time of birth, going to hospital without any documentation would mean being mistreated and moved from hospital to hospital without anyone wanting to take on responsibility for a *pepino* (hot potato). The folder was a prerequisite to be considered a citizen and a responsible mother.

The relationship between health professionals' registering actions and accountability was expressed by several of my interlocutors concerning registry and documentation. Even though they found these registration practices tedious and thought they were drawing critical attention away from the patient, they also thought they were necessary to protect themselves in case anything happened. The following extract is from a conversation with the nurse in Jacami's *posto*, where she is reflecting on an infant's death in the region.

> " *... this death took place in a very near 'povoado'* (little village) *so I went to the house with all the reports and showed them everything, I showed them my action and the actions of the doctors, everything ... how she had more than six prenatal consultations, the medication she was taking. Look – I said – we did everything that was in our hand ... and she responded: yes, I know, you can relax."*

Accountability is a major issue in healthcare in Brazil, and this is also evident in one of the technical manuals for high risk pregnancies launched by the Ministry of Health in 2012:

> *Health professionals are living a new reality today in health services assistance. Every day there is a new case against a doctor or a health care service, this is currently known as: defensive medicine. In this confrontation, health professionals need to have their rights also ensured. For this reason, rules and procedures have been established in the current legislation. Everyone needs to be aware of the importance of medical records, especially in those cases where there is an incident. Annotations will be considered fundamental tools in the elucidation of the cases in administrative and legal forums, and may represent an important tool in the defence of the professional. The health records are a right that must be guaranteed to all, and more than that, they are critical in the exercise of citizenship (2012,19).*

This 'culture of fear' when attending low-income women and the connection to litigations has also been reported in other countries such as the United States, where high risk factors lead to a form of 'defensive medicine' and the consequential increase of medical interventions (Oparah 2015, 15). In Jaboticaba, this situation was exacerbated by the material precarity of the region's health infrastructure and points to the crucial role that documents play in the management of uncertainty. Earlier on, I illustrated the difficulties women had in securing an appointment with the only local obstetrician available through the SUS. At the time of my research, the local lab which had an agreement with the SUS to provide tests for the population was blown up (when the adjacent bank was attacked by a local gangster mob) and the only public ultrasound machine available at the hospital was broken. The local hospital was not fully accredited to assist births (although it attended many) and women never knew where they would end up birthing. There are numerous ways in which biomedical practices seek to tame uncertainty, with registering and documenting being one of them.

Prenatal documents were also critical in accessing cash-transfer programmes such as *Bolsa de Familia.*[132] This, in turn, was dependent on prenatal compliance. In the case of *Licença de Maternidade Rural*[133] (maternity leave for rural women), those women who wanted to leave work 28 days before giving birth had to present an original medical certificate, specific to pregnant women. In some cases, this measure was used strategically. As one doctor told me: *"we began to spread the word in the communities that if women did not come for prenatal care early in the pregnancy we would not give them the certificate to receive the rural benefit* [she is referring to maternal leave for rural women]. *This expanded quickly and had some very good results."*

Seeking the population's cooperation with biomedicine through welfare programmes is part of the modern Brazilian project. To be a good citizen is to be healthy. As citizens exercising their right to health, women have to comply with biomedical prenatal regimes, its disciplines and measuring. Prenatal care is also about creating 'modern subjects,' and specifically neoliberal subjects, where "wealth, value and destiny" (Povinelli 2011, 156) are assumed to be an accumulation of individual choices reflecting a personal moral responsibility.

[132] Created by Law 10,836 / 04, the *Bolsa Família*, a direct income transfer programme, benefits families living in poverty and extreme poverty. Monthly income limits include two situations: Families with incomes per person up to R $85.00 and families with income per person between R $85.01 and R $170.00 (with children or adolescents from 0 to 17 years old). Conditions for reception in the area of health include attendance at prenatal consultations. Families failing to comply risk gradual corrective measures: warnings, blocking, suspension and finally cancellation (SEDEST 2018).

[133] *Licença de Maternidade Rural* access: https://www.inss.gov.br/beneficios/salario-maternidade-rural/

12. Women wait in a rural community for a monthly scheduled medical visit
That day they waited for hours, and no one turned up. Photo by the author.

Silence, biopolitics and anonymous care

On a hot and humid Wednesday morning, Maira goes to the *posto* for one of her last prenatal consultations. During the examination, the nurse claims that Mairas' belly is too big. She may be at some sort of risk, her uterus may be tired and could burst. Maira furrows her brow, and quietly but firmly replies that she usually carries big. The nurse says that she is worried because this is her seventh child and she is already 35 years old. Maira insists that she is okay and feels absolutely fine. She says that she drinks herbal tea, but the nurse responds negatively: *You should not drink things you do not know, the modern mind does not do that*. Maira frowns again, now more severely and says her *vovó* taught her, and her *vovó* is '*das antigas'* (the old ones). *Vovó* knows. The nurse urges Maira to have another ultrasound scan, and it will have to be private. *Você tem condições?* (Have you got the means?)

Later, in the *comunidade*, Maira tells me that the nurse was '*ignorante*' (stupid), and when I prompted her to elaborate further she just says: *how she treated me is just stupid*. She then focuses the conversation around her worries regarding how she is going to find the money for another ultrasound scan.

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The above excerpt illustrates how in the prenatal consultation 'other knowledges' were silenced, whether they were to do with the local knowledge of plants, or of women's embodied knowledge of their pregnancy and their bodies. For Maira, the fact that her *vovó* was old legitimized her knowledge. *Vovó's* authority based on her experiences attending other women, living from the land, and her everyday knowledge of plants. She also relied on knowledge about her own body and the fact that she had 'lived' the experience of six other pregnancies.

Prenatal consultations were characterized by silence in the interactions. I was intrigued by what this silence represented and began to think about the things that could be said during this silence, such as informing women about their birthing rights, about the possibility of developing a *plan de parto,*[134] about the fact that there was a law[135] which had been passed to protect pregnant women and to enable them to have a companion at birth. I also thought about the kind of things women could potentially talk about, such as their subjective experiences of pregnancy and so on. Although data was being produced with the objective of generating indicators that could inform evaluations and the development of improved programmes and interventions, the reality was proving different. Weighed down by bureaucratic demands, a reductionist form of care was being delivered.

Such bureaucratised care is 'biopolitical' in nature, that is, it is understood as mainly concerned with managing populations through the exercise of technologies focused on individuals (Foucault 1976 (2003), 242). In such cases, the individual voice is silenced by facts and numbers, by technology and expertise. It is in these spaces of silence that the materialization of the State's care becomes palpable and salient. The non-verbal enacted interstices inform the patient about their invisibility as individuals, translating them into registration forms and numbers. The repeated actions at every prenatal session, the measuring gestures, the silence, all speak to an anonymous form of care. This anonymous form of care is also layered with other concealed meanings. A Cuban doctor, reflecting on the different approach of 'doing medicine' from her country of origin to what she observed in Brazil elucidated in amazement: *Can you believe some Brazilian doctors will not touch their patients??!! … And you know why that is…*– she tells me as she points and rubs her index finger across the brown skin on her forearm. Although 'not touching the patients' was not a behaviour I observed in my fieldwork, we can deduce (see Oliveira and Kubiak 2019; Gomes 2016)) that in these clinical encounters, deprived of contact, the absent gestures can be charged with racial meaning, however silent, which inscribe unspoken codes onto the racialised body. As Smith (2016, 13) argues, "the embodiment of race and racism has everything to do with its repetition and the perpetuation of embodied actions over time."

[134] Introduced by the *Rede Cegonha* (Stork network), the *Plano de parto* (Birth Plan) is a letter of intent. Here the pregnant woman declares the medical interventions she accepts and her expectations of care for her and her baby during the process of birth and afterwards.

[135] Federal Law No. 11,108 / 2005, which guarantees birthing women the right to be accompanied by a person of their choice during the whole period of labour, delivery and in the postpartum period in the SUS.

Returning to the hidden logics of anonymous care (Stevenson 2014, 5), it is clear that central to this approach is the idea that 'who the patient actually is' seems to be irrelevant; what matters is that they are kept alive, at least for now. This fragment of the population (mothers and foetuses) who statistically on the global scene represent the level of development and 'civilization' of a nation-state, need to be kept alive to create good numbers and comply with national and global health targets. These numbers will eventually morph, moving from the estimates of the biopolitical to the calculus of the necropolitical State, where the Brazilian democratic project becomes interrupted and the anthropophagic nature of its internal mechanism becomes exposed, (as indicated in Part I of this thesis). Christina Sharpe, as she reflects about the "still unfolding aftermath of Atlantic chattel slavery" (2016, 2), indicates "In the wake [of the slave ship], we must connect the birth industry to the prison industry, the machine that degrades and denies and eviscerates reproductive justice to the machine that incarcerates" (2016, 87). How can the very system that now cares – however anonymously – for this fragment of the population (mothers and foetuses) be the one that in their life-cycle condemns them to 'future criminal' and 'former mother'? (Sharpe 2016, 87-92).

These questions are connected to the diverse ways in which the State exercises its power and confirms and reproduces marginal spaces where processes of exclusion and inclusion exist simultaneously, encompassing a rationale of 'both/and' (i.e. both indifferent and attentive, caring and coercive, recognizing and stigmatizing), and thus the State operates its magic (Das 2007) through diverse modes and artifacts, creating an ambivalent appeal for its sub(o)bjects as it equally guarantees and violates rights. We can see that through prenatal care registration, and by keeping their 'folder,' these women belong to the State, but in many ways are also excluded from citizenship. The inclusion of the population of Jaboticaba in the national health system, the right to health care, and thus their access to citizenship is constantly challenged by the evident and not so tangible barriers that rural women confront in their everyday attempts to access State resources and services, and when they manage to access them, what is at stake is the quality of those services. The State relies upon these numbers (gathered at the prenatal consultation), and it requires the population to adhere to the rules, but in practice it excludes them by a form of abandonment. This abandonment, at some level and most of the time, is cruelly obvious, but in so many other ways it is not so easy to detect. An abandonment that is conjured in the ordinary micro-difficulties in women's everyday lives, which become normalised and made natural. This is the process that Christensen A. Smith (2016, 80) argues "produces black people as objects of the nation without subject-citizen status."

Thus, the State is intermittently present and absent in conjuring a form of abandonment that is not monolithic and absolute but malleable and adaptive. It materialises in the lack of resources and services and it becomes hyper present in its demands to adhere to rules that require those same resources (Dwyer 2017, 95), as Mairas' requirement for a scan exemplifies. These practices present yet another riddle, we see that Maira is required to exercise her right to health in a context of abandonment, which under a neoliberal form of governance, places the responsibility and blame on the citizen. On many occasions when I saw women struggling to pay for their scans, they always replied with: *"I will have to make it somehow because you never know the risk.*" On many occasions, extended family had to help and as one woman said, *"I will do anything for my baby."* This is a language that has already assumed a form of individual choice and risk. Thus, this type of care, although anonymous on a large scale, is minute and individually targeted in the deployment of its disciplining techniques, which are mainly conceptualized within the language of risk. Furthermore, in this we also see that women adhere to this creation of perceived risk and control. Some women may resist against it yet they remain beholden to it and they sense a duty to comply. In some cases, it does not improve the care the women subsequently receive, but in other cases, compliance is the gateway to not being perceived as irresponsible and non-adherent.

Controlling risk

Vovó is waiting for Rosieni to come into the consultation room; her little figure is almost disappearing behind her big belly, and she walks in like a duck. The estimated delivery date has already passed. *We are following instructions, we were told to come, and we are here – vovó* explains. The doctor suddenly asked for and was granted 10 days holiday so the nurse is making the decisions at the *posto.*

Rosieni is being referred to the hospital in Jaboticaba; the community health worker is going with them and a driver will take them in the council car. The nurse says in a strict voice: *This is a risky birth because she is only fourteen*. *Vovó* starts crying: *A risky birth!! Oh Meu Deus …* (Oh my God!). Rosieni puts her hand on her belly, her almond eyes wide open. She looks serious, concerned, but she remains quiet. The nurse starts writing every detail in the report: *In this way she will not be sent back home*, she tells us. We all signed it as witnesses: the nurse, *vovó*, the community health worker, the auxiliary nurse and I. She looks at the community health worker, *you need to push for her to get a C-section, we cannot take the risk … if anything happens … this girl has no passage, she is too young, her body is not formed!!* She says this standing in the middle of the room, Rosieni is sitting in the recycled school chair, she begins to look panicky although she remains still and silent.

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That day Rosieni went to the hospital and she was sent back home. This happened several times in the following week until she was finally admitted into Jaboticaba's hospital on the basis that the birth had started. As she was only fourteen, the doctor decided to refer her to Yapira hospital, a two-hour drive away. She gave birth to a baby girl in the ambulance on the way there. During the birth, Rosieni's mother fainted and the auxiliary nurse who accompanied them had to take care of them both.

The way in which these events unfolded was not uncommon. Saturated by notions of risk and danger, they traversed experiences of pregnancy and birth alike (this is explored in detail in Chapter Seven). During my observations, there was a pervading sense that prenatal care was about controlling risk. Doctors and nurses confirmed repeatedly that birth was a risky business, unpredictable, a '*caxinha de surpresas'* (a box full of surprises). Consequently, one of the main prenatal care duties was to control, manage and organise potential dangers.

In the context of infrastructural uncertainty (with a lack of linkage between the pregnant women and the maternity of reference where they will deliver),[136] and the additional material scarcity, 'risk' becomes an organizing principle, a means to control reality, providing the whole scenario with a sense of 'certitude' as well as a justification for imposing measures and rules. Risks are facts and facts "are calming, they are also magical, functioning as a kind of epistemological anxiolytic" (Stevenson 2014, 32). Likewise, risk generates norms, which helps to provide a sense of safety insofar as they invoke an experience of possible judgment and assessment (Povinelli 2011,129). The nurse did not know what was going to happen with Rosieni and the anxiety around the uncertainties concerning her birthing and the cascade of possible disasters in the nurse's imagination, could be controlled through diagnosis. Rosieni's '*body is not fully formed yet', 'she has no passage',* Rosieni *'needs a c-section.*' The nurse created a coherent narrative through the mystification of technology and intervention as the best means to a secure outcome. Technology can bring things back to 'normal.'

Technology was key in controlling risks. As I mentioned earlier in the chapter, the SUS only covers one ultrasound per trimester for pregnant women (in theory). However, in one of the *postos* I visited regularly, women were asked to have a scan every month. As the nurse said, *"this doctor likes to have things right … secure …"* When talking to the doctor and asking him

[136] Although already a law, no. 11,634 of December 27, 2007. It is also a recommendation of the Stork Network for the integration of prenatal care services and delivery care.

about this, he responded, *"well… to have children is not cheap,"* an expression I heard him say often to the pregnant women in the consultation.

During prenatal care consultations, women were given clear instructions about appropriate diets, the type of clothes they could wear, and the activities they could engage in, among other topics. *"The first session* – another doctor explained – *I call it the 'puxada de orelha'* (pulling the ear),*"* as women were basically told off for some of their habits and behaviours. Some women attended their first prenatal care later than recommended for diverse reasons, including a desire to hide pregnancies, difficulties with transport, and other time-consuming demands that were prioritized before prenatal care. Other authors have examined the way in which risk, as conceptualised by the biomedical prenatal care structure, is part and parcel of liberal governance, where ideas of cooperation and responsibility are intimately tied to morality and the capacity of specific populations to make 'reasonable' decisions based on calculations of cost and benefits (e.g. Ruhl 1999, 96). Health professionals have complained about what they consider to be irrational reproductive decisions: teenage pregnancies, fatherless children, large families in situations of economic difficulty. *"Can you believe it?!"* – a nurse told me – *"I have never seen a woman come here because she is planning to get pregnant. A planned pregnancy!! We are not asking for too much, are we?"*

The bodies of these rural women were perceived in many cases as unruly, risky bodies. Emanating from Brazilian socio-cultural colonial legacies, the constitution of the imaginary about rural populations[137] and the space they inhabit was plagued by notions of risk and danger, together with the masked racist associations about blackness.[138] The *interior* (as in Brazil the rural areas are commonly known) is perceived as *atrasado* (backward) and *carente* (lacking). The configurations of the *equipe* (upper-class white doctors and nurses with strong middle-class aspirations) were also key in the construction of these meta narratives of risk and danger, which extended beyond the pregnant body to the space surrounding this population's life, the *mato* (bush). To them, this was an unruly space that concealed bandits, homed poisonous snakes, and was crosscut by impassable dangerous muddy roads where uneducated people

[137] The characterization of rural Brazil as being populated by "ignorant, ragged, chronically ill, anaemic and lazy" individuals, is personified in the literary figure of Jeca Tatu, created in 1918, which still remains very much alive in the national imaginary (Coimbra 2018, 1S).

[138] This is done through diverse chains of concealed meaning, for instance: "where distinctions made between those "with" and those "without" culture discretely draws on racial ideas that link whiteness to "civility" and discipline and blackness to incapacity and lack, even as they do not neatly map onto phenotype" (Roth-Gordon 2017, 91).

lacking knowledge lived amongst mosquitos, transmitters of leishmaniosis and dengue. *Equipes* constantly alerted me to the dangers of the area including: physical violence, *verme* (intestinal parasites) and schistosomiasis. They repeatedly warned me about how I needed to be aware of the risks I was taking, with the *equipe* being explicit in the risks they were taking in providing medical care to the population of this area. As one Cuban doctor put it: "*Every time I go to the rural areas, I ask my god. Please god keep me safe so I can deliver health to this population.*"

Conclusion

Overall, this chapter has shown how prenatal care in Jaboticaba is characterised by a twofold conflict. On the one hand, we have seen how daily care at the clinical encounter has become hijacked by bureaucratic routine practices. These practices have led to a deterioration in immediate prenatal care, a situation which is further aggravated by a network characterized by an overwhelmingly insecure infrastructure and uncertainty that is unable to provide the 'safe birth standard' that the State assures pregnant women will have if they adhere to prenatal protocols. Thus, rather than contributing to women's protection and to service improvement, some documentation practices reduce the time health workers spend listening to the women's articulated concerns. This negatively impacts on the quality of care received. However, bureaucratic rationales are not univocal, and at times these practices create fault lines where women and health professionals find more intimate, nurturing and concerned forms of care.

Furthermore, the dynamics of placing 'measurement' at the centre of the prenatal consultation has had additional consequences. Originating from the Brazilian culture of medicalized birth and intersecting with national imaginaries about the rural world, notions of risk have expanded. As technology and documentation are deployed rigidly in an attempt to contain uncertainty in a context characterized by a lack of medical resources (resulting from the direct State's abandonment) and acute material scarcity, strategies heavily focused on technology are reproduced, reinforcing a formula that may not be accurate, nor straightforwardly attainable.

Most concerning of all, the language of risk and danger is key in disciplining women's subjectivities under neoliberal forms of governance that deviously morph State abandonment

into personal moral responsibilities. The gestures, registers and measurements of the prenatal consultation wordlessly reveal pregnant women's place in the clinical encounter, while simultaneously informing them of their place in Brazilian society at large – invisible at some levels, hyper-surveilled at others.

Finally, this chapter reveals the contradictions embedded in Brazilian democracy, where through the access of maternal healthcare such as prenatal care, the State exercises its power by confirming and reproducing marginal spaces where processes of exclusion and inclusion exist simultaneously, creating an ambivalent appeal for its sub(o)bjects as it equally guarantees and violates rights.

Chapter Seven

BIRTH: PRECARIOUS CARE

Tenho um grito entalado na garganta.
Um grito longo, fino, estridente,
Um grito dolorido, abafado.
Um grito de mulher.

[...]

– O corpo é meu! [139]

Jenyffer Nascimento (2014, 28)

Numbers

It's slightly cold and raining on this early July morning in Salvador as we drive towards the *Ministério Público do Estado da Bahia* (the Bahia Public Prosecutor Office) along Avenida Vasco da Gama. The driver, a professional nurse-obstetrician and long-time birth activist, overtakes cars, vans and motorbikes; she moves swiftly around the aggressive traffic with admirable expertise. As she yanks the gears back and forth, I hold tightly to the grab handle and listen to her. *I don't know why I am coming,* she says. *I already know what the problem is.* We are on our way to the seminar *'Mortalidade Maternal: Avanços e Desafios na Garantia dos Direitos'* (Maternal Mortality: Advances and Challenges in Guaranteeing Rights). She explains:

> *I used to be part of the maternal mortality committee, but I gave up … Every time it was discovered that the death had to do with obstetric violence, with over-intervention, over-medicalization. If a doctor was involved, the investigation would be stopped … in most cases. Yes, it would be investigated for a few months … the hospital … the medical records … but doctors protect each other … Here in Bahia we have a saying 'tá tudo como dantes no quartel d'Abrantes', that is, everything remains the same … Change?… it's difficult. Entendeu?* (You understand?)

***

The vignette above explicitly raises crucial questions regarding the delivery of maternal healthcare and the difficulties embedded in shifting birth paradigms in Brazil. We see how a desire to see change and the determination to not succumb to resignation is mixed with an overwhelming sense of futility, a conflicting sentiment that reflects Brazilian birth politics at its absolute core. In this scenario, maternal mortality in Brazil echoes the country's

[139] Translation: I have a scream stuck in my throat. A long, thin and shrill scream. A painful, muffled scream. A woman's scream […] This body is mine!!

advancements, stagnations and paradoxical results in maternal health care policies, clearly depicting Brazilian health disparities and the impact this has had for Afro-Brazilian women.

Current trends in the country highlight the political meaning of these deaths, their multidimensional nature and the deeply rooted interlocking vulnerabilities they present. In this chapter, I reflect critically on epidemiological practices, focusing on the fundamental importance of data collection, and by specifically referring to the crucial indicator of race, I show how this significantly affects the visibility and invisibility of different populations. In these processes I emphasize the limitations of reducing vulnerabilities to biological issues.

In the second part of the chapter, using ethnographic data I think through these issues, illuminating the interconnected vulnerabilities existing in the experience of giving birth in Jaboticaba. I describe two birth stories, each focusing on one of the major aspects at stake in maternal mortality and morbidity: network and quality of care; looking to reveal and identify their underlying causes and effects. In this process I unpack racialised and gendered forms of treatment, embodied by and resulting in the experience of *vergonha* (shame). These processes, I contend, are part of a continuum of precariousness that goes beyond the structure of the health system and rural communities' material difficulties to encompass a 'precarious existence' that links a colonial past to a 'democratic' present.

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Maternal mortality in Brazil

At the main hall in the *Ministério Público* the air conditioning is on full power although it is winter in Bahia. Most of the audience members are female obstetric nurses. There is a shared aesthetic in their appearance: long straightened hair, immaculate make-up and trendy outfits. Many show signs of cosmetic dentistry by wearing braces. In the mixed crowd, there are also some health managers from different municipalities, a small number of *Prefeitos* (city mayors) and students from various health disciplines. There are hardly any doctors and very few people of African descent.

The 'Maternal Mortality: Advances and Challenges in the Guarantee of Rights' seminar starts with a panel discussion and the recognition that "*the numbers are shameful."*[140] Beyond

[140] As an illustration, in 2011, MMR in Brazil was 63.9 deaths per 100,000 live births. In Bahia the same year the MMR was 87.9 deaths per 100,000 live births (Coelho et al. 2016, 02).

this initial *mea culpa,* the disposition of this gathering is to be constructive and committed to the rights of women. The Public Prosecutor, Rogerio, is aware of the failings in the system, especially its fragmentation, and assures health professionals that the Ministry is on their side, *"the approach is pro-active rather than reactive."* This comment is received with a round of applause. Their approach is to reinforce the concept of 'network' so that services such as testing and transport, as well as the linkage between the pregnant woman and the facility where she will give birth are all effectively linked and coordinated. The emphasis is on empowering women by providing them with information about their rights. "*We must guarantee rights and rights are not given, rights are 'luta'* (struggle)*,"* a female doctor, part of the Maternal Mortality Committee in Bahia, states in this opening talk.

Finally, a researcher from the National School of Public Health poses a difficult and disturbing question:

> *"Who are the women who are dying?"* She asks this rhetorically; her own reply is: *"Black women living in poverty."*

She follows this immediately with the statement, *"The State must admit its negligence."*

In August of the same year (2018), *Folha de São Paulo*, one of the most influential newspapers in Brazil, informed readers of the rise of the maternal mortality level in Brazil.[141] Another report in the same newspaper published in July of the same year announced that for the first time since 1990, there was an increase in the infant mortality rate.[142] It stated that further rises are expected, as these numbers are closely associated with the economic crisis (Collucci 2018). The following month, in an analysis of the future of Brazilian public healthcare published in *The Lancet*'s correspondence section (Doniec et al. 2018), the authors warned that the political and economic crisis is diverting attention away from the government's implementation of a neoliberal model of healthcare through austerity, privatisation, and deregulation. As Greice Menezes, an epidemiologist at the Federal

In 2015, the highest MMR were in the states of Maranhão and Piauí (116.5 and 103.6 respectively), followed by Paraíba and Bahia (81.8 and 75.4 respectively) (Brazil, Ministry of Health 2018, 47).

[141] Ministry of Health (Brazil). Maternal mortality ratio. http://svs.aids.gov.br/dantps/acessoa-informacao/acoes-e-programas/busca-ativa/indicadores- -de-saude/mortalidade/razaode-mortalidade-materna.xlsx (in Portuguese). Based on last official consolidated available data from 2016.

[142] Ministry of Health (Brazil). Infant mortality rate (under 1 year). http://svs.aids.gov.br/dantps/acesso-a-informacao/acoes-e-programas/busca -ativa/indicadores-de-saude/mortalidade/taxa-de-mortalidade-infantil.xls (in Portuguese). Infant deaths reached 14 in every 1000 live births in 2016, a 5% increase on the 2015 figure of 13.3.

University of Bahia explained in the *Folha* article, "International literature shows that maternal and infant mortality are always the first triggered indicators in times of crisis" (Collucci 2018, para. 19).

Maternal mortality is defined by the WHO (2019) as the death of a woman while pregnant or within 42 days after pregnancy from any cause related to the pregnancy or its management, although not from accidental or incidental causes. It is a complex issue, involving ethical, legal and social aspects of health care (Ventura 2008, 217). Revealing only the most visible face of the precarious attention provided to women's health, it represents a serious public health problem (Reis, Pepe, Caetano 2011, 1145). As a key indicator, maternal mortality reflects the place women occupy in societies (WHO 1996) and their living conditions, providing an important indicator of poverty and inequity. Maternal mortality is a failure of the State and it reflects the State's negligence in protecting women's rights to health and life (Ventura 2008, 217). As an overall marker of social injustice, maternal mortality is a political issue linked to citizenship.

Brazil has been part of international endeavours to reduce maternal mortality. As a signatory of the United Nations Millennium Development Goals (MDGs) in 2000, the country was committed to complying with the 5th Millennium Development Goal (MDG 5),[143] which required a series of improvements in maternal health care and the reduction of the maternal mortality ratio (MMR)[144] by 75 percent. To meet the challenge, in 2004, the government promoted the National Pact for the Reduction of Maternal and Neonatal Mortality.[145] Brazil made important progress: from 1990 to 2015 the maternal mortality ratio decreased by 56 percent, falling from 143 to 62 deaths per 100,000 live births.[146] The MDG, however, was not met (WHO 2015b).

[143] Target 5.A. Between 1990 and 2015 reduce the maternal mortality ratio by three quarters. Target 5.B. Achieve, by 2015, universal access to reproductive health (WHO 2015).

[144] The maternal mortality ratio (MMR) represents the obstetric risk associated with pregnancy and is defined by the ratio of live births that result in maternal deaths during a year. It is calculated per 100,000 live births (da Silva et al 2016, 486).

[145] The pact integrated national strategies such as professional care during pregnancy, childbirth and post abortion for all women, the training of health professionals in Evidence-Based and Humanised Obstetric Practices, guaranteed referral of medical care for high risk cases, right of beds for women and babies and right of company during labour and delivery (Diniz 2009, 314).
Also see Brasil Ministério da Saúde. Informa da Atenção Básica. Pacto nacional pela redução da mortalidade materna e neonatal. Ano V. Maio/junho 2004. At: http://dtr2004.saude.gov.br/dab/

[146] See: https://www.who.int/gho/maternal_health/countries/bra.pdf?ua=1

Underreporting and MMR Calculations

The production of data around maternal mortality in Brazil can be problematic. It can be limited and unreliable, with significant underreporting of deaths and inaccurate reporting of causes of death (Barros et al. 2010; Araujo et al. 2017). Other studies have suggested that estimating MMR in Brazil is not a straightforward process (Silva et al. 2016; Cecatti and Papinelli 2011; Soares et al. 2008). For example, Laurenti et al. (2004) found a level of underreporting of 40 percent in some areas, and Luizaga et al. (2010) proposed a correction factor to minimize the underreporting of maternal deaths. In recent years, the implementation of information systems[147] and the establishment of compulsory investigations through the maternal mortality committees[148] in all municipalities have improved this situation. However, sub notification of death and its causes remains a key problem. This was confirmed to me directly by the president of the Maternal Mortality Investigation Committee in Bahia. When I asked her what she perceived as the biggest challenge, she sternly stated "*a subnotificação é um serio problema"* (underreporting is a serious problem).

Taking into consideration the issues mentioned above regarding an estimation of MMR in Brazil, Cordeiro da Silva and colleagues call for a cautious interpretation of data. In their study "*Maternal mortality in Brazil from 2001 to 2012: time trends and regional difference"* published in 2016, the northeast and midwest showed the highest values of MMR, with the northeast having the highest underreporting levels. As an illustration of this difference, in 2009, the MMR in the northeast was double the national ratio[149] (Araujo et al. 2017, 13). The striking socio-economic disparities between many Brazilian regions explains part of the variance in MMR (Silva et al. 2016, 491).

Despite significant progress in almost all maternal health related indicators, the MMR in Brazil remains high in relation to the country's economic development. We see that women are having fewer children with longer intervals between them, and greater numbers of prenatal and postnatal visits with access being almost universal and most births being attended to in hospitals by skilled professionals. Still, on average, the MMR is five to ten times higher than

[147] The Mortality Information System (SIM) and the Information System on Live Births (SINASC) create systematic records using data on mortality and survival by means of the Declaration of Deaths and the Declaration of Liveborn Infants.

[148] Brasil. Manual dos comitês de mortalidade materna. Brasília: Ministério da Saúde; 2009. Some authors, such as (Rodrigues and Siqueira 2003), have concluded that in order to make the Committee's actions more relevant they should situate themselves beyond a strategy of epidemiological vigilance and move to a political and institutional position in order to account for the complexity of this issue.

in countries of similar economic status (Leal et al. 2018, 1921). The main causes of maternal death continue to be preeclampsia, postpartum haemorrhage, sepsis, and unsafe abortions, which should be easily avoidable (Pacganella et al. 2018). By 2012, efforts to reduce maternal mortality over the last 15 years had plateaued (Diniz, d'Olivera and Lansky 2012, 98). In addition, research evidencing serious cases of severe morbidity led experts to declare that maternal mortality was just the 'tip of an iceberg,' with many near miss cases lying underneath the surface (Costa Reis et al. 2010, 1142).

Thus, a paradox emerges when one compares Brazil's coverage of prenatal and childbirth services to the country's MMR. In 2009, Carmen Simone Grillo Diniz, a renowned researcher in the area of maternal health care in Brazil, questioned why investment in the extension of access and services had not had an impact on maternal mortality. She unravelled crucial factors including: the inappropriate use of technology (condensed into the familiar maternal health adage 'too much too soon, too little too late'), often accompanied by a lack of accord to protocols based on scientific evidence, with its consequent iatrogenic harms. Furthermore, she pointed out the conflict of interest in the way in which medical care is structured, with medical hegemonic corporatist concerns lying above the health of the population. This is illustrated, for instance, in the massive numbers of unnecessary C-sections (Occhi et al. 2018). Finally, she outlines the way in which cultural constructions of gender, including reproductive culture, are intimately intertwined with all of these considered factors (Diniz 2009, 316-317-320).

The recognition of inequities in the delivery of appropriate maternity care remains a challenge in contemporary Brazil (Pacagnella et al. 2018, 502). With the Sustainable Development Goals, Brazil has internationally committed itself to reducing the maternal mortality rate, currently around 60 deaths per 100,000 live births, to 20 per 100,000 between 2015 and 2030 (Pacagnella et al. 2018, 503). International evidence shows that global deaths in childbirth occur due to delays[150] in obtaining adequate care (Pacagnella et al. 2012). In Brazil, maternal death is largely related to a delay in transportation to higher level facilities and delays in the provision of adequate treatment at healthcare institutions (Pacagnella et al. 2018, 501). Consequently, it is critical to identify both the gaps in the care network and the inadequacies in the type of care delivered. The Brazilian Ministry of Health, aware of these technical and structural flaws, instituted the 1st National Mobilization Week for Women's

[150] This can take place in one of three phases:
I – delayed decision to seek care by individuals and/or their family.
II – delayed arrival at a healthcare facility that can provide adequate care.
III – delay in the provision of the necessary care at the necessary time at the institution of reference (Pacagnella et al. 2012, 501).

Health in the SUS, on May 31, 2018. With maternal mortality as the opening theme, this initiative aimed to strengthen activities that were already in progress.[151]

To reach this goal, besides the differences between states and regions, the differences in maternal mortality between populations also needs to be considered. MMR is not randomly distributed among the populations in Brazil. Studies that examine the magnitude of racial disparities in maternal mortality are infrequent and they point to higher mortality rates among black and indigenous women (Martins 2006; Teixera et al. 2012). As an illustration, the state of Mato Grosso do Sul registered 166 maternal deaths from 2010 to 2015, of which 92 (55.4 percent) involved *parda* (brown) women. Maternal mortality rates for indigenous and black women (162.3 and 186.3 per 100,000 live births, respectively) were three to four times higher in comparison to the state rate of 65 per 100,000 live births. The risk of death for black and indigenous women was four times higher than for white women (Picoli 2017, 730). However, demonstrating health inequalities, disparities, or inequities should extend beyond statistical data, since instances like racism are not always explicit and measurable in social interactions (Lopes 2005, 1595).

Beyond the bounds of numbers

Returning to the main hall of the *Ministério Público*, the seminar on maternal mortality advances. Most of the audience have now covered themselves with shawls as the air conditioning has rendered the conference hall into a freezer-like space, a reminder that technology is a sign of modernity and status in Brazil. The morning is filled with presentations covering issues specific to Bahia, such as its MMR and the structure of the Stork Network.[152]

[151] Such as the *Rede Cegonha* (Stork Network), birth centres, midwives in obstetric care, the supply of contraceptives and the insertion of intrauterine devices (IUDs), the implementation of programmes for postpartum and post abortion, the projects to improve the quality of obstetric care, and specific care for vulnerable populations (Pacagnella et al. 2018, 503).

[152] The Stork Network (*Rede Cegonha* – RC) for health assistance to women and children (Ordinance No. 1459, of June 24 of 2011) was established in 2011. It aims to ensure women the right to reproductive planning and humanised care for pregnancy and childbirth and the right to safe birth and development for the child. Objectives: to encourage the implementation of a new model of women's health care and child health (from zero to 24 months); to organise the Maternal and Child Health Care Network to guarantee access, reception and problem-solving; and to reduce maternal and infant mortality. RC consists of four components: prenatal; childbirth; puerperium and the integral attention to the health of the child, as well as a logistics system, which refers to health transport and transfers. The RC organization aims to enable attention on maternal and child health care for the population of a territory while following these guidelines: pregnant women are guaranteed to be received by health facilities and classified according to their risk and vulnerability; the link between the pregnant women and the hospital of reference should be guaranteed through secure transport; good practices in birth and labour are guaranteed; a guarantee of children's health from zero to 24 months; and a guarantee of assistance with reproductive planning opportunities (Brasilia 2016, 59/60).

There are also presentations focusing on vulnerable populations such as pregnant women with sickle cell anaemia, and homeless expectant women. In the afternoon some small municipalities share their experiences of implementing the Stork Network and performing 'humanised births.' It feels promising.

Before lunch we all listen attentively to one of the presenters remembering and discussing the case of Alyne da Silva Pimentel Teixeira.[153] Her case (and more recently the case of Rafaela Silva[154]) reveals crucial aspects of the multidimensional problem of maternal mortality in Brazil. Most importantly, the cases reveal the importance of going "… beyond addressing violations experienced by individuals and … consider[ing] the whole cycle of accountability in the health system" (Yamin, Galli and Valongueiro 2018, 118).

The speaker, a researcher from the prestigious Fiocruz National School of Public Health, focuses on Alyne's case and talks to the audience about the systemic journey of negligence: lack of medical records, refusal to offer referral care, lack of beds, and successive medical errors that led to Alyne's death. She places particular emphasis on two factors: firstly, her death was not reported accurately (the official death was recorded as digestive haemorrhage), and secondly, the crucial role discrimination played in her death. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) describing the intersectionality of Alyne's vulnerabilities, established that this discrimination was due to

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For a full discussion on the feminist critique of *Rede Cegonha* see: Diniz SG. 2012. Materno-Infantilism, Feminism and Maternal Health Policy in Brazil *Reproductive Health Matters*. 20 (39);125–132 and Carneiro RG. Anthropological dilemmas of a public health agenda: Rede Cegonha programme, individuality and plurality. *Interface - Comunic., Saude, Educ.* 17 (44); 49-59.

[153] Alyne da Silva Pimentel Teixeira was 28 years old when she died in 2002; following her death, Alyne's mother was represented by the Center for Reproductive Rights, a legal advocacy organization based in the USA, and a Brazilian NGO *Advocacia Cidadã pelos Direitos Humanos*. Together they submitted the case in 2007 to the Committee for the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). It was accepted for review as Brazil was a signatory of the CEDAW. This was the first time a United Nations human rights committee decided on a maternal mortality case. A ruling was issued in August 10, 2011 and the Brazilian State was accused of violating effective protection of women's rights, the right to health and the right to life.

For full access to the case: www.reproductiverights.org/press-room/Brazil-Takes-Step-to-Implement-Historic-United-Nations-Ruling-in-Maternal-Death-Case%20.

For a follow up on the CEDAW recommendations see: Yamin AE, Balli B and Yalongueiro. 2018. "Implementing international human rights recommendations to improve obstetric care in Brazil." *Int J Gynaecol Obstet*, 143 (1);114-120.

[154] Rafaela Cristina de Souza Santos, an Afro-Brazilian girl aged 15 years, was admitted to the Mariska Ribeiro Women's Hospital, Rio de Janeiro, in April 2015 with extremely high blood pressure and signs of pre-eclampsia. After delays of being attended to, "she was allegedly given treatment that would be inappropriate for pre-eclampsia. Upon going into eclamptic convulsions, Rafaela underwent a cesarean delivery and died" (Yamin, Galli and Valongueiro 2018, 118).

Alyne being an African descendent woman from an underprivileged economic group (Brazil 2014, 1). The researcher from Fiocruz poses two fundamental questions to the audience at the seminar:

> "*What are the invisible mechanisms that provoke these gaps between laws and rights and in which ways are these reflected in people's lives?*
>
> *Why and how do fissures between rhetoric and reality take place?"*

Alyne's case not only exemplifies the problem of under-reporting, but also the processes which render specific lives invisible. It shows the important role epidemiological data plays in making the violation of rights visible and how this information can open pathways to establishing claims for the enactment of these rights. Additionally, it illustrates the complexities involved in the procedures of epidemiological objectification, which cannot be separated from the ideological processes that produce the visibility and invisibility of specific phenomena. The struggle to include the indicator of race is a clear case (Lopez 2016, 147). In Brazil, the statistical invisibility of the black population is founded on the country's historical colour blindness, based on the myth of racial democracy. In practice, researchers have found that patients' dislike having data about race recorded (Pagano 2011) and similarly that health care providers are hesitant to ask patients their race (Araujo et al. 2010). In addition, the SUS emphasis on universality was conceived in a context marked by left wing political views; thus it was characteristically more focused on addressing socioeconomic disparities and access to health care than dealing with issues of race (Caldwell 2017, 102).

It was not until the mid-1990s that health data by race/colour, the product of the struggle and activism of the black rights movement in Brazil,[155] started to be collected in Brazil. This was a slow process that still faces challenges today. For instance, sometimes the information is not registered in health records, or records are not based on self-identification and race/colour is attributed by the health worker without consulting the patient (Caldwell 2017, 101). This is something I often witnessed first-hand in diverse clinical settings during my fieldwork. With the lack of this information the health specificities of the Afro-Brazilian population become invisible and so does race as a factor in creating social divisions and inequalities (Caldwell 2017, 102).

Furthermore, as Cook points out, an over-reliance on statistics can disguise and alienate the human side of maternal mortality, removing accountability and giving maternal mortality "an

[155] For a full discussion on race and health data in research in Brazil see: Laguardia J. 2004. "O Uso da Variável "Raça" na Pesquisa em Saúde."*PHYSIS: Rev. Saúde Coletiva*, Rio de Janeiro, 14 (2); 197-234.

existence simple and objective," resulting in the "loss of sight of the actual women" (2013, 4). In relation to this, Lopez (2016, 148) adds it is "as if the stories, the lives of those women who died, were erased from the bureaucratic memory, of public policies and the guarantee of human rights," that is, lives dispossessed of their social and political dimensions. The case of Alyne is important because it brings visibility to the links between maternal mortality and the multi-faceted vulnerabilities that provoke it. In their study, Teophilo et al. (2018) explore the vulnerabilities that black women face in prenatal and birth care, focusing on the ways racial relations are shaped in Brazil. Following Ayres et al. (2003) they consider that the vulnerability is formed by, and the result of, "structural constraints that indicate the susceptibility of certain populations to any particular question" (Teophilo et al. 2018, 3506), in this case maternal health. Thus, it is essential to recognise the historical discrimination the black population has endured in Brazil, which continued after the abolition of slavery in 1888. This is at the core of the Brazilian social fabric, and consequently embedded in the culture of Brazilian public institutions, for what is known as institutional racism.[156]

Additionally, Lopes (2016, 163) critiques[157] the tendency to reduce vulnerabilities to mere 'biological aspects' in health policy. As, for instance reducing, 'care of women' to a technical discussion of physiological processes, or 'care of the black population' as solely focused on particular diseases such as sickle cell anaemia. She states that the process of objectification that gives legitimacy to create a public policy silences the embodied experiences of the subjects. She goes on to question:

> "*How do we treat a social body in all its political depth and complexity in the context of bio-legitimacy, which biologizes the living and leaves aside - or in some cases overrides - the political dimension of life?"*

[156] In 2001, the Program to Combat Institutional Racism (PCRI) was created in Brazil to address the lack of governmental continuity in fighting racial discrimination. It described the characteristics of institutional racism thus: "They can be seen or detected in practices that are consolidated in everyday life, processes, attitudes and behaviours that contribute to discrimination through prejudice, ignorance, lack of attention and racist stereotypes that prejudge groups (CRI 2006, 98 in Caldwell 2017, 94).

[157] In order to answer the following question: How are the tensions between 'the politics of life' and the 'politics of the living' (objectivization and subjectification respectively) expressed in the construction of maternal mortality as a sanitary object? L Cecilia Lopes (2016) draws on Fassin's (2012) biopolitical approach, which considers the 'politics of life' as the moral economy underscoring contemporary societies' values when thinking of questions related to the existence, physical and social, of individuals. In contrast, the 'politics of the living' refers to bare life (as understood by Agamben), that is, the biological, devoid of the social and the political. For Fassin (2004) 'sanitary objects' (such as maternal mortality) are constructed in the tension between these two forms of politics. Based on this, Lopes (2016, 63) argues that public health policies are anchored in objectifying processes based in biolegitimacy (that is 'politics of the living'), rather than focusing on socio-political dimensions (that is the 'politics of life'), which ultimately reduces racial issues to biomedical risks, thus making invisible other critical aspects in maternal mortality like the workings of racism.

These questions can be likened to Ticktin's (2011, 217-218) reflections about recognition: while biology provides hope for a better life, this politics of care refuses inclusion or recognition, shifting the object of care from citizen to patient. The solution is to strive for *political rather than biological forms of recognition*.

These last thoughts and the information presented above give context to a better understanding of the ethnographic data depicted in the next section. Through the subsequent stories I illustrate what giving birth in Jaboticaba can involve. I focus on two major aspects of maternal mortality and morbidity, these are: transportation to higher level facilities, and the delivery of adequate treatment at healthcare institutions. In both stories presented below, it is not the 'delay' of these procedures that is relevant but the context and the way in which they are mobilized. In so doing, they produce inter-connected vulnerabilities.

Stories: Two births

1. Giving birth on the road

The local hospital sits on the upper ridge of the city. From this height, the eye can reach the far horizon, the surrounding valleys waving out like a green blanket, a river close by, the mangroves beyond. In the distance, houses overlap one another in harmonic disorder, testimony of Jaboticaba's rickety urban growth: plain brick, palm trees. Nearby, an empty football field soaks up today's heavy June showers.

The nurse and I walk towards the doctor's office. *Doutor ... a gravida ...* (Doctor … the pregnant woman). A reminder.

In the pre-delivery room, I find a short woman named Iara lying upright in one of the two available run-down beds, her bent legs wide open. As usual in Brazil, she is fully shaved. Her face is distressed, strained, as she groans and pushes. At the bottom of the bed, an older woman watches her from an oxidized bench; her stiff posture reveals the seat's missing leg, her wrinkly hands tightly hold a worn handbag. She looks at me, serious and silent, bites her lips and goes on to explain: *She is very tired, the doctor has told her to push for a long time now.*

The physician on duty rushes in and confirms by vaginal examination that she needs to be moved to the delivery room, *But wait for me to get there. Hold it till I come back*. Iara looks puzzled.

About 10 metres away in the delivery room she is prepared by two nurse assistants. She receives intravenous glucose serum and the amniotic sac gets artificially broken. They have performed three pelvic exams in 20 minutes. The delivery bed is broken, one of the leg holders drops flat when she places the leg on it, the other is twisted towards the left so the heap moves outwards. She looks extremely awkward and uncomfortable; her body is slipping down the delivery table and her contractions keep coming. It is 10:31 am.

Nurses and technicians start to manoeuvre her body in various ways. In one of these actions, they place a small scruffy foam mattress underneath her head. Her neck is now totally bent forward making a ninety-degree angle. Gazing at this poor sight, they quickly remove it. *I cannot take it anymore*, she says. The nurses encourage her, and they ask her to trust in God. The doctor requests the nurse to make sure the scissors are sharp in case they are needed. Several vaginal examinations follow, and two nurses begin applying the Kristeller manoeuvre.[158] The mobile phone of a technician rings for the second time, and again she answers, *I am in a delivery, call me later*. A series of new attempts to make her posture in the bed more comfortable fail. The birth progress seems to be stuck. After a while in complete distress, she screams, *Help me doctor, I do not want to die!!* Her eyes are full of desperation. The doctor holds her hand and strokes her shoulder. *Don't worry, we are taking care of you*.

It's 12:00 and the doctor wants to transfer her to another hospital … The nurse assistant argues angrily, *No way doctor, she cannot, she will give birth on the road*. His response is: *Well, better she gives birth there, somewhere safe … it's better she gives birth in the car.*

The doctor walks away nervously to fill in the paperwork. The older woman (Iara's mum) is crying in the hospital corridor. Iara (whom I have never met before) beseeches me, *Do not abandon me girl, come with me!!*

The ambulance is by the main hospital entrance, Iara is placed inside and left alone, back doors wide open. We can hear her howl. People pass by and look at the scene, they nod their heads, kiss their teeth in a sign of concern. A paralyzed figure cries in a corner: her husband, covering his face with his hands. I can taste and smell the fear of maternal and infant death.

I approach the ambulance and see the baby crowning. *It's here!!* I scream. A whole team moves around me and finishes the attendance. The baby's loud cry from inside the ambulance cuts through the thick tense air. Like two bubbles bursting at once, the father and grandmother begin to sob powerfully. It seems like the whole town can breathe again.

Later, I visit Iara in the postpartum room. Almost an hour has gone by since she gave birth, she is still breathing heavily and is unresponsive to the baby. Her mother sits in the next bed looking at her daughter zoned out, also exhausted. I am told the husband returned to their home in the rural area to attend to their three other children.

***

As the nurse assistant had predicted, Iara did not make it to another hospital. Had the ambulance begun its journey she would have given birth on the road. These types of proceedings were not uncommon. Laiane, a fifteen-year-old quilombola girl whom I followed throughout her pregnancy, also gave birth to her first baby girl on the road. On her arrival to the local hospital in Jaboticaba, the doctor refused to attend the birth and transferred her because she was a primigravid and very young. *"He was scared,"* she explained to me,

[158] Fundal pressure during the second stage of labour (also known as the 'Kristeller manoeuvre' involves application of manual pressure to the uppermost part of the uterus directed towards the birth canal. It is not a recommended practice by the WHO (2018) and involves potential risks (Hofmeyr et al. 2017).

"*because it was my first child."* After a 40 minute drive, the ambulance had to stop, and she gave birth in the ambulance at the side of the road, attended by her mother (Dona Eduarda) and the nurse. When I asked Laiane how she felt about having given birth on the road she replied *"Eu senti muita vergonha* (I felt embarrassment/shame)."

In Jaboticaba there are two possibilities for transfer*: Centro de Parto Normal* (CPN), (Center for Normal Birth) in the locality of Macaiba (74 km*)*, or one of the two hospitals in Yapira (130 km). Although Macaiba is closer, most women are transferred to Yapira because the road to this region is in much better condition. I was informed that in Yapira this was creating serious overcrowding. The procedure to transfer a woman should be done through the referral system where the receiving hospital informs the referral call centre when a bed becomes available; this can take a long time. A local nurse referred to this situation of 'uncertain wait' as something that "*ninguém merece*" (no one deserves) and for that reason expecting women are commonly just sent in the ambulance accompanied by a medical record. However, it is ultimately up to the receiving hospital to refuse or admit them upon their arrival, provoking the well-known and common *peregrinação* (the word translates as pilgrimage and refers to the phenomenon of pregnant women traveling to multiple access points in search of appropriate care). This generates a situation of extreme vulnerability for labouring women in a region where distances between hospitals are huge. Since 2007 under Law 11.634/2007,[159] every pregnant woman has legally been guaranteed a bed in a hospital, and the right to know and visit beforehand the facility where she will give birth. However, as a prenatal nurse told me at the health post: "*aqui isso fica meio solto*" (here, that stays kind of loose).

[159] The CEDAW report on this issue states that, "Although this law has been in force for over four years, it was never implemented or enforced (…) It is of paramount importance that Brazil revaluates and reforms the fragmented and disjointed referral system. The referral system must be more comprehensive and should take into account the various regions' diverse geographical settings and populations' access to transportation" (Centre for Reproductive Rights 2011, 10).

13. Jaboticaba's hospital. Photo by the author

A precarious network and 'a terra do nunca' (the land of never)

In 2011, *Rede Cegonha*, (the Stork Network) was implemented in Brazil under Dilma Rouseff's government. It is not a coincidence that this strategic policy was launched after the case of Alyne Pimentel. It was established to help Brazil achieve the MDG, and it encapsulates something Manuel, one of the Stork Network key representatives in Bahia, calls *"a paradigm shift."* The policy aims to tackle issues at a multidimensional level, focusing primarily on three objectives: first creating a shift in the obstetric and neonatal model (from a medicalized-technocentric model to a model centred on humanised and evidence-based practices), thus qualifying care; second, establishing a solid articulated network, thus creating a line of continuous care, and finally it aims to reduce maternal and infantile mortality. In an interview, Manuel explained how even seven years after the arrival of *Rede Cegonha*, "*There were municipalities in Bahia which still don't know how to implement it."* Jaboticaba is one of these municipalities.

In Jaboticaba the local hospital, which is a *Hospital de Pequeno Porte,*[160] *HPP* (small size hospital), carries the name of a past local doctor. A historical relic from when primary health

[160] *Hospital de Pequeno Porte – HPP* (small size hospital). These are located in health regions of the *interior* (rural areas), usually with fewer than 30,000 inhabitants, and hold between five and 30 beds.
Before the arrival of the *Programa de Saude da Familia* (PSF) (Family Health Program) in 2004, HPPs were the principal point for the delivery of healthcare for the population in a given territory. However, with the consolidation of primary health care through the PSF they are encouraged to join (through the State Health Department) a new contractual process, where their role in the service network is to redefine quantitative and

care had not yet been introduced to the region, the hospital was the principal point of health delivery for the population since the 1960s. For many people it still has that role. Health professionals become frustrated and impatient, "*Senhor, your case is not an emergency. The doctor will attend to you out of kindness. Next time go to the health post, d'ya understand?"* I continuously witnessed these sorts of situations during my observations at the hospital's triage unit. Local statistics based on the Hospital Information System of the National Health System (SIH-SUS), showed that the principle causes of hospitalization of residents in the municipality in the last four years (2014-2017) were related to pregnancy, birth and post-partum (31 percent out of all admissions) with 1,473 women attended in this period (Plano Municipal de Saúde 2018-2021).

However, the hospital was not really prepared to deliver this level of care. Every 24-hour shift would have one general practitioner, one nurse and two nurse assistants. The team was responsible for attending any emergencies that arrived, including births, for a population of approximately 36,700 inhabitants. Some doctors pronounced openly that they did not feel confident attending births and consequently did not want the trouble. Others faced the job like any other emergency, as part of their daily work. In some cases, women were transferred, even though the likelihood of a birth on the road was high (especially if they were primigravids or had had no prenatal attention – in Brazil that is considered less than four appointments. The structure of the hospital is poor. For birth attendance, the space is divided in two. There is one room with two beds for pre-birth, and one toilet and a shower which is often broken. When the water does come, it is cold. In this space, companions can assist the pregnant woman and she is free to move around. Once the expulsion stage is established, she is moved to the birthing room. Here no companion is permitted, perhaps because the space is small with most of it being occupied by an old broken birthing bed, an oxygen machine, a cupboard with medicines, and two benches with basic equipment.

Having fallen into some sort of administrative limbo, the structure and finances of the local hospital in Jaboticaba is uncertain and precarious. The hospital was never *credenciado* (certified or licenced).[161] "*Several times they tried,"* I was told by health professionals but,

qualitative targets in line with a general budget, replacing a traditional and problematic payment method (SIH/SUS), (Uga and Lopez 2007, 916). More information about the HPP is at: http://portalms.saude.gov.br/atencao-especializada-e-hospitalar/assistencia-hospitalar/politica-nacional-de-hospitais-de-pequeno-porte

[161] This has to do with footnote 160 on the new role of HHP.

"*they never managed."* A long local history of health being used as a political token (*politicagem*) has produced an absence of infrastructure and of governance. As a result, the lack of records showing the hospital activities and services has meant federal monies have been removed or not extended (the version depended on who you talked to). Currently the hospital relies solely on municipal funds, thus it runs on an extremely tight budget.

Other authors have spoken about the effects of pervasive clientelism in northeast Brazilian rural areas (Scheper-Hughes 1992; Arons 2004) and Baixo Sul in particular (Schmitt 2015; Rezende 2015; Renato 2016; Martin Gualberto 2018). In Jaboticaba, corruption has hindered the development of a more democratic access to services, particularly with respect to access to transport and referrals between facilities. I listened to accounts about how past local councillors offered their private cars to take pregnant women to hospitals. Assistance for arranging tubal ligations have also followed this type of exchange, something authors such as Caetano and Potter (2004) have registered elsewhere in north eastern Brazil. A member of the municipal health department confirmed that attempts in the past to introduce the SAMU[162] were stopped because offering private cars was more profitable politically. However, he did not perceive corruption as being bonded to just politicians; for him, there was a general moral degradation in Brazil where corruption pervades every stratum of society. He explained the way in which a public benefit[163] allocated to compensate pregnant women for their transport expenses when in labour had been revoked *"because too many people were lying so we stopped it."*[164] This was a decision that affected many women in distressing ways.

Being transferred to a more complex hospital also entails not knowing when and how a woman and the baby will come back home. Iracema, a quilombola woman (whom I got to know) explained how she was discharged on the 9th of May and could not return home till the

[162] *Serviço de Atendimento Móvel de Urgência*, SAMU. The SAMU is a service administered by the municipality, through the Municipal Secretary of Health partnered with the Ministry of Health. The service can be triggered by a phone call. It has three objectives: attendance to clinical cases, the regulation of the system of urgency, and emergency vacancies in secondary and tertiary hospitals by a 24-hour call center and education in urgency and emergency (DATASUS 2019).

[163] Through the Provisional Measure 577, pregnant women will receive financial support to travel to prenatal consultations and to the place where the child will be delivered. Full access at: http://www.brasil.gov.br/noticias/saude/2012/02/saude-garante-auxilio-deslocamento-para-gestantes

[164] As he stated these words, I recalled him at a recent local public hearing about *Bolsa de Familia.*[164] The place was absolutely packed, it was hot and muggy and the sound of the crowd was deafening. People from rural *comunidades* had come to town to attend this event as for so many, *Bolsa de Famili*a keeps extreme poverty at bay. Over the microphone he suggested that people *"should survey each other."* A man later explained to me, as we drove through muddy roads back to the *comunidade*, that this was *"because those who are lying are taking from those who deserve it."*

15.th Unable to afford the bus fare to Jaboticaba, she had to wait for the Municipal Health Department to send a driver to fetch her. She described how she had run out of clean clothing while waiting and was also hungry. The situation was extremely difficult. She was discharged from hospital but had nowhere to go, becoming completely dependent on the good will of the hospital staff and/or a competent social worker to help her. Several women gave similar accounts, with an outraged community health worker describing the horrific case of a young woman in her community who, after a C-section, a still birth, and a full hysterectomy, returned home by bus with the dead foetus in a bag. After this trip, it took the young woman several months and a number of courses of antibiotics to fully recover *"as everything had gone swollen and infected.*" After gazing at me deeply, the community health worker stated sternly: *"Can you see the magnitude of this torture?"* One of her colleagues, displaying similar frustrations over the lack of care his community had to face and the precarious situation in which he had to exercise his work as a community health worker, described Jaboticaba in the following terms: *"Here in Jaboticaba, we are used to having things taking away from us, nothing reaches us, only empty promises… here we live in 'a terra do nunca'* (the land of never)."

There are many factors to consider in any general discussion about birth attendance. The political culture in which health services are situated is one of them. In the case of Jaboticaba, local political dynamics have hindered the development of fully democratic and safe access to birth care. Local health managers argued that policies were being implemented but when I listened to people's narratives and observed their daily difficulties, the limitations and precarity of the services were evident. This situation had further impact, extending beyond the delivery of healthcare. By exerting dominance, they reminded people of their precarity, mirrored in the services they received, which simultaneously informed them and reflected their expected place in society (as discussed with regard to prenatal services in Chapter Six).

Still, there is an additional temporal dimension to consider at this juncture. Christen A. Smith, in order to decipher the place of the past in the present and grasp the ways in which colonial practices are not confined within unilineal temporalities, calls on the analytical framework of the 'palimpsest,' where "time is not a series but an interlocking of presents, past, and futures that retain their depths of other presents, pasts and futures, each age bearing, altering, and maintaining the previous ones" (Mbembe in Smith 2016, 63). It is in this interlocking temporal dimension that pervasive precarity becomes hauntingly re-energized in Jaboticaba.

Imagining and resisting precarities

Although cases of maternal mortality were rare in 2018, stories of near misses, mistreatment and negligence circulated. Tales of horror births were hugely present in the population's imaginary. When Iara began to scream: *I do not want to die!!!* she was articulating the insecurity and fear plaguing local pregnant women, their families and perhaps even some doctors.

In Jaboticaba, some of the stories circulating seemed to acquire a life of their own and they were repeated over and over in different locations by different people: Take the case of a young girl giving birth in hospital. Her grandmother accompanied her, but overtaken by nerves, passed out. The baby fell to the ground and died. Another much repeated story concerns a baby's skull being crushed by forceps. And another harrowing story involves a young woman's birth journey from Jaboticaba to the neighbouring municipality of Tiririca, and then to the southern city of Yapira, before being sent to the northern city of Macaiba (passing through Jaboticaba). The whole journey was about 300 kms, and the baby was stillborn. Another story involved a young15-year-old girl who, after five nurses had forcefully applied manual pressure, returned home with badly bruised legs and abdomen. Tragically, she never even saw her dead baby. These are just a few of the many stories. It wasn't just bodies that were scarred, but also collective memory.

Myths, rumours and whispered stories are usually where silenced discourses of violence emerge (Das 2007, 108). In this sense, these stories represent a form of 'violence' which began during the colonizing process. They continue due to the "neo colonialist reconfiguring of reproductive practices" and "the negotiations played out on the ground over control in the domains of women's health and birth" (Geurts 2001, 395). Entangled in other local histories of violence - past and present - such rumours portray an additional layer of injustice in an already precarious existence. This existence is characterized by an ontological insecurity which is embedded in the historical memory of the north eastern rural condition (Scheper-Hughes 1992). These stories also speak to other events, other images and narratives that extend and complement an overwhelming sense of abandonment, vulnerability and abuse. Conceição Evaristo (2003) has called this a '(re) memory' of slavery and colonialism, referring to the subtle ways in which understanding present life possibilities are haunted by the past, or by what Christina Sharpe articulates as "encountering a past that is not past" (2016, 13).

During birth, feelings of abandonment, fear, and loneliness are not uncommon in Brazil, and other authors have explored these themes thoroughly (McCallum and Reis, 2004, 2006; Teixeira and Pereira 2006; D'Olivera, Diniz and Schraiber 2002). When Iara heard she would be transferred, her desperate plea for company, "*do not abandon me girl, come with me,"* to a complete stranger captures these fears. Some women were concerned about experiencing similar scenarios; the stories made them afraid. "*E tanta coisa que a gente escuta*" (there is so much stuff we hear), they would tell me. Local imagination captured women's vulnerabilities and replayed them in stories as a warning, through their repetition they confirmed a crisis of confidence in the care provided by the State, voiced in the multiple imaginable horrors that could unfold during a birth.

These stories were grounded in the direct personal experiences of family members or members of their *comunidad*es. Yet this precarious network was met with diverse forms of resistance. Some scholars have explored the way in which women resist the precarity of birth attendance in Brazil (Behague 2002, McCallum 2005). Their studies show how medical staff are prejudiced against black, impoverished women and single mothers. McCallum's research suggests women are not only aware of this, but also respond by searching for the best quality care within their own socioeconomic circumstances (McCallum 2005, 230). In a medically standardized environment, for instance, women may strategically display non-complying birthing practices such as screaming, moving around, and demanding the presence of their family, so that doctors are more open to intervene, that is, to perform a C-section, which is the outcome desired by some women (Behague 2002, 491). In this type of reading, birth is not only a site for domination but also a place where women attempt to reshape power relations.

In the context of a precarious birth care network like that of Jaboticaba, it was common for strong senior women to accompany younger pregnant women to hospitals. Often female *liderança*s or old *parteiras* would take this role. Already used to facing authority, they were more confident confronting doctors and medical staff if necessary. Dona Ju told me that at several births she threatened health workers with calling the police or with recording negligence with a mobile phone. Another local community leader, Dona Cosmiana, explained how women would often try and find out which physician was on duty before reaching the local hospital, and if they did not feel confident in the person on duty, they would travel to the neighbouring municipality's hospital of Tiririca. Dona Cosmiana also spoke about an incident which arose during her niece's birth, during which she complained to the doctor about his lack of attentiveness. The doctor challenged Dona Cosmiana's authority to protest, and he

questioned her knowledge based on the fact that she is illiterate. She lucidly responded, "*to know when you are mistreated is based on experience. I am illiterate because I did not have the same opportunities as you, 'doutor', otherwise you can be sure it would be me who would be standing in your place."* Some rural women were outspoken and protected each other.

Several families explained how, after bad experiences with maternal health services, they organised and collectively mobilised resources to pay for private birth attendance (this took a massive financial toll on low income families). Some women expressed a more drastic form of resistance by refusing to fall pregnant due to trauma and fear. A community health worker, when talking about his daughters' experiences, said that he had become disgusted with what he referred to as 'the whole issue' (meaning the attendance to childbirth) and said it did not surprise him that some women hid their pregnancies from him. These women avoided registration in the health system, and preferred to give birth in the *roça* helped by an old *parteira*, a *comadre* (comrade) or a family member. On one occasion, the mother of a young quilombola girl I knew explained how the young girl locked herself in the toilet and preferred to give birth on her own rather than be taken to the health facilities.

This precarious situation extended to diverse layers of society. Doctors took up their positions on insecure contracts, and it was not uncommon for salaries to be late. Most doctors who came to the region were, as one of them put it, *aventureiros* (adventurers). Facing daily difficulties in accessing medical resources doctors managed situations in sometimes troubling ways. For instance, one day at the local hospital the physician on duty, after cautiously examining some women and looking at their medical records, completed a couple of requisitions for emergency ultrasound through the SUS. These women were likely to need a transfer for a C-section. At this the nurse pointed out: *"Doctor, I do not want to argue with you but the ultrasound machine is broken. These women will initiate the bureaucratic process to no avail."* To which he responded, *"that is not my problem, I only care for what I can, the rest is not my problem."* He then handed out the requisitions. Several hours later, the two women returned having had ultrasounds done in a nearby private clinic. When I asked, both told me they had borrowed money from their relatives.

The image and fact of giving birth *na estrada* (on the road) reveals several aspects related to black rural women's vulnerabilities in terms of access to birth care networks in Jaboticaba. Local political legacies of corruption and clientelism have impacted financial resources, which, combined with outdated facilities and sometimes unprepared staffing, has hindered the

development of a secure birth attendance infrastructure impeding also the arrival of national programmes such as *Rede Cegonha.* A precarious network is the result. In this context women (and to some extent health workers) must develop strategies to endure and protect not only their lives, but also their dignity, a topic I will expand on in the following section.

2. Giving birth with 'help'

In Yapira's hospital. We are both focused. The young medical student and I are carefully observing an ob-gyn doctor in the consultation room, notebooks in hand. Suddenly another doctor storms in and indicates that we should follow him. *Come!!* He walks rashly through the corridors. *Girls, this will be a didactic birth!* His broad body stomps forward, white coat opening in the air.

As we enter the delivery room, we find a woman in a lithotomy position, the husband holding her hand, looking rather petrified. The doctor goes on to explain, *She is a primigravid, so we always need to perform an episiotomy cut.* He performs the cut and then moves on to describe the movement of the baby's head when coming out and adds, *civilized women do not birth standing up, only Indian women or 'lavanderas de rio'* (river laundry ladies). The student nods her head. I am quite perplexed. The baby is born.

Once the doctor finishes the episiotomy stitching, he calls the husband, *Look, look what a piece of art,* while pointing to the woman's stitched perineum. *Thank you, doctor, thank you,* the woman says. Holding her hand dearly, the doctor responds, *Oh … if only all patients were like you … you were magnificent!* The nurse injects some oxytocin and the woman moans. The nurse smiles and comments, *A gente maltrata cuidando* (We mistreat while caring).

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This couple was full of compliments and grateful words for their doctor. He had done an excellent job and treated them with enormous care and consideration. But his performance, whether consciously or unconsciously, conveyed specific ideas about racialised and gendered bodies. This type of performance is transferred from older doctors to younger ones in an authoritative context where the obstetric profession is presented as imbued with absolute scientific rigor. This ever-repeated cycle reproduces a gendered and racialised order that keeps women in their place, dictated by patriarchal logics, and it affixes minority groups back into colonial imagery (Chadwick 2018, Bridges 2011). Kalckmann et al. (2007) and Lopes (2005) have discussed how racial stereotypes in Brazil dehumanise black bodies and are part of the discourse that makes some doctors believe that black women can endure more pain. For instance, Leal et al. (2005) found that in Rio de Janeiro black birthing women received less analgesic than white birthing women. More recent journalistic investigations in Brazil (Ribeiro 2020, Paiva 2019) and public health analyses (Leal et al. 2017, 10) have called attention to the

continuation of these dangerous stereotypes and their impacts. Most alarming is the fact that this trend has been registered throughout the African diaspora (Silverstein 2013; Kreling, Pimenta and Garanhani 2014; Hoffman et al. 2016).

The comments and actions of the doctor in the vignette above illustrate the profound gap between scientific evidence and obstetric practice in Brazil, an example of the importance that "institutional, technical and corporative culture has over scientific rationality" (Diniz 2005, 632). This is sustained by a medical hegemonic culture based on authority. Several studies (Diniz et al. 2016; Hotimsky et al. 2013; Aguiar 2010) show that abuse and disrespect are not an exception but part of the common protocols of obstetric attendance in Brazil, with many such events taking place in university hospitals (Hotimsky 2007; Palharini 2017). These studies have demonstrated how, in the training of medical students, a widespread naturalised culture uses the vaginas of poor women delivering within the SUS[165] for skill development purposes (these exercises are performed without providing information or obtaining previous consent from the individuals). Thus, in many medical schools, cutting and suturing vaginas by performing an episiotomy is the first opportunity doctors of any given speciality have to practice their surgical abilities (Diniz et al. 2016, 255). This reflects a set of values that gives predominance to health professionals while disempowering women (Niy and Silva 2015), who are perceived not as subjects with rights and autonomy, but as objects doctors act upon (Diniz 2016 et al. 254).

As Diniz et al. (2016, 255) in their paper '*A Vagina escola'* (The vagina school) state:

> Non-consented interventions on genitals at childbirth - without clinical indications and only for didactic purposes - are faces of the same phenomenon. They reflect a society in which normalization and impunity for abusive access to the female body persist, reproducing social hierarchies of gender, class and race/ethnicity.

The actions of the doctor in the vignette explicitly express a generalisable colonialist mentality, driven by Eurocentrism, that exists in the Brazilian hegemonic classes, which most doctors come from. For instance, in the state of São Paulo, the CREMESP (the Regional Medical Council) has provided information showing that most medical students are "white and rich" (Colucci 2015, para. 1).

[165] In 2014, at a public hearing against obstetric violence in São Paulo, Mary Dias, a black university student, reported that in a hospital school she received two episiotomies during the same birth. She says she heard one of the professionals talking to a student saying, "*you cut right and I will cut left*" (Diniz et al. 2016, 254).

The protection of a woman's bodily integrity is a key indicator of the quality of care (Diniz 2009) and a constitutive principle of reproductive rights (Rotania 2000, 23). The abusive medical culture of interventionism on women's bodies in Brazil has long been an object of denunciation by the Brazilian feminist movement (Aquino 2014; Diniz et al. 2015). In Brazil, episiotomy is the only surgery which is performed without a patient's consent (Violência Obstétrica 2012, 80). In the *Livro do parto* (delivery register) in the hospitals I visited, the number of registered episiotomies[166] was still high — for every 25 births there was an average of seven to nine episiotomies. Although this prevalence suggests that episiotomies[167] were not done routinely, many women in rural communities received this procedure without being informed and, therefore, without their consent. As a researcher, it was difficult to gauge whether or not these episiotomies were needed. However, it is likely that many women suffered the consequences of these operations for a long time. A devoted Pentecostalist young woman from the very isolated quilombola community of Terra Brava, for example, told me quietly, *"My episiotomy scar is still hurting a great deal after more than 12 years."* She had never spoken about this to anyone because she felt *vergonha* (shame).

In 2011, the Perseo Abramo Institute report (which was based on interviews with 2,356 women in rural and urban areas in all regions of Brazil) found that 53 percent declared they had experienced some form of violence during their hospitalization for childbirth. The Perseo Abramo study also showed that violence[168] was not equally performed across class, race or regions. Women at the top of the social strata, white and/or educated women, reported experiencing less abuse. As maternal death occurs more often among black, unmarried and young women, or those on a low income, morbidity is distributed unequally in society and

[166] An illustration of the neglect of the integrity of women's bodies is how data collection on episiotomy and perineal outcome is not available in DATASUS but depends on PNDS studies available every ten years (Diniz 2012, 98). This reflects an underlying ideology that overestimates the benefits of technology and underrates the impact of its negative outcomes (Diniz 2009, 313), reflected in the fact that for the most potentially harmful interventions little data is collected routinely in the SUS data system. DATASUS is focused on indicators such as the number of antenatal visits and access to drugs, surgery and tests, but it is imperative that data regarding the appropriate usage of technology is collected so that evaluations on over-intervention can be established (Diniz 2009, 313).

[167] Episiotomies are only recommended to be performed in very extraordinary occasions.
See: Jiang, H., Qian, X., Carroli, G., & Garner, P. (2017). "Selective versus routine use of episiotomy for vaginal birth." *The Cochrane database of systematic reviews*, *2* (2)

[168] The most common, according to the study, are screams, painful procedures without consent or information, lack of analgesia and even neglect. However, there are other forms of violence. See:
http://apublica.org/wp-content/uploads/2013/03/viol%C3%AAncia-obst%C3%A9trica.pdf

statistically affects black and impoverished populations at a higher rate (Costa Reis et al. 2010, 1143). Brazilian episiotomies have been regarded as a 'class issue,' insofar as women receiving private healthcare will be what is colloquially referred to as 'cut above' (i.e.: they will be more likely to have a caesarean), whereas the women who rely on the public system will be 'cut below,' (i.e. they will be more likely to be given an episiotomy (Violência Obstétrica 2012, 89). McCallum (2005, 226) has spoken about the value attributed in Brazil to keeping female genitalia intact. Untouched, it represents modernity and progress, rendering vaginal birth primitive and backward.

Thus, the evidence shows that the social markers of difference structure birth assistance and the abuses that can take place in the system (Diniz et al. 2016, 255). However, these abuses are not perceived and understood univocally. The nurse's bold statement about "*mistreating while caring*" takes me to the next section, where I discuss the relationship between the notion of 'help' and obstetric violence and care.

'Ajuda' (help): *the blurring of violence and care*

Obstetric violence[169] is a thorny issue in Brazil and goes hand in hand with its remedy, humanisation.[170] Both topics arouse strong, passionate views among health care professionals and the public alike. Primarily, the movement of humanisation demands an evidence-based approach to birth and calls to stop the current trend in which women's rights and their integrity (moral, bodily and psychological) are violated (Diniz 2014, 218). Here, it is important to mention how the concept of 'obstetric violence' is engrained in birth activism in Latin America. Birth movements in the region have highlighted the political aspect of these practices, disrupting previous categorizations that narrowly define them as a problem related to personal

[169] The WHO (2014) typifies forms of obstetric violence and highlights five categories of legal definitions: 1 - routine and unnecessary interventions and medicalization (on the mother or the infant); 2 - verbal abuse, humiliation or physical aggression; 3 - lack of material and inadequate facilities; 4 - practices performed by residents and professionals without the woman's permission after providing her comprehensive, truthful and sufficient information; 5 - discrimination on cultural, economic, religious and ethnic grounds (Castrillo 2016).

[170] It should be noted that the term 'humanisation' is polysemic, admitting different meanings (Rattner, 2009). In this section, the sense adopted refers to practices legitimized by scientific evidence and related to women's rights. The humanisation of birth appears as a paradigm shift based on a criticism of the technical organization of care, and it is based on the idea that birth has become something inhumane. Although national efforts to humanise childbirth date back to safe motherhood programmes in 1998, the Ministry of Health, pressured by national social movements (such as ReHuna in Brazil) and international organizations (WHO, UN), began to launch programmes such as the Programme for the Humanisation of Prenatal and Birth in 2000 and the Programme for the Humanisation of Hospitals in 2003 (Diniz 2005, 631). These initiatives introduced key areas of intervention such as training professionals, and the financing and restructuring of care (McCallum 2005, 224).

interactions. The term is "overtly political and provocative and linked to efforts to critique social relations of marginalization embedded in gender, class and race oppressions" (Chadwick 2018, 102).

These practices refer to the violence exercised by health professionals and the way in which they affect access to, and the quality of, services. They also have repercussions on patients' adherence to treatment and impact levels of maternal and infant mortality (D'Olivera et al. 2002). As mentioned earlier, obstetric violence in Brazil is not inflicted equally, with evidence showing that black and low-income women suffer more abuse and mistreatment than white women or women from more privileged socio-economic groups (d'Orsi et al. 2014; Leal et al. 2014). Learnt and initiated in medical school for 'training purposes,' these violent practices come to be shaped by social hierarchy, where it is not only about what interventions women will receive but also about the way in which these interventions will be delivered. In this process, the fact that vulnerable women are subjected to negligence and humiliation becomes normalised (Diniz et al. 2015, 380).

In the rural *comunidades,* women were not familiar with the concept of obstetric violence *per se.* Some had come across these practices but accepted them as part of the experience of hospital birthing. This coincides with the already established fact that in Brazil most women expect to suffer some form of mistreatment when giving birth (Marques de Aguiar 2010, 1). Other women expressed their experiences in such terms as "*They treat you like a chicken,*" "*The doctor was ignorant,"* "*They thought I was 'besta'* (thick, an idiot)," *"I was 'largada'* (abandoned)," *"Eles colocam nome nas pessoas* (they call you 'names')," *"Me chamaram de vaca* (I was called a cow)." These narratives were accompanied by expressions of frustration and anger. In some cases, practices that are considered as obstetric violence were mixed with experiences of what they considered attention and positive care, which made the whole event ambiguous. An extreme example of this occurred when I first arrived in the *comunidades.* During a communal mass celebration another visitor, who had trained as a doula,[171] and I talked casually to a teenage girl who had recently given birth. When I asked her informally about her birth experience, she explained, "*the nurse was really nice, she stayed by my side and encouraged me."* Then I asked her if she had received an episiotomy and if they had performed the *Kristeller* manoeuvre. She replied, *"Yes, they were very good and helped me, although the cut still hurts when I sit down."* My companion commented, "*well, that was violence, obstetric*

[171] A woman, usually without formal obstetric training but with other forms of training that prepare her to offer help and guidance to other women during pregnancy, childbirth and after birth. Her job is to provide the birthing mother with emotional and physical support; to be her companion.

violence." The girl looked puzzled, confused and ashamed. I considered this comment inappropriate and tactless – the girl was young and the birth was recent; she also seemed to be happy about her experience. Sadly though, a moment of realization seemed to fall upon her, she became quiet and reflective and left shortly afterwards. The way in which this young girl portrayed her experience shows how the interpersonal qualitative aspect of care prevails over certain practices; what remained most important was the fact that someone was 'helping her.'

The idea of *ajuda* (help) appeared in many discussions, interviews and observations about attending women during childbirth. I had a conversation with a doctor who stated that some women "*needed a bit of 'ajuda'"* and to deny "*this would make women suffer more, it would almost border on negligence.*" With 'help' he referred to practices such as episiotomy, the Kristeller manoeuvre, or a drip of oxytocin and misoprostol to '*make the cervix soft.'* A nurse assistant in Jaboticaba's hospital even told me: "*Oh, what would we do without 'Santo'* (Holy) *Misoprostol!![172] Our biggest help!!*

The notion and practice of *'ajuda'* links humanisation and obstetric violence in interesting ways. At a *Centro de Parto Normal* – CPN (Normal Birth Centre) – at the border of Baixo Sul with the Recôncavo, the following scene took place:

The centre is based on a model of care that follows the Stork Network principles (in structure and design but not in practice and human resources). The rooms are all equipped with comfortable birthing beds and equipment, such as a Pilates ball and a special stool, used to facilitate vertical labour and ease birth pain without pharmaceuticals. A volunteer doula is assisting Samuele, a young girl who is giving birth for the first time. Since her arrival she has walked about, received massages with essential oils, and her mother and the doula are by her side.

The expulsion phase is coming and at this point the obstetric nurse steps in and begins to *'help'*, as she says. She makes Samuele lie in lithotomy position and keeps introducing her fingers in Samuele's vagina, trying to open it. Every time she does this Samuele screams, to which the nurse responds, *I am helping you …* Samuele is visibly getting more and more distressed. The birth progress begins to slow down and Samuele makes desperate cries and says she cannot do it…

The doula becomes really impatient with the nurse's conduct. After a while, she takes me to the hospital corridor to vent, *this is not 'helping', this is 'bad practice.' This nurse is crazy and is stopping the whole progress…*

Eventually, after much hardship and tension, the birth concludes. Samuele's mother and the doula exchange phone numbers; this incident of bad practice needs to be followed up …

[172] For a summary of the use of misoprostol for cervical ripening see https://inamay.com/a-summary-of-articles-published-in-english-about-misoprostol-cytotec-for-cervical-ripening-or-induction-of-labor/

Later that afternoon over a coffee, the doula and I tried to shake off the discomfort the experience has left us with. She pondered in disbelief, "*How could an obstetric nurse at a CPN call obstetric violence 'help'?!*"

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The blurring between care and violence, their intersections and overlaps has been explored by several authors (Stevenson 2017; Bielh 2012; Garcia 2010). The question of "What is pursued, supported, hoped for and what is avoided or excluded in order to render a certain performance as 'good' or 'bad' care"? (Mol, Moser and Pols, 2010) depends on the context. As Thelen (2016, 508) states, "care should be freed from its overtly positive, normative framework and seen as a process with an open outcome." From this perspective, complexities and ambivalence are entangled in such ways that the good and the bad coexist.

In the case of birth in Jaboticaba and the referral hospitals where local women were transferred, obstetric violence practices (e.g. the denial of the presence of the companion of the women's choice; lack of information about the different procedures performed during care; unnecessary caesarean sections; deprivation of the right to food and walking; routine and repetitive vaginal exams without justification; frequent use of oxytocin to accelerate labour; episiotomy without the consent of the women, and the Kristeller's manoeuvre) are combined with humanised ones (allowing a companion, free movement of the body, information). Paradigms are interspersed with each other in unexpected ways where the line is at some points blurred with *ajuda* (help) as a practice condensing care and violence at once.

In the conversations with and between health professionals there was a sense that change was taking place. The number of episiotomies performed routinely in the country had been reduced, although it was still routinely performed in many cases (Leal et al. 2019, 9). Birth care had undergone significant changes in Brazil, but the 'paradigm shift' that Manuel – one of the key promoters of the Stork Network in the state of Bahia – spoke about was advancing slowly. Jaboticaba was still waiting. The regional hospitals where women were transferred exercised a mixture of old and new practices (read technocratic and humanised ones respectively). Thus, rather than established formal changes they appeared as changes arising from the practices of some individual healthcare professionals. Consequently, they were implemented in an inconsistent and erratic fashion depending on which doctor was on duty. On many occasions, obstetric nurses consciously acted as barriers to protect women from unnecessary interventions. A head nurse in the hospital of Yapira told me, "*Depending on the doctor on duty we make sure he does not get too close to the women, we then do all the work."* However, nurses'

attitudes were varied; for instance, an obstetric nurse from the CPN in Macaiba who was also the sole current obstetric nurse in Jaboticaba's hospital told me, *"you get into the habit and you stop questioning procedures; so you put in the drip and 'do all that follows' as routine."*

Research exploring this shift in Brazil argues that the country currently sits between the technocratic and the humanistic paradigms of birth (Williamson 2018, 7). However, I would argue that in the hospitals I visited versions of these two paradigms coexisted in surprising and unexpected ways, making an uncertain network of care even more precarious.

The 'precarious care' that manifested in maternity care feeds and operates within a broader context of precariousness, which although it also includes poverty and material deprivation, comprises much more than that. This precariousness ultimately functions in ways that reveal how an insecure life can rapidly turn into an ungrieveable death (Allison 2013, Butler 2009) expressing "hopelessness that bedevils the future itself" (Denyer Willis 2017, 148).

Embodying Precarious Care: vergonha (shame)

'Precarious care' during childbirth in Jaboticaba emerges as the result of uncertainty and abandonment. Through the stories I have presented we see how pregnant women have to constantly respond and adapt to unpredictable circumstances where the care they will receive in a fragmented and precarious network can be inconsistent and arbitrary. Under 'precarious care,' colonial, gendered and racialised regimes intersect allowing certain populations in this unique neoliberal context to become "differentially exposed to injury, violence, and death" (Butler 2009, 25). Women's narratives about *vergonha* (shame) in Jaboticaba expressed the varied ways in which 'precarious care' had direct consequences on their subjectivities and sense of belonging. The many forms in which *vergonha* took shape spoke to a 'normalized humiliation.' These practices were at times explicit, and there were other instances when they were silenced under Brazilian cordial social codes, where in everyday interactions forms of subtle discrimination and 'othering' were cordially concealed.

Embodiment has been defined as "a way of describing porous, visceral, felt, enlivened bodily experiences, in and with inhabited worlds" (Harris 2016, para. 1). 'Precarious care' is embodied not only in the invisible pain of an episiotomy scar, intimately registered and hidden, but also in intersubjective relations where black, rural women were treated as ignorant, dirty and uncivilized. For instance, making the patient feel *vergonha* was used as a corrective to what was perceived as 'deviant' reproductive behaviour. The following reflections made by an obstetrician working in the territory of Baixo Sul illustrate this clearly:

> *"Recently, my colleague and I attended a birth ... he is a paediatrician … as the baby was born, he asked the mother how many children she had, to which she replied four. My colleague then went into a rampant sermon about why so many children if she had no 'condições*' (means) *and so on. The tone was paternalistic and authoritative. I spoke to him afterwards, he thought he was 'helping' because he cared, he thought he was doing 'good', but really he was making things worse, making the woman feel bad about herself, making her feel 'vergonha.'*

These situations unfolded in settings with unequal power relations, further exacerbated by the critical situation of birth where sensitivities and a sense of dependency were heightened. Many studies have called attention to obstetric violence in terms of language abuse yet this form of humiliation does not necessarily involve overt insults. In Jaboticaba's hospital, I became very bothered by a male nurse's recurring joke. He would grab the newborn baby and place it next to the doctor commenting on their physical similarity, thus implying the doctor's possible paternity. In the CPN of Macaiba, which supposedly functioned under a humanised approach, I also witnessed the obstetrician on duty pretend as a joke that the newborn had fallen on the floor. In that moment the mother laid immobile receiving stitches from an episiotomy, her face twitched in horror.

These observations reflect patriarchal settings where disrespect towards women's reproductive journeys is normalised. Gendered prescriptions on how female bodies need to appear under the medical gaze also create situations of humiliation and *vergonha.* Iracema explained to me how she cut herself badly as she was shaving while preparing to go to hospital while already having intense uterine contractions because she did not want to feel *vergonha*. Her mother clarified this later in an interview: "*We need to go all prepared* [referring to having their pubic hair fully shaved] *because you do not want to be called 'porca'* (dirty/a pig) *and get treated as such."*

In Jaboticaba, I witnessed other normalised micro aggressions, events such as leaving the woman naked and uncovered after birth, not informing the mother about the baby's wellbeing for more than half an hour, refusing to provide water, and scattered information about birth progression were regular occurrences for birth after birth. Anthropologists of birth (e.g. Jordan 1993 and Davis-Floyd 2003) have explored how the techniques deployed during birth are laden with meanings and values around gender, race, class, nature and power; ideas tied to practices that become (re)confirmed and strengthened each time they are performed, revitalising and validating a particular order.

Throughout this chapter I have emphasized how black, rural women, who struggle with deep social and gender inequalities, face many difficulties in negotiating their way into the healthcare system on their own terms. Julia, a female communal leader active in fighting for gender equality, explained how rural women go to the doctor while feeling *vergonha* about their condition of poverty and illiteracy, which reflects an "embodied self-awareness and the way they experienced their 'situation in the world'" (Denyer Willis 2020, 350) which is repeatedly marked by this sense of shame.

In this thesis I have previously pointed out the need to acknowledge the subtle meanings that take place in interactions and what silences and 'no action' can tell us. As Smith (2016) states, "violent encounters are one space, where these non-verbal communications are most influential" (Smith 2016, 99). Following this, corporeal conversations such as continuous vaginal examinations, unnecessary exposure of the naked body and birthing in inappropriate locations such as by the side of the road, create subjectivities where dignity is threatened. As Rachel Chadwick (2018, 126) reminds us, "while these kinds of structural violations often remain invisible as a form of violence, they have powerful visceral and affective consequences," with *vergonha* being a manifestation of these scenarios. Ultimately what these regimes of 'shame' do is to operate in a system that not only confirms the 'otherness' of black rural pregnant women in racialised and gendered terms, but also, by relying on the historical legacies of discrimination, they are part of the contemporary technologies of 'othering' in current Brazil, thereby fulfilling a continuum that connects and overlaps the past with the present.

Black rural women, immersed in rampant socio-economic inequalities rooted in historical legacies of colonization, receive a form of institutional birth attendance characterised by patriarchal oppression and domineering behaviours. In these settings several forms of structural violence overlap, such as financial and geographical barriers and the lack of resources and poor quality of many of the reproductive health services, illustrating how different forms of violence are interconnected (D'Oliveira et al 2002) and unequally distributed. Structural racism, sexism, and class privilege create arrangements that produce a 'precarious form of care,' which ultimately has an effect on the subjectivities of the women attended, producing 'shame.' However, this precarious care is not executed without meeting resistance, with some women, through diverse strategies, raising their voices as legitimate recipients of care and full bearers of rights, and thus citizenship.

Conclusion

Maternal mortality is a visible indicator of social injustice. The death of Alyne da Silva Pimentel in 2002 reflects the numerous factors involved in the precarious maternal health services many Afro-Brazilian women receive which, as I have shown in this chapter, continue to plague maternal health services in Brazil. My intention has been to make visible the multidimensional processes that answer the burning question of why an increase and extension of access and services has not led to a corresponding decrease in maternal mortality. In doing so, I have called attention to the crucial importance of epidemiological data, as the registration of the indicator of race illustrates, while simultaneously considering its embedded limitations.

Through ethnographic research, I have delved into two key aspects of maternal mortality and morbidity: transportation and referrals to higher-level facilities and the delivery of adequate treatment in the rural area of Jaboticaba. By investigating these processes, we can see the way in which abandonment and uncertainty pervade a precarious and fragmented network where birthing black rural women become at times subjected to over-intervention, while at other times they are left neglected. Such scenarios are permeated by gendered and racialised practices where institutional racism, gender bias and socioeconomic vulnerability create landscapes of precarious care. These forms of care have an effect on the subjectivities of the women who are attended to, producing shame, an embodied experience that links into a wider social experience of exclusion where disenfranchised black rural populations are cast aside from full citizenship by the State.

Chapter Eight

POSTNATAL: VOIDS in CARE

As mãos de minha mãe, cada vez mais idosas,
guardam, em suas linhas, o segredo de nosso destino,
elas se cruzam no ventre da espera,
e gestam frutos de um futuro
sempre feliz, sempre feminino.[173]

(Livia 2015)

When time was respected

The health post is very busy today. In the small waiting room, bodies are squeezed together on the benches. Women's protruding bellies rest against their female companions. Mothers, aunties and grandmothers talk at the same time, Dona Eduarda amongst them. Anecdotes, stories, memories and reflections intersect with continuous background laughter. There is a feeling of excitement. This atmosphere is unusual. Normally, the space is quiet, with patients looking bored, tired of waiting.

In a corner I kneel down and listen:

> *The only reason you are going to the hospital is because you never gave birth with a 'parteira,'* an older woman tells a young girl in a joking but condescending manner. *That was good service, my dear, good attention; the rubbing of warm medicinal plants on the body and belly … the herbal teas … the prayers …*

The general discussion breaks down into small groups who whisper about where different herbs can be found. Here techniques, ideas and experiences are exchanged. Some confirm that they continue these practices before taking women to hospital, as well as during the *resguardo* (postnatal safeguarding period). I can hear someone saying to Bruninha – *my darling, the time of safeguarding cannot be broken!* Bruninha nods, holding one of her newborn twin babies.

Soon afterwards one of the senior women, projecting her voice to catch the group's attention, exclaims:

… and the 'cachaça'! Let's not forget about the 'temperada' ('*cachaça*' with medicinal plants) *… with one of my births by the time the baby came out, I was totally drunk!* She laughs naughtily, the few teeth left on full display. She covers her face with both hands pretending to be ashamed, and then with mischievous eyes and a mocking voice says – *it did not hurt at all!* The rest of the women join in frenetic laughter, while the two nurse assistants shake their heads disapprovingly, though with soft smiles.

The conversation becomes more organised. Dona Eduarda points out that, *the 'resguardo', like birth, is about the care involved, the 'carinho'! This used to be a period of absolute silence. Time was respected! …* Another woman describes how *… the rooms at home smelled so nice … of 'alfacema'* (lavender) *and burnt incense … but these days, these days … my Lord, these*

[173] Translation: My mother's hands, getting older, keep, in their lines, the secret of our destiny. They cross in the womb of waiting, and bear the fruit of an always happy future, always feminine.

days it only smells like 'umbigo' (umbilical cord) - and she makes a gesture as if smelling something foul.

***

In the literature on the anthropology of reproduction, much emphasis has been placed on the medicalization of birth and its movement from home to the hospital. This move has not only affected birth but also practices around postnatal care, also known as the fourth trimester. In the vignette above, the voices of the women capture this shift, and their expressions represent much more than nostalgia for a vanishing past. They refer to local conceptualisations around the body and the traditional therapeutics mobilised during childbirth.

This chapter delves into women's experiences and the attention and activities surrounding the postnatal period in Jaboticaba. I begin by outlining the importance of this phase in preventing maternal deaths and morbidity, and in ensuring quality of life by looking at the existing gaps between the recommendations of the World Health Organisation (WHO) and the documented difficulties involved in fulfilling the stated agenda. Moving to the current scenario in Brazil and the situation of formal postnatal adherence, access and coverage, I spell out the diverse factors involved, including the sociocultural matrix and power relations in which women are immersed. By scrutinizing postnatal attendance at the local health services, and by highlighting the resulting processes that make women invisible, I demonstrate that women receive fragmented care that is mainly focused on containing their reproductive capacities and keeping them alive solely 'as mothers.' In so doing, other dimensions of their experience and personhood are silenced.

Subsequently, I leave the health post behind and follow the women back to their rural communities. Here I describe, in rich ethnographic detail, the period known locally as *resguardo,* which entails a series of safeguarding practices and restrictions aimed at restoring maternal health. This comprises temporal, spatial and gendered elements, usually involving a confinement period of 40 days where the mother and her baby are looked after by women from their social network. During *resguardo,* women receive help with childcare, meal preparation and general household chores. There are other detailed regulations, mostly related to food and activities which aim to contain external threatening forces and re-establish equilibrium. Vernacular notions of the body are expressed in these practices where *resguardo* gives women the time needed for *the body to close* and *a dona do corpo* (the lady of the body) to settle back in its place. Through women's narratives and my observations, I address how traditional postnatal care is practiced and how its continuities and ruptures are experienced and spoken

about. I emphasize the way in which intergenerational hierarchies and authority are expressed in a context where local knowledge has been discredited, and where the continuation of traditional practices reaffirms and anchors a sense of identity and dignity, an illustration of the stern resistance to processes of subalternization.[174] Finally, I argue that there is a disturbing tendency to reduce the biomedical gaze to a concern for women's reproductive capacities which combined with socioeconomic changes and the gradual shift of traditional cultural norms, is creating worrying voids in care during the postnatal period.

The Postnatal period

The postnatal period[175] refers to the phase following childbirth, set by the WHO as a duration of six weeks. It is considered a critical phase for the mother and her newborn baby as most maternal and infant deaths take place within the first month, and particularly on the first day (WHO 2015, 1). Research shows that globally almost half of postnatal maternal deaths occur within the first 24 hours, and 66 per cent occur during the first week (haemorrhage, eclampsia and sepsis). With respect to infant mortality, globally 2.8 million newborns died in their first month of life in 2013, including 1 million who died on their first day (WHO 2015, 1). In Brazil, data from the Ministry of Health (2012, 12) indicates that of the 74 percent total maternal deaths investigated in 2010, 56 percent occurred in the postnatal period.

Conceived as preventive care practices and assessments, postnatal care services are designed to identify and manage complications for the mother and the neonate (Langlois et al. 2015, 259). Appropriate and timely postnatal care is vital, as most women who die during this period have at least one severe maternal co-morbid condition, which if identified and managed can make the difference between life and death (Diniz et al. 2007, 1597).

In terms of timing and the number of postnatal visits, the WHO recommends that mothers and babies should receive postnatal care in the first 24 hours, regardless of where the birth occurs. In health facilities, they should not be discharged before 24 hours, and in the case of homebirths contact should be made as soon as possible within this time frame. All mothers and

[174] This is the process through which the knowledge and practices of specific groups of people are excluded and displaced, thus denying them their agency and voice and placing them in a position of subjugation to dominant and hegemonic groups and their views.

[175] Following WHO (2010) recommendations I will use the unifying term 'postnatal' when referring to both 'postpartum' (issues pertaining to the mother) and 'postnatal' (those concerning the baby) for all questions pertaining to the mother and the baby after birth up to 6 weeks (42 days).

babies should have at least four postnatal checkups in the first six weeks: day one (24 hours), day three (48–72 hours), between days 7–14, and during the sixth week. Home visits in the first week after birth are recommended for the care of the mother and newborn, and this can be done by midwives, other skilled providers or well-trained and supervised community health workers (WHO 2015, 2).

In their systematic review about inequalities in postnatal care in 'low and middle income countries,' Étienne V Langlois et al. emphasize that it "remains unclear if these numbers and timings of postnatal consultations recommended by WHO are optimal and achievable in every setting" (2016, 264). Postnatal care has the lowest coverage of interventions on the continuum of maternal and childcare, "with a reported median for the Countdown countries[176] at just 28 percent" (Sacks and Langlois 2016, 442).

The low use of postnatal care services is associated with lack of education, poverty and limited access to health-care facilities. Consequently, poorer, less educated, and rural women have less access to postnatal care (Langlois et al. 2015, 259). It is not, however, only coverage and access[177] that is important in postnatal care. Sacks and Langlois (2016) call attention to the urgent need to address the critical issue of quality in postnatal care services, placing particular emphasis on the content of postnatal care. A key problem they highlight in terms of quality is whether the care provided to the mother–baby dyad is integrated, culturally sensitive, and patient-centred. For instance, inadequate postnatal health care can be due to different perceptions and priorities among health professionals, mothers and families, consequently impairing the adequate provision of the mother's needs (Fogel 2017, 16). Thus, Sacks and Langlois suggest that "postnatal care quality needs to be addressed at the facility, household, and community levels" (2016, 442).

Accordingly, the importance of the postnatal period is not solely reliant on serious health risks such as postpartum hemorrhage and sepsis, but also on the whole spectrum of adjustments that maternity and motherhood entail. The postnatal period is considered a complex event because it encompasses biological, psychological and sociocultural dimensions. Thus,

[176] As of 2012, Countdown tracks coverage for 75 countries, which together, account for more than 95% of all maternal, newborn, and child deaths. For further information see: http://countdown2030.org/2015/countdown-data

[177] In the Bulletin of the World Health Organization 2013, Evans, Hsu and Boerma explore the relationship between access and coverage, stating that "Universal health coverage is attained when people actually obtain the health services they need and benefit from financial risk protection. Access, on the other hand, is the opportunity or ability to do both of these things. Hence, universal health coverage is not possible without universal access, but the two are not the same" (2013, 546).

postnatal care must provide the fundamental needs of mother and baby so the transition into this new period in life can be achieved with ease and security. Alongside biomedically standardised approaches, these necessities are also culturally bound and context-specific.

Prescribed postnatal care in Brazil

Several authors have confirmed (e.g. Matijasevich et al. 2009; Teixera et al. 2015; Alderdice et al. 2016) that this critical period for women and infants in Brazil "is under-researched and under-served" (Diniz et al. 2007, 1597). In terms of adherence to postnatal consultations, the last National Survey on Demography and Health in Brazil (2006) registered that 60.8 percent of the women interviewed did not attend even a single postnatal visit (Ministry of Health Brazil, 2009). Moreover, SisPreNatal[178] only registers attendance to one postnatal consultation and lacks a quality indicator for the assistance received. Given the existing concerns about the quality of prenatal care, Blanco et al. (2013, 53) suggest that, inevitably, postnatal care must be producing poor outcomes. As an illustration, studies in diverse Brazilian regions show that health services for postnatal care are deficient in several ways, including organizational problems in the service network, a lack of education and health promotion components, weak relationships between women and health workers, and an unhelpful focus on medical issues and the protection of the newborn, neglecting issues related to the health and well-being of the mother (Teixera et al. 2015, 622).

The sociocultural matrix and power relations in which women live shapes care practices during the postnatal period. In terms of gender, this is particularly evident when considering social expectations related to motherhood. In Brazil, a study in Mato Grosso (Teixera et al. 2015, 627) for example, documented how postpartum women felt challenged by their roles as carers of children and households and their need to rest and avoid overload during the postnatal period. In terms of healthcare interactions, Souza et al. (2012, 124) have emphasized the way in which health care professionals only envision postpartum women as 'mothers,' reducing them solely to their reproductive selves. The provision of women's health care in Brazil has often been reduced to women's reproductive and motherhood roles, and this has become a key

[178] This is a software developed for adequate follow-up of the pregnant women enrolled in the Humanisation Programme in Prenatal and Birth (PHPN), within the Unified Health System (nationally known as SUS). This is fully explained in Chapter Six: Prenatal.

issue in Brazilian feminist health demands[179] (Aquino 2014, Diniz 2012,). In Bahia, Almeida and Silva, in their investigation of puerperal women's needs in a maternity hospital in Salvador, discuss how these gendered approaches to health care (that reduce women exclusively to their reproductive capacities) became neutralised and naturalised through biomedical and biological practices that further silence the experience of women during the postnatal period (2008, 348-354).

In Brazil, as part of the 'continuum of care'[180] from the prenatal period onwards, the Ministry of Health (2013) has established, for both mother and infant, a series of actions and guidelines to meet the needs of this specific time. For the mother, the focus is primarily on a series of gyn-clinical and psycho-emotional assessments and subsequent care, including guidance on hygiene and infant care, and information about family planning. For the baby, the focus is on the Guthrie test (a diagnostic tool for metabolic screening), vaccination and breastfeeding. Ideally, women should be encouraged throughout the prenatal period, (in the maternity hospital and by the community health agent) to return to the health post a week or so after the birth, and to attend the 'first week of integral health' (*Primeira Semana de Saúde Integral,* PSSI). This is a healthcare strategy for mothers and their newborns within the *Rede Cegonha* (Stork Network).[181] If, for whatever reason, a woman does not visit the healthcare facility in the first week after birth, all these procedures take place in the puerperal consultation, which must take place "up to 42 days after the end of gestation — for effective control of women's health, both general and gynecological" (Ministry of Health 2013, 259).

[179] The implementation of women's health programmes in Brazil has oscillated between a maternalistic rhetoric and a discourse of women's rights (Leite 2013,1). The original implementation of the national women's comprehensive healthcare programme (PAISM), for instance, was highly politicized, with a strong feminist focus on the idea that the "technical is political" and a notion of comprehensiveness that included the emotional, physical and social aspects of health. Caring for women was not just reduced to their reproductive years; it was conceived away from the "materno-infantilism" approaches that Diniz describes as "a focus on women as mothers in a sexist and authoritarian system of medical practice" (2012, 126).
In 2004 PAISM moved from being a programme to become a policy, and in the process, was simplified into a list of medical conditions that needed medical procedures and drugs. PAISM became depoliticized and "lost ground to the discourse of medical consumption" in a context where healthcare is enacted as "the poorly regulated public purchase of medical services from the private sector" (Diniz 2012,126).

[180] The 'continuum of care' emphasizes the delivery of required services by different providers in a coherent and timely manner (Haggerty et al. 2003).

[181] This has been fully explained in Chapter Seven: Birth, particularly in footnote 152.

Postnatal care at the *Posto* (health post)

Dona Eduarda, an original dweller of the isolated quilombola community of Terra Brava, now lives in the quilombola community of Caguaiba. Today, she is accompanying one of her teenage daughters Laiane, now at-term, to one of the last prenatal sessions. She is in a rush and asks the receptionist to let her pass through to the consultation room. She cannot be delayed as she has '*a parida em casa'* (a new mother at home). Carol, her daughter-in-law, gave birth a few days ago and Dona Eduarda is taking care of things for her. Following Dona Eduarda and Laiane's turn, Bruninha (another community member from Caguaiba) comes into the consultation room. Bruninha's older sister is also pregnant, and they have arranged to come together so Bruninha can have assistance carrying the twins. Dona Eduarda's son, who owns one of the few cars in the community of Caguaiba, has driven them all to the health post. Without a lift, Bruninha and her sister would have taken the community truck over bumpy and muddy roads to Jaboticaba's urban centre. From there a *lotação* van (a vehicle for informal public transport) would have been taken to Jacami's *posto*, a difficult mission while carrying twin babies.

Bruninha is nineteen years old, the twins are her third and fourth children. She fell pregnant for the first time when she was thirteen. She was not using any contraceptive method, but her next pregnancies happened while on the pill. Now, she wants *"to try the injection"* and eventually have a tubal ligation because "*four is enough."* The twins were born by vaginal delivery at eight months in Jaboticaba's hospital. The physician on duty that night was an obstetrician so *"she was lucky,"* he told her. With another non-specialist doctor on duty, she would have been referred to another hospital, and at that stage of labour, would have given birth to the twins on the road. The birth was fast and easy, and she felt well looked after and well attended. She was discharged after 24 hours. Before leaving the hospital, she received advice about how to breastfeed the twins.

The pregnancy had been difficult. She bled for the first four months and had to spend most of the time during the gestation resting; she was also in pain most of the time because of the weight of her belly. When I first visited Bruninha at her home around a week after the birth of the twins, her wooden shack was extremely hot. The twins were small and inactive, lying nicely groomed in her double bed under a mosquito net. Bruninha showed a neighbour and myself how she was having trouble breastfeeding. Months later, Bruninha told me how she thought the twins would not survive. I told her I was worried too, and the neighbour had equally expressed concern.

Today is her first visit to the health post and several weeks have passed since the twins were born. Lucia, the nurse, is very happy to see them. She gives a little shriek of joy when they enter the consultation room; and she is eager to have a photograph taken with the twins, "*one in each arm!!"* she says. After the photograph, Lucia grows serious and procedures begin. First there are instructions for breastfeeding, such as "*choose one breast for each baby."* She tells her to eat *jaca* (jackfruit) and *couscous* (corn meal). "*The milk is full of immunity because you have taken vaccines,"* and she provides Bruninha with a list of good reasons to breastfeed. Yet, Bruninha is having difficulties, the babies do not latch on properly, she is struggling. As she listens, I can see the anguish and worry in her gaze, but she does not verbalize this. Eventually, Bruninha's twins will end up on milk formula. As the weeks pass, she will become more concerned and anxious about them not gaining visible weight, being too quiet, and having what she considers poor suction. This will be a heavy economic burden for a low-income family like theirs, as formula milk is very expensive, more so when there are twins.

Are you bleeding? - Yes.

Normal? - Yes.

Lucia explains that they have run out of other contraceptives so *"for now you can use condoms*" and hands out a strip of them with some sachets of lubricant. Bruninha is not asked if she wishes to have more children or about her experience and history with previous contraceptive methods. Instead, the nurse insists on Bruninha not listening to *vovó's* suggestions about feeding *mingau* (porridge) or giving *chás* (teas) and water to the baby, "*those are things from the past, now your head should be modern."* This is a common expression in Lucia's consultations.

No more actions or questions are directed towards Bruninha's health; the rest of the consultation focuses on normative instructions about infant care such as clothing, diet, hygiene and medical procedures, including vaccines and the Guthrie test. Now that the babies are out of her body, the attention to the woman diminishes and she begins to occupy a secondary status. This observation confirms the findings of other researchers exploring the SUS delivery of postnatal care in Brazil (Stefanello et al. 2008; Reis, Santos and Junior 2012; Teixeira et al. 2015; Souza et al. 2012) as well as other settings across the globe (Calgren and Berg 2008; Tully et al. 2017). Patricia Rezende, who examined the delivery of postnatal care within the SUS in a rural village in Baixo Sul, noted that "the body that carries another body stops being the focus of biomedicine and biopolitics" (2015, 174). The State, in accordance with the discourse established since the prenatal period (through the medicalization of the reproductive process), only regards the woman as important as long as she is associated with the

foetus/infant's well-being. Her voice and actions are reduced to her reproductive function. The female body becomes visible when it is seen to be a container carrying an unborn child, a legitimate recipient of care insofar as it is the carrier of another life. Here the tension between a hyper-visibility during the time of pregnancy and childbirth, and an invisibility once this has been concluded, makes explicit the instrumentalization of the female body "whereby the health of women is perceived only as a medium to ensure the health of a child and not as a right on its own" (Freedman 1999, 234).

The accounts from the health post offer a glimpse of an ever-present underlying ideology that is embedded in the delivery of healthcare in the SUS. The health system was conceived to serve 'the poor' and treats patients as objects of intervention rather than as subjects with rights (Sanabria 2016, 132). What becomes visible now is Bruninha's potential fertility. Her previous failures with contraceptive methods are not investigated; her experiences are invisible. The SUS, operating within a neo-Malthusian vision, perceives uncontrolled fertility as the main cause of poverty (Sanabria 2016, 5), an idea supported by the assumption that low-income groups lack sexual restraint (McCallum 1999, 275). Under this gaze, Bruninha is told to use condoms. The nurse does not explore whether she feels comfortable with this, or if this is something she will be able to achieve in her personal life. Bruninha must take responsibility using whatever means available.

Paradoxically, within these gaps and voids, the nurse still recognises Bruninha as a rightful recipient of care, as she identifies the importance of the postnatal moment for the mother, *"You must respect all the 'resguardo' … respect this time,"* she tells Bruninha in a serious tone. However, for the nurse, the location and provider of this care has now shifted to a more intimate realm, that of the home, family and community.

Once they are out of the room, the nurse looks at me and tells me about her concern because "*some of these girls … you know … they do not respect 'resguardo.' They need to be reminded about the importance of tradition."* To which I agree, baffled, since during the consultation I observed that some of her remarks alluded to traditional practices as things which should be consigned to the past.

Resguardo: the safeguarding period

Resguardo, in Portuguese, is the act and effect of *resguardar*. *Resguardar* means to keep carefully, to defend with vigilance, to put something in a safe place away from inclement weather. It means to screen and observe attentively. In its generic sense, *resguardo* points to

an array of regulations, including restrictions on dietary intake, physical activities and circulation in space during a socially marked time. The person undergoing *resguardo* must devote him/herself to complying with these sets of instructions in order to avoid negative consequences (Dias-Scopel 2014, 167). Hence, this concept can be applied to many different contexts. In Brazil, for example, people may undergo *resguardo* after a religious ceremony, menstruation, mourning, a surgery, or the postnatal period, among other reasons.

The practise of *resguardo* during the postnatal period is considered a critical, and liminal[182] event, aimed at protecting the health of the woman. Some authors have deemed it "a cultural element that contributes significantly to the prevention of maternal death," because it guarantees a safe space for mothers and their babies to recover and adjust (Belaunde and Macêdo 2007, 108-117). The restrictions prescribed during this time come from cultural conceptions around a woman's psychology and physiology, and are associated with particular care practices. They differ from biomedical approaches and may acquire specific detailed expressions from family to family or in different geographical regions, but overall they "present a set of commonalities within the cultural repertoire of rural communities in the northeast, which is generally known as 'popular traditional knowledge'" (Belaunde and Macêdo 2007, 108). Postnatal *resguardo* practices in rural Baixo Sul share common and basic characteristics, many of which have been observed globally in traditional postnatal contexts, as in the practices of Thai *yu duan*, Mexican *cuarentena*, Chinese *zuoyuezi*, Cambodian *sawsaye*, and Japanese *sa to gae ri bunben* (Eberhard-Gran et al. 2010). Although the exact procedures associated with confinement vary considerably across cultures, a qualitative systematic review of traditional postpartum practices and rituals (Denis et al. 2007) found many "commonalities in practices or rationales for practices across cultures." The commonalities revolved around prescribed periods of rest lasting on average for forty days, with restrictions on activities and the existence of 'hot' and 'cold' principles; food and sex restrictions, the practice of social support rituals and the long lasting effects on the women's health when the prescriptions are

[182] The term 'liminality' is derived from the Latin word *limem* meaning 'threshold.' It is a concept that describes a transitory state of being betwixt and between and is most associated with the work of Victor Turner ([1969] 2009), who was inspired by Van Gennep's ([1960] 1909) work on 'rites of passage.'
Van Gennep observed that individuals in any society moved through different passages and stages. He examined how these were socio-culturally constructed and marked by ceremonies and rites. These 'rites of passage' arrive in three stages, each associated with particular rituals: separation (pre-liminal), transition (liminal) and incorporation (postliminal). During exclusion people move away from their previous identity/way of life; in the liminal zone they are not what they were but still not what they will be – a zone of ambiguity; finally, through incorporation the individual is recognised in the new status (Rapport and Overing 2000, 229).

not followed. A review focused solely on Asian countries also emphasized similar practices, although with significant differences in cultural detail (Withers et al. 2018).

In the rural communities of Jaboticaba, the practice of *resguardo* traditionally entails a form of *autocuidado* (self-care).[183] *Resguardo* is the final phase of the birthing process. Its importance is reflected in the great efforts women's social networks devote to ensure that mothers and babies achieve a safe transition through enabling compliance to the prescribed restrictions. This process is characterized by the tension between the body now being open (*corpo aberto*), with some of its parts such as *dona do corpo* (the lady of the body), having to return to their original spaces, with various external forces, such as *friagem*[184] (coldness) threatening a positive outcome. The procedure is permeated by a sense of vulnerability and marked by slow adjustments. Events cannot be forced and must be allowed to follow their own organic rhythm. As one of my informants, Dona Jeje, an old *parteira* and *Mãe-de-santo* (candomblé priestess) put it: *"'Minha filha',* (my darling) *there are things in life that cannot be rushed and 'resguardo,' just as birth, is one of them." Resguardo* practices and traditions are the ordinary care that follows a home birth attended by *parteiras*. Organically linked to the environment of a home birth, *resguardo* manifests a type of attention focused on the biological rhythms of a women's body, in contrast to the fractured biomedical and mechanistic understandings that are ruled by the clock time of hospitals. In the following section, I describe how this attention is deployed through a range of therapeutics based on local conceptions of the body.

Traditional therapeutics used during *resguardo*

As I come down the muddy hill after a *passeio* (visit) to see the new babies, Dona Eduarda waves to me from the entrance to her wooden shack, gesturing me to come in. Sidestepping the freshly collected *guarana* spread on sheets by the front of the house, I am mesmerized by the image of the seeds: a thousand red inquisitive eyes. I look away and walk inside. Dona Eduarda pours a small black coffee and offers me coconut cream biscuits from an oxidized tin. She has been "*attending the 'paridas,'*" she explains; "*eu sei* … (I know),*"* I reply while I grab a biscuit.

Two of her teenage daughters have given birth consecutively, as indeed has her daughter-in-law, Carol. Carol's mother had arranged to come and stay but she was too scared to leave the nearby community of Terra Brava because of rampant violence in the area. They live in a

[184] Such conception relies on a humoral theory, also called the "hot and cold diseases theory," which states that diseases may result from the hot-cold effect on the body (Stefanello, Nakano, Gomes 2008, 281).

cluster of houses close to each other along a steep hill in the quilombola community of Caguaiba, close to the centennial dam, originally built by a formerly enslaved runaway population. In the land surrounding their houses, one can see *mata brava* (wild bush) extending as far as the eye can see. Nearby, the land grows *cacao* (cocoa), *cupuaçu*, *guarana*, *banana da terra* (plantain), *rambutan*, *cravo* (clove) and other products cultivated to be consumed, sold or exchanged. Dona Eduarda is well-versed in local ways; her mother, grandmother and *tia de criaçao* (step auntie) were famous *parteiras* in the quilombola community of Terra Brava. "*I learnt everything with them.*" She has been providing all the care for the new *paridas*, and her other daughters and older grandchildren have helped. Women from the community have also come at different times to assist with household chores, especially the laundry.

"It is very important that in the first three days women remain quiet and in bed, their body when laying needs to be facing sideways," she tells me. She confirms my observations that, in the first days, the baby is usually washed by a senior female member of the family. A few months ago, I saw Dona Cosmiana take this opportunity to informally baptize her sister-in-law's baby as she murmured prayers and made the sign of the cross on the baby's forehead, chest and belly.

14. Dona Eduarda's wooden shack. Photo by the author.

15. A quilombola woman doing the laundry in the river. Photo by the author.

Dona Eduarda's daughter-in-law, Carol, and one of the teenagers are moving about, but not doing any tasks in the house. They can slowly begin their usual chores, but have to avoid sweeping, carrying heavy weights, blowing fires or bending down. They all gave birth in the *rua.* When they arrived home, Dona Eduarda gave them an *esfregaçao* (massage/rub) with a warm homemade mix of *óleo de amêndoa* (almond oil) and ground *folhas de horta*[185] (herbs). Women have different approaches to how they do this; some like to extend the massage to the whole body, even pulling the toes and fingers thoroughly; others focus solely on the abdomen and legs. After the massage, a piece of cloth covered in a mixture of ground plants is tied around the belly, strapping it up. This abdominal binder is left in place for a week or ten days. "*The idea,"* Dona Eduarda says, "*is to bring a 'dona do corpo' back to its place and help the belly stay in."*

A Dona do Corpo

Although narratives around *a dona do corpo*[186] (the lady of the body) have mostly disappeared in urban Bahia (Sanabria 2016, 51), in Jaboticaba, *a dona do corpo* appeared in many of the conversations I had about the female reproductive body with younger and older women alike. Explanations differed. Some women equated it with the uterus, others expressed

[185]*Pedra-ume* (Alum stone), *aroeira (*Schinus terebinthifolia*), matruz* (Chenopodium ambrosiode).

[186] For a full exploration of a *'Dona do Corpo'* see: Macêdo, U. 2007. *A "Dona do Corpo": um olhar sobre a reprodução entre os Tupinambá da Serra-BA.* Dissertação de mestrado. Ciências Sociais da Universidade Federal da Bahia (PPGCS/UFBA).

a clear differentiation from the uterus and understood it as an 'entity.' Gabriela, a young quilombola woman from the community of Santa Anna and a mother of three children, described it as follows:

> *"Look, I understand that the 'dona do corpo' is something beyond the uterus. It is inside the uterus; she accompanies the child from the gestation. Women are already born with it; it is like a lump because that is how I felt it … a round lump. She will not hurt you, it only bothers you when the child is born. What happens is that she misses the child and starts looking for the child in the belly, moving about with her legs* [she laughs] *and we have the remedies so that she calms down: the liquor of Ampanho, English water* (herbal medicinal water), *the 'atemperada'* (a mixture of caxaça and herbs), *I took it all. We also use the 'folhas de horta'* (herbs from the vegetable garden) *for tea, sitz baths and herbal baths. She bothers when the child is born because she misses the baby, she would like the baby to stay there with her, feeling cozy."*

Gabriela explicitly said that '*dona do corpo does not harm,'* however, she needs to be looked after through diverse therapeutic processes so she can return to her place and be calmed. Other authors exploring '*a dona do corpo'* amongst *Tupinambá*[187] in southern Bahia found that this entity was also in charge of the regulation of the blood in women's bodies (Macêdo and Belaunde 2007, 114). This is similar to what some women in Jaboticaba insinuated by saying that *"ela toma conta de todos os negocios da mulher"* (she takes care of all women's business) or *"ela comanda o corpo da mulher"* (she governs the woman's body). The displacement of a *dona do corpo* contributes to creating a fragile body, which is denominated as a *corpo aberto* (open body).

O corpo aberto

Dona Jeje told me about the dangers of being in a state of *corpo aberto* (open body) for the first time after I had shared a story about a birth I had witnessed at the local hospital in Jaboticaba. I told her, in amazement, how a woman had been left unattended after birth for more than 20 minutes fully naked, legs wide open and trembling, with blood and other bodily fluids splattered on her body and around the hospital bed. The baby had been taken away because it had swallowed meconium and no-one was attending to the mother or letting her know what had happened. Dona Jeje sighed deeply and told me that *friagem* and *corpo aberto* were "*very bad for a new mother," "things can happen …"*

[187] The *Tupinambá* are an indigenous group from the north east of Brazil.

Restrictions and therapeutics during *resguardo* are also aimed at sealing the body again. To have an open body is dangerous. We can appreciate this sense of vulnerability in the limitations set around activities such as watching TV, or getting close to the fire (in both these cases the eyes could be harmed because of the intensity of the light). Women have to avoid *friagem*, for that reason, they do not walk barefoot, eat cold food, wash their hair or take cold showers. As one woman explained when she almost died of a haemorrhage after birth: *"I felt the 'friagem' travelling up and I knew that if it entered my heart I would die, because that 'friagem' was 'death.'"*

Another significant dimension of resguardo is sound. *Paridas* cannot be around loud noises, or receive a *choque* (shock), which can come from sudden noises, bad news, or *raiva* (rage/anger). To illustrate this, Dona Cosmiana told me that when she was ten years old her mother had died during childbirth, leaving eight small children behind. Her auntie, Tia Tata, explained that what really happened to her sister was that her *resguardo* was *quebrado* (broken); someone blew a firecracker by her side and she "*tomo choque"* (had a shock) and died shortly afterwards. Thus, death can be a direct consequence of not following *resguardo* regulations. An *open body* entails being in a delicate psychological/emotional state, which needs to be cared for. As Dona Jeje said:

> *"Open body is not just that you are open down there because you have given birth, nooo … your body is ALL open, that means the head also, your head is open and maybe you start thinking differently, and you have to be careful … that is it! Opens all over, and the head as well … you see then, girl ... it's the material life and the spiritual life too."*

Women also follow restrictions in terms of movement, and often these are tied to *resguardo* around the baby's well-being, as the babies' bodies are also in an open state. Until the seventh day, the mother and baby do not leave the house. All the clothes are kept inside and are not washed until the 7th day. If the room has no door, a curtain must be put up to separate the spaces, warning off *o mal do sete dias*[188] (the evil of the seventh day). After this day, people can start visiting to drink *temperada* (caxaça with medicinal herbs), and eat *escaldado* (chicken soup). Babies have their hands, feet and head well covered to avoid *friagem* (coldness) until they are two months old. Particular details, as mentioned earlier, varied from family to family. Some people washed the baby's clothes separately and hung the clothing on a separate line,

[188] *'Mal do sete dias'* is related to infant tetanus.

while others mentioned that the baby's clothing should not be exposed to the *sereno* (the night cold). Some families did not allow the baby to be touched by the streams of light seeping in between the wooden boards in the shacks, as this could produce colic.

Dona Eduarda described how she took care of the umbilical cord by removing the clip, cutting the cord shorter and then tying it with a string. Long and consequently 'ugly' umbilical cords cut in the hospital are something many women complain about. Maria de Jesus, an old *parteira*, received many visits from local women to perform this procedure. "*It is important to bury the 'umbigo' because if a mouse or rat gets hold of it the baby may become a thief'*." The *umbigo* can also be kept, *"in the event that the infant's eyes ever became sick, you can make a tea with it, it's a powerful 'remedio',"* Maria de Jesus explained. Many *simpatias* (spells) were used for the *umbigo* to heal inwards and flat, something women gave much importance to. This would be done by touching with the index finger anything with a circular shape, such as a cut piece of *quiabo* (okra), a coin, an ant's nest, or the sink's drain, to after perform circular movements. The same circular movements would be replicated above the baby's belly button, sometimes accompanied by a prayer. Some of these traditional practices could be classified as sympathetic magic, that is, 'like produces like.'

Spiritually, babies need to be protected. All the women I met had accounts of their children being subject to *mau olhado* (the evil eye). It is very easy to see when a baby has *mau olhado* as it sleeps and wakes erratically, yawns a lot and looks disturbed. As seen in Chapter Five, some people know how to *rezar* (pray) to remove these negative energies with their words, which have mainly been produced by other people's jealousy, whether consciously or unconsciously. To protect the baby and secure a good future, some women show them to the moon and the sun. With a prayer, they ask these luminaires to help to raise the child.

Food restrictions, or *resguardo de boca* (mouth restrictions), are key to a good outcome in *resguardo*. Although closely tied to breastfeeding, food restrictions are also directly related to the effects that can occur when closing the 'open body' and appeasing the *dona do corpo.* Families save money to ensure they have sufficient supplies to prepare the food the *parida* needs. The first food eaten is usually a chicken soup, then beef and fruits are slowly introduced. *Comidas remosas* (strong foods) are avoided, and the times at which they are reintroduced differ from family to family. The condition of *remoso* has also been identified in other studies in Baixo Sul (Rezende 2015), and in southern Bahia (Macedo and Belaunde 2007). Ribeiro Baião et al. (2013, 314), following studies among fishing populations in northeast Brazil, describe *remoso* as "food that, in situations of organic (and symbolic) vulnerability, presents a potential danger to the flow of body fluids (humores) due to the body's low capacity to resist

its effects, causing illnesses *recaída* (relapse)." Equally important is the fact that the food has to be freshly prepared; food should not be reheated for the *parida.* Finally, besides food restrictions, sex should also be avoided until after the 40th day post partum.

Overall, during *resguardo* women are sheltered to ward off detrimental exogenous forces and assisted in restoring equilibrium and assuring recovery, following what is perceived as a major transformation. *Resguardo* then is about re-establishing boundaries in a body that "exists in continuity with its social, natural, and metaphysical environments" (Sanabria 2016, 54). This process is embedded in a domestic rhythm within the home and supported by the attention of the family and the community.

Breaking *resguardo* and its consequences

Quebrar o resguardo (breaking the safeguarding period), whether committed voluntarily or involuntarily, can have serious consequences. In the case of Dona Cosmiana's mother, death was brought upon her by somebody else's actions. Tia Tata was not clear whether or not her sister should have been in an environment where firecrackers were being blown up. When I asked her about this, she simply reiterated that her sister's "*resguardo was broken.*" Tia Tata's concerns were more focused on emphasizing the devastating consequences of her sister's death on the family, "*with that bunch of kids to take care of."* The repercussions were felt by the whole community. In *resguardo,* although it is socially supported, personal responsibility plays a key role. By respecting and following *resguardo,* a woman is not only safeguarding her health but also safeguarding her family and community; and ensuring that she will be healthy enough to fulfil her role as a mother.

This last point also relates to a woman's psychological capacities and well-being, as a disturbed mother cannot fulfil her role. Psychological disturbances can be another serious consequence of breaking *resguardo*, or as Dona Jeje puts it, *"To start thinking differently." "Sometimes this is only temporary but in others it stays with the woman*." By 'thinking differently' she is referring to depression, which, she clarifies, can be temporary or chronic.

In this phase, women can be exposed to a condition from which there is no known cure. In interviews with postnatal women and their family members, Stefanello, Nakano and Gomes (2008) found that the irreversible nature of *quebrar resguardo* is due to the body closure at the end of the *resguardo* period. All the problems acquired during this period remain inside the body once it closes, and "if for any reason the abstinence is broken in a given moment, and

some health alteration comes, it is necessary to cure it before the end of quarantine" (Stefanello, Nakano and Gomes 2008, 278). Some women who had given birth at home in Jaboticaba emphasized the importance of the 40th day, when the body would finally be closed by the closing of the *eixo* (hips). In this process, the woman lies on her side and a *parteira* or other knowledgeable woman sits on the hip to fully close the body.[189] This is done in the intimacy of the home.

The idea that not observing *resguardo* results in permanent and irreversible damage, either immediately or in later life, was mentioned by many women. Vaginal discharge, cancer, fatigue, back aches, tired legs, cramps, difficult menopause, migraines and especially big bellies and premature aging were all reported to be possible consequences of not strictly complying with *resguardo's* restrictions. When talking to older women about their reproductive lives, at some point the conversation would always lead them to proudly show their flat and wrinkly bellies. Slapping and holding their abdomens gently, they would call out the number of pregnancies they had: "*Look, fifteen babies and look … not like women now … a couple of kids and they are 'acabadas'* (finished)*."*

These remarks were contrary to that of the local gynecologist-obstetrician who had worked in the area for more than 15 years attending to women at several private clinics (including his own) and at the SUS. When I described these local observations, he stated:

> *"The recovery of younger women is much better and faster than it used to be. Childbirth is done in more adequate conditions; I mean hygienic conditions. Women also have fewer children, their overall health has improved. They have been using iron supplements and their nutritional condition during pregnancy is much better than before, so all this helps to provide a much faster and better recovery.*"

When I asked him what *quebrar resguardo* meant, he said that it was based on empirical knowledge and emphasised *"orientações idiosincrásicos"* (idiosyncratic orientations); but no-one had ever been able to explain to him what *quebrar resguardo* actually entailed. He then went on to describe how a woman had come to the consultation recently with pelvic pain saying that it was due to her *resguardo* having been *quebrado* ten years ago. He argued that the reason for this was not evident because "*there are no standard clear rules … it is not scientific, it does*

[189] However, it is important to mention that the body will be vulnerable to becoming open again for many other causes, such as menstruation.

not make sense, it is just myths from the region." That latter point was, according to him, the main reason why the younger generation were less interested in following these practices.

In actual fact, the reason why younger women did not comply with *resguardo* restrictions varied. Some justified it with socioeconomic arguments. A twenty five year old who had moved from a rural *comunidade* to the peripheral neighbourhood of Engenho Velho in urban Jaboticaba explained to me: "*Some women have 'carteira assinada'* (work with a contract) *and then they get paid for four months* [referring to the established maternity leave], *those of us who have no fixed salary* [meaning working in the informal economy], *despite not receiving pay we should 'respect the time,' for our own sake, but sometimes it is not easy … it is not possible to do so."* A community health worker complained that a young girl in the *comunidade* of Onça Vermelha was in the collective truck going down to the urban centre to collect *Bolsa de Familia,*[190] *"I understand … but it is too early!! … that bumpy road,"* he reflected as he grimaced.

In most cases, *resguardo* was undertaken in a patchy fashion. Older women complained that they had to *amarrar* (chain) the younger ones. Dona Esther was exasperated when she found out that her daughter-in-law, recently *parida* and under her care, had gone to a barbecue and eaten sardines. When she explained this to a group of friends, all the women cried out in unison*: "Saaardinaaaas!?"* (sardines) in absolute dismay. Some young women who practice the *resguardo* do so while they are being looked after, or in the surroundings of senior women; once they leave their care, they may stop. This does not mean giving up completely, but only occasionally. These types of actions express the agency and autonomy of the younger women against their older kin's control and surveillance but simultaneously convey a form of respect, as *resguardo* regulations are observed when around female elders.

The studies that I have mentioned previously took place in southern Bahia, among a fishing community in Baixo Sul (Rezende 2015) and with the *Tupinambá* (Macedo and Belaunde 2007). These studies also identified intergenerational tensions in the practice of *resguardo*. Rezende (2015, 177), for example, highlights how young women are rejecting *resguardo*, basing their arguments on the lack of scientific evidence supporting these practices. Macedo and Belaunde, point to the influence of biomedical concepts acquired in school, while also emphasising conversion to new religions as an additional reason for these cultural practices being discredited. They argue that different generational experiences are key in the various

[190] Government programme of cash transfers to low-income families.

levels of adherence to traditional *resguardo,* and notice that the "elderly's knowledge becomes more appreciated as women gain more personal experience" (2007, 110-11). Clearly, there are several ideas about why *resguardo* is being followed less frequently or less strictly by newer generations, and the factors that come into play. In the next section, I explore how ascribing to these cultural customs is based on family duty and respect for the older generations in Jaboticaba. We see that senior members base their practices and knowledge on identity, community and the good life. This appears as a form of resistance to historical processes of invisibility and subalternization, which collide with new conceptualizations around the body, making adherence to *resguardo* a site for intergenerational tension and negotiations.

Resguardo and intergenerational dynamics

Processes of urbanisation and modernisation in Jaboticaba are significant factors that influence the practice of traditional[191] postnatal care among young mothers. As they have been exposed to biology and the biomedical science of reproduction in school, they may also be more prone to listening to the indications of the health teams, who often refer to traditional practices as based on 'ignorance.*'* The desire for upward social mobility also makes some women opt out of this 'discredited knowledge.' Younger generations are immersed in the social dynamics social media has brought about where particular attitudes of 'immediacy' are fostered. For example, a young girl, hearing the women talk about the restrictions of *resguardo* said: *"Me? At home all day without eating all those good things? ... Oh no!"* On another occasion, when an older woman reprimanded a new *parida* for not strictly following her *resguardo de boca*, she replied: "*Bah!! that is just bobagem* (silliness). *I ate it* [restricted food] *already and nothing happened."* To which the older lady replied: "*you won't feel it now girl, you will feel it later*."

Most families in the *comunidades* follow the beliefs and practices of their ancestors. They adopt the old ideas because as a community health worker put it, *"they work; we see the results."* The shifting of childbirth care from the home to the hospital has been key in establishing a new relationship with the body as women become embedded in the biomedical system from the moment they first interact with maternal health services. Dona Nina, a sixty-

[191] My standpoint is a critical approach to the notion of traditional practices and knowledges, but it also attends to these as possible sites of resistance outside essentialisms or reductionism as the mere preservation of memory. For instance, Appadurai (2002) has warned anthropologists who attempt to explain the present in terms of the historical and cultural traditions that may appear to produce it. As a consequence, this tactic can foreclose possibilities to the future and endorse a monolithic understanding of modernity.

six-year-old *quilombola* woman, who had all her eight children with the local *parteira* "*in the roça"* talks about this:

> *"… with my daughter, that one there sitting on the couch, she had the baby here with the 'parteira,' she did 'resguardo' my way, how I wanted, but my other daughter … she thought that because she had her births with a doctor she did not need 'resguardo' and 'agora ela vive sintindo' (she now feels things* [in her body])."

This shows how the place of birth can be a factor in shaping care practices during the postnatal period, but this is not always the case. In a recent homebirth attended by Dona Jeje, the woman, who was already mother to seven children, did not want to follow a strict *resguardo,* despite Dona Jeje's suggestions. When reflecting on this, Dona Jeje indicated how frustrating it was that these days "*tá tudo liberado!!"* (everything is allowed).

When women do not comply with *resguardo,* they may be regarded by their elders as *temosas* (disobedient), or blamed for lacking *juizio* (common sense) and *respeito* (respect), not only for themselves but also for the knowledge provided by their elders and ancestors. Thus, *resguardo* is not only about solidifying community ties through reciprocity and communal help, but also about recognizing the authority of the older kin and reinforcing a sense of continuity and identity. As a morally imbued and normative social practice, *resguardo* involves a series of rules and prescriptions, which *paridas* subscribe to by replicating the order, or disrupting it. In their study on postnatal women in Rio de Janeiro, Ribeiro Baião et al. (2013, 315) found that some of the women valued family knowledge over scientific knowledge because following the former allowed them to reproduce the socially accepted skills and functions of a 'good mother,' someone who was perceived to be responsible and protective. This, in turn, increased women's self-confidence.

In Chapter Five I discussed how *respeito* (respect) and *consideração* (to show respect/to care) are of great importance in Baixo Sul's social relations**,** particularly in intergenerational relations. These concepts are captured in acts such as *pedir a benção* (to ask for a blessing) where the hierarchy within the family is recognised and reconfirmed. Observing *resguardo* can be seen as one of these acts. Many of my interlocutors stated that older generations were the legitimate sources for the acquisition of *fundamento* (knowledge) and *memória* (memory). For instance, Dona Cosmiana, forced by her mother's death to take care of her younger brothers and sisters at an early age explained: *"I learned to treat old people well. To respect them because they inform, teach … One gains experience with the elders; they taught me how to*

survive." Dona Maria, an older *rezadeira* (folk healer) and *raizera* (herbalist) from the quilombola community of Santa Anna told me that young people were good to joke and laugh with, but in order to access real knowledge, one needed to be with the elders. Similarly, some youth find security and pride through their connections to tradition and family. One late afternoon, as Gabriela and I spoke outside her wooden shack about her reproductive life, she stated:

> *"Today there are people who do not care about these things, but I follow my own culture proudly and if I was to give birth again today I would follow all the indications. All my children were taken care of as my mother taught me … these days violence is too strong and there are things we need to 'resgatar'* (rescue) *with urgency."*

For Gabriela, the possibility of a peaceful life lies partly in respecting the knowledge and practices conveyed by her mother. Similarly, respecting these practices upholds their ties to *comunidade* as a foundation upon which to build their lives. Nina and other older women refer to *resguardo* as part and parcel of the *vida boa* (the good life), which is linked to relationships of *compadre* (a type of kin), and the autonomy of life in the *roça.*

> … [resguardo] *entails a lot of care for one another, mountains of clothing other women washed for me at that time … and if they saw me doing anything extra, I was badly scolded, that is the good life … in the same way if we went to the 'rua' to collect our pay and my 'comadre's' pay had not arrived I would halve mine without comment, and so would she … and this is how the life in the 'roça' is …*

The idea of life in the *roça* as a place where the traditional order of things and the '*good life'* can be guarded from the *rua* was also expressed by a teacher from a quilombola community, who told me how he had witnessed many families falling apart when they moved away from the bounds of the *comunidade* and into the *rua*. Another quilombola teacher, talking about the vanishing practice of *resguardo,* made direct links to this shift and the general state of Brazil:

> *"If we as a community are not taking care of the birthing women…then* [she sighs deeply] *… then people wonder: Why is Brazil in this state? … there is so much stuff … depression … lack of support … lack of care for the family."*

Traditional practices and ways of being through community networks and memory attached to territoriality become a resource, not only for cultural affirmation in its confrontation with a dominant medical system and a long legacy of racial inequality and violence, but also as a way to maintain traditional livelihoods within a framework of dignity and pride.

The practice of *resguardo* entails a paradoxical temporality of prevention, involving acting now in the name of the future. This does not apply solely to the care of the birthing mother and her baby, and *resguardo* protecting practices also involve important intergenerational dynamics. Amidst a long history of biomedical institutions discrediting local knowledge, we find that the practice of *resguardo,* on the one hand, conjures a form of resistance that is linked to identity,[192] dignity and community, while simultaneously containing a critique of modernity and an imposed subalternity. On the other hand, the non-compliance of *resguardo* captures generational tensions and the search for singularity among the collective in newer generations, while also reflecting broader shifts in cultural values and social realities.

Conclusion

This chapter provides an overview of postnatal care in Jaboticaba, attending to the factors that influence its continuities and ruptures. A review of the current literature on maternal health reveals that postnatal care is considered crucial for the well-being of the mother and the newborn baby, although it still remains a neglected area in healthcare and research. In Jaboticaba, this situation is influenced by two key factors. On the one hand, we find that local health services offer fragmented care where quality is not registered; and biomedical and biological practices end up limiting 'care' to that of women's reproductive functions. In this gendered approach, the tension between a 'hyper-visibility' during the time of pregnancy and childbirth, and an 'invisibility' once this has been concluded, reveals the instrumentalisation of the female body for reproduction. On the other hand, we find that in the rural communities during *resguardo,* women are sheltered to ward off detrimental exogenous forces and are assisted to restore equilibrium and assure recovery after what is understood to be a major period of transition.

This process is expressed within vernacular notions of the body, where *resguardo* comprises the time it takes for *the body to close* and *dona do corpo* (the lady of the body) to settle back in its place. These observations are normative, have moral dimensions, and belong to the sphere of family, to hierarchy, and to respect. Consequently, ascribing to these cultural customs is

[192] Here I understand identity, following the work of Pina-Cabral and da Silva (2013) in Baixo Sul through the term '*identidade continuada'* (continuous identity), as when "a member of a pair is 'invested' with the marks from the world of the other member. They are mutually 'invested in' a common world through a process of emotional imagination. So, continuous identity is the way in which the world reflects back on ourselves" (Pina-Cabral and da Silva 2013, 23).

based on duty and respect of older generations who base their practices and knowledge on identity, community and the good life. I contend this to be a form of resistance to historical processes of invisibility and subalternisation, which collide with new conceptualisations around the body, making adherence to *resguardo* a site for intergenerational tension and negotiations. Ultimately, I argue that the conflation of the biomedical gaze's tendency to reduce women to their reproductive capacities, coupled with socioeconomic changes and the gradual shift of traditional cultural norms, is producing some worrying gaps in the provision of care during the postnatal period.

CONCLUSION

Ahistorical care is (part of) how we get to a place of mistreatment and inadequate care.
Dr. Joia Crear-Perry (2018, 10)

This ethnographic thesis has explored black rural communities' struggle in Brazil for survival and for a future. Using care as an analytic lens, the thesis has focused on reproduction generally, and the process of birth, specifically. By investigating the various manifestations of care which emerge in maternal healthcare practices, it has been possible to reflect on what these reveal about contemporary Brazilian democracy. In particular, we have seen how the Brazilian State, which is deeply shaped by colonial legacies and severely constrained by current neoliberal logics, has ended up reproducing marginal zones of vulnerability and abandonment. This occurs alongside Afro-Brazilian rural populations' resistance as they challenge the multiple daily struggles that deny them access to full citizenship and belonging in a country that has historically positioned them as invisible and disposable. Scrutinizing the way in which these conflicts find expression in the realm of maternal healthcare while focusing on black rural women's engagement with liberatory practices has been at the very centre of this ethnography.

Many of the dynamics discussed throughout this thesis have been accentuated during the COVID-19 pandemic. Brazilian researchers and activists have been troubled by the impact of the pandemic on pregnant women in general (Takemoto et al. 2020; Lima and McCallum 2020), black pregnant women in particular (Souza Santos et al. 2020) and black rural populations overall, especially the quilombola (Arruti 2020). The chronic problems haunting maternal healthcare in Brazil, such as poor quality prenatal care, lack of resources, and obstetric violence, are just a few of the issues at stake, and they appear to be worsening with the pandemic (Takemoto et al. 2020; Nakamura-Pereira 2020).

The crisis management of the COVID-19 pandemic in Brazil under the current government has been marked, so far, by an uninterrupted sense of calamity, with some scholars arguing that the country has the worst pandemic response in the world (Saad-Filho 2020; Ferigato et al. 2020). The president's continuous pronouncements against personal protection measures while also undermining the pandemic by referring to it as a "small flu" are partly responsible for the national response's lack of effectiveness. The quick succession of two Ministers of Health (one resigned and another fired) and the ultimate appointment of a military general with no medical

expertise, are a few snapshots of the climate pervading Brazil's public health governance at the peak of the pandemic during 2020. To this unsettling scenario we must add the already well-known "pervading historical and structural racial inequalities that have kept most black rural communities out of growing state and municipal public health policies" (Arruti 2020). Researchers in Brazil are also pointing to the concerning aspects of under-reporting and lack of disaggregated data by race. They state that "missing data not only hinders the analysis of racial inequality during the pandemic but also makes it more difficult to develop solutions" (Pilecco et al. 2020,1). Authors are discussing how this lack of epidemiological analysis during the COVID-19 pandemic is another expression of the necropolitical character of the Brazilian State (Santos et al. 2020; Granada 2020). Some populations have mobilized themselves to take matters into their own hands, such as the quilombola. Mired in an absence of information about the impact of COVID-19 in their communities, they organised partnerships with universities and civil society groups, ultimately creating their own platform to monitor cases (Arruti 2020).

Reflecting on the current political situation in Brazil and the way in which the pandemic has been (mis)managed, it is clear that the analyses presented in this thesis are important for understanding the way life and death are regulated by the Brazilian State. As Granada (2020) puts it, "the management of the pandemic should be understood within a broader framework of the functioning of contemporary neoliberal capitalism, in which it is not enough to control bodies and manage their conduct, but more properly, to decide on those who should live or and [sic] who should be left to die."

The 'politics of death' (Mbembe 2003) that the COVID-19 pandemic illustrates does not work in a vacuum; it is closely connected to a larger project of dismantling Brazilian democracy. Several authors (see Giovanella et al. 2020; Viveros de Castro 2019) have boldly affirmed that Brazilian democracy today is immersed in an unfinished tragedy as the project of the ultra-right-wing government advances its crusade against reproductive rights, indigenous rights, public education, public health, environmental protection and justice, to name a few of the constantly unfolding setbacks that keep materializing, one after the other (Taddei, Bulamah and Schavelzon, 2020). The COVID-19 pandemic has thus magnified a collection of chronic historical injustices that have continually plagued the Brazilian social landscape. This thesis describes some of the mechanisms through which the Brazilian State reproduces and secures the extension of 'death worlds' (Mbembe 2003), particularly for the Afro-descendant populations. Although these tendencies are evident throughout Brazil, I have illustrated how they function in rural settings, such as Jaboticaba. Aiming to elucidate the intersections of life

and death, I have placed my analysis at the intersection of biopolitics (the State management of life) and necropolitics (the State's imposition of death), foregrounding their interconnections during neoliberal times.

Belonging and reproduction

In Part I, I focused on unpacking some of the multifaceted aspects of reproduction in black rural communities, placing particular emphasis on the sociocultural and political contexts in which reproductive practices unfold. Moving beyond pregnant bodies, I then followed other social reproductive concerns such as access to, and provision of resources; and the organisation of households and kinship. Exploring these concerns allowed me to identify links between the local and the wider national landscape. This, in turn, revealed expressions of violence and *death* in Brazil and the impact these have in the black rural population's sense of futurity and belonging. In this section, I also attended to the way in which *life* is fostered by black rural women in their communities and how a sense of belonging is cultivated through particular forms of care, such as those manifested in agroecological practices, *parteiras*' caring practices, and the establishment of female local networks to protect one another from exploitation. This section also reveals the complexity of human reproductive processes and the interdependency of socioeconomic, gender and racial justice embedded within them, conclusively revealing the critical importance of applying an analytical approach that includes a reproductive justice lens.

In Chapter Four I have argued that through diverse forms of violence, Brazil condemns black populations to overwhelmingly hostile environments. To illustrate this, I have attended ethnographically to the ways in which the lack of access to resources through secure and well-paid employment and the insufficient provision of social services (both of which are drivers of poverty and exclusion), coupled with a neoliberal construction of citizenship (based on a consumer citizen), have produced irresolvable tensions in peripheral urban contexts and rural areas alike. This has created spaces of abandonment and death. I have also shown how these patterns blur the local landscape of a rural municipality in Bahia like Jaboticaba with trends in the national panorama, ultimately exposing the fragility of Brazilian democracy while also revealing its necropolitical disposition. Furthermore, I have argued that as part and parcel of the Brazilian racial economy, pervasive violence causes insecurity and fear to haunt local subjectivities and imaginations, eroding a sense of community and hopes for the future. Most importantly, this research has illustrated the diverse ways in which the racial economy of violence in Brazil influence particular dimensions of reproduction, and these ultimately

condition local women's sense of belonging, membership and citizenship as they do their best to 'raise a child.'

These accounts are politically significant. They demonstrate the critical ways in which, as it has been claimed by the reproductive justice movement, questions around reproduction (social and biological) need to fully address structural inequalities. In this way, intersectional oppressions can be challenged and the complexity of necropolitical scenarios can be fully exposed.

Another fundamental finding in this thesis is that racial violence, although it is ever present and transverses the black rural experience, does not define it. I have aimed to describe the multiple ways in which black rural life thrives and unfolds, and how these everyday experiences reject much of what the Brazilian State has repeatedly prescribed for them through concrete individual and community emancipatory projects that invoke a livable future.

To advance this argument in Chapter Five I have attended through rich ethnographic detail to black rural women's socio-political position within their communities in the multiple gendered realms they inhabit, paying particular attention to the way in which life is maintained, reproduced and organised. I have shown how black rural women carve unique spaces in which to exist and foster well-being through diverse networks of care, organisation and leadership. These spaces equally defy racialised and gendered agendas evidencing women's sturdy resistance to oppression. We have seen how these actions are guided by notions such as *ancestralidade* and *memória,* which recall a particular historical experience that both sustains and inspires current emancipatory efforts. The narratives of my interlocutors have illustrated varied conceptions and practices of care. My focus has been on describing how these care practices are interwoven with land, kinship, community, mothering, and birth attendance. These practices have shifted and adjusted in response to wider sociocultural and political contexts, as seen in the examples of *parteiras'* caregiving, the arrival of bureaucratic requirements such recording and registration, and the processes of *epistemicidio* illustrated in this chapter (Chapter Five). Turning ethnographic attention to the various gendered realms in the life of three women (a *parteira,* a rural worker and a grandmother) has allowed us to appreciate reproduction, not solely as a site in which oppression and harm take place, but also as a dimension in which processes of social transformation, emancipation and resistance are negotiated. This has shed light into underexplored aspects of resistance and reproduction in black rural communities in Brazil from an intersectional perspective. Furthermore, this analysis

has equally contributed to debates about the political potential of care by showing how it can be generative of counter-hegemonic and socially transformative practices – in which a sense of belonging and a liveable future are cultivated.

Throughout this thesis, I have endeavoured to present relevant ethnographic material illustrating the creative ways in which black rural women mobilize spiritual, cultural, and legal-administrative resources to grapple with inequality and foster life. However, I have equally tried to identify how interlocking discriminatory spaces marked by gender, race, socioeconomic class and geographic location come to condition access and delivery to maternal healthcare for black rural women. Other authors have emphasized the overt brutality of the Brazilian State (Alves 2018; Smith 2016; Perry 2013) and the abject position that the black population experience in contemporary Brazil. I have given further nuance to this discussion by asserting, as a central tenet of this thesis, that through maternal health care, black rural women are simultaneously included and excluded from a sense of citizenship and belonging revealing a form of quasi-citizenship. Moreover, through the notions of abandonment and precarity, I have offered insights into how State violence penetrates reproductive and maternal healthcare scenarios for black rural women. This has allowed us to perceived the ways in which the State's lethal violence operates at the level of the everyday.

As a result, we see that he constitutional right to healthcare is a critical achievement of Brazilian democracy. Nevertheless, I argue that it also becomes a site where vulnerability and 'ontological precariousness' can be reproduced as colonial residues entangled with neoliberal regimes of governance. As has occurred in other settings in the world, in Brazil "rights have arrived, but justice has not followed" (Unnithan and Pigg 2014, 1181). My fieldwork findings have pointed to the limitations of a democracy that endorses a rhetoric of democratic rights while simultaneously supporting practices that make the black population disposable.

Maternal healthcare and quasi-citizenship

In order to show the intricacies of these contradictions as they manifest in healthcare, in Part II of this thesis I have scrutinised the network and services of public hospitals and small health centres in the rural areas. This has helped to fill a significant gap in the literature on 'birthing while black' outside of urban settings in Brazil, with my analysis furthering understandings of the way in which ethics, political economy and intersectional discriminatory practices manifest in particular practices of care. In Chapter Six, for example, I discussed the delivery of prenatal

care, demonstrating how disciplining women's subjectivities under neoliberal forms of governance morph State abandonment into personal moral responsibility. This takes place in a context in which the requirement to produce metrics through registration and monitoring by strict 'measuring' ends up hijacking the clinical encounter, with counter-productive consequences for black rural women. The chapter also shows how the almost complete disregard for bodily and personal autonomy results in women's bodies being simultaneously hyper-surveilled and neglected. In these processes, female voices are ignored, and they are made to carry the burden of inadequate access to medical technology by paying out of their own pockets for services such as ultrasound scans. This endorses, I argue, a 'bureaucratic form of care' in which the bureaucratic process dominates the clinical consultation while the patient becomes of secondary importance. My analysis on the role of metrics in Brazilian maternity care adds to the literature showing how commitment to numbers has negatively impacted the quality of health care women receive (Brunson and Suh 2020; Oni-Orisan 2016; Adam 2005). By analysing how notions of risk and practices of measuring are deployed in the delivery of prenatal care, I give visibility to some of the processes that reinforce the stigmatisation of black rural women and exacerbate their disenfranchisement. Crucially, these processes often take place while healthcare professionals attempt to contain uncertainty in a context characterized by a lack of medical resources, yet another manifestation of the State's abandonment.

Pointing out resource scarcity is important. In a network characterized by precarity (like the one experienced by my interlocutors), and a biomedical paradigm overreliant on technology, other sources of knowledge are set aside and ignored. Here, I am not only referring to women's embodied knowledge, which is fundamental, but also to forms of knowledge arising from communities' expertise, experience and wisdom. These conditions make preserving dignity in maternity care difficult and contribute to maintaining an elaborate economy of suffering for historically disenfranchised populations. Chapter Seven carefully unpacks some of these issues, navigating the journey of multiple structural inequalities that might lead to maternal death for black rural women in Bahia. Exploring notions of uncertainty and abandonment, I illustrate the shift that takes place from a hyper-surveilled body during the prenatal period to an at-times-neglected, at-times-over-intervened body during childbirth. Under this scheme emerges what I call a 'precarious form of care,' where a fractured biomedical network merge with processes motivating racialised and gendered forms of treatment. This culminates in the embodied experience of *'vergonha'* (shame). Precarious care is part of a larger continuum of precariousness which goes beyond the structure of the health system and rural communities'

material difficulties to encompass a 'precarious existence' that links a colonial past to an alleged 'democratic' present.

These historical continuities coincide with present-day epidemiology outcomes for black populations in the COVID-19 pandemic in Brazil, which are sadly equally corroborated by data on black populations in the USA (Tai et al. 2020) and UK (Kinght et al. 2020). George Canguilhem (1991, 161) famously claimed that each society has "the mortality that suits it" and that statistical profiles of mortality provide evidence about political decisions that shape equality and justice – revealing whose lives count and whose lives do not. Maternal mortality is the most visible face of precarity; it is a failure of the State and a marker of social injustice. These gendered and racial historical injustices become invisible if data is not accurately collected and recorded.

Indeed, this thesis has attended to the tensions that arise due to an imperative to collect quantitative data (see Chapter Six), yet I have been equally concerned with the critical role that quantitative data collection plays and its impact on the visibility and invisibility of particular populations. In doing so, I have called attention to the crucial importance of registering the indicator of race in Brazil, while also considering the challenges and limitations involved in the collection of population data when it is used to reduce vulnerabilities to biological issues, stripped of their political and social dimensions (see Chapter Seven).

Exploring the tension between 'invisibility' (due to systemic negligence), and 'hyper-visibility' (due to control and surveillance), Chapter Eight shows how the gendered tendency for the biomedical gaze to reduce women to their reproductive capacities produces worrying gaps in the provision of care during the postnatal period. We see, for example, how women move from being 'hyper-visible' during the time of pregnancy and childbirth to 'invisible' once the childbearing period has concluded. These gaps are accentuated by intergenerational tensions present in traditional therapeutic practices. Chapter Eight describes, for example, the way in which traditional care therapeutics for postpartum women known as *resguardo* are reinforced by diverse actors, but at the same time are being contested and gradually fading. I argue that in a social setting where vernacular knowledge has been historically dismissed by hegemonical powers, *resguardo* practices reaffirm and anchor a sense of identity and dignity. Ultimately, these matters illustrate the stern resistance black rural populations manifest to processes of subalternisation. However, women's adherence to traditional postnatal care practices is irregular and generates conflicts between younger and senior women. This reveals intergenerational tensions reflecting hierarchies in the passing of vernacular knowledges.

By and large, the analysis and descriptions in this thesis expose the particular techniques, practices, and ideologies that (re)produce national and local regimes of gender and racial domination and highlight their links to a historical past. This is important because it can both help decolonise the forms of governance that structure the health system and illuminate links to other global expressions of gendered anti-Black violence (Alves and Costa Vargas 2020). This research contributes to extend these debates to the realm of maternal healthcare as yet another manifestation of the State's anti-Black violence in the aftermath of slavery.

Overall, I have aimed to unveil the subtleties and undercurrents embedded in everyday practices at the institutional and intersubjective dimensions through the lens of care by approaching care practices at multiple scales and multifaceted angles. By pushing the debate beyond socioeconomic domination, policy and rights in reproduction and healthcare, I have unveiled important questions around the dynamics of structural racial and gender exclusions, violence and oppression in which reproductive health is not divorced from key survival issues.

Reclaiming the future

Much of my research has focused on scrutinizing Brazilian democracy through an investigation of maternal healthcare and reproduction in black rural settings. I have highlighted the social spaces of death (Mbembe 2003) that the State (re)creates and energizes through systemic abandonment (Povinelli 2011) and precarity (Butler 2009). Thus, a constant underlying quest has been to interrogate liberal democracy by illustrating the limitations of discourses of citizenship, rights and policy (however important) when they are coupled with brutal politics that render particular populations 'expendable' (Alves and Costas Vargas 2020), exemplifying "where democracy has lost its claims" (Davis 2005, 122-124).

Nevertheless, this research is ultimately driven by a concern with life and the institutions and practices that sustain it. Through an inquiry into reproduction and care, I have explored the creative manifestations that imagine alternatives and assert the maintenance of life. We have seen how some nurses and doctors exercised their care by breaking through the limitations imposed upon them by the neoliberal logics permeating bureaucratic care. We have also seen how rural women created networks of organisation and support based on their historical experience and ancestral knowledge. These are not just daily routines deployed in order to endure the ordinary while struggling to survive. They are political acts, rooted in the everyday, and they offer new possibilities for a liveable life. Ultimately, birthing matters, when listened

to attentively – as a form of care – may bring with them a transformative potential that can reclaim belonging and the future for/by black rural populations.

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