

ORIGINAL ARTICLE

Extracting vitalities: Cuts in Indigenous women's bodies-territories (Brazil)

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Abstract

In this article, I explore the connections between the medicalization of childbirth and environmental devastation through Guarani-Mbyá understandings of life and the living. I argue that the cuts made to Guarani-Mbyá women's vaginas (episiotomies) in Brazilian hospitals are experienced and situated on the same cosmopolitical level as the cuts made in their ancestral territories by fences that demarcate soybean plantations and cattle ranches. What I call an extractivism of vitalities occurs precisely through both bodies and territories. In exploring this issue, I highlight connections obvious to Indigenous women: Their bodies and territories are inherently linked by vital forces that are shared and modulated through different qualities of relations involving humans and other-than-human beings.

KEYWORDS

extractivism, Indigenous women, nonconsensual episiotomies, South America, vitalities

INTRODUCTION

Pará, a Guarani-Mbyá woman, gave birth to her first child in a public hospital in Southern Brazil. When she arrived at the medical institution, Pará was told by the obstetrician to stop crying and making such a fuss. She was 16 years old, and her mother, Yva, was frightened by the way the medical staff were treating both of them. After a few contractions, Pará felt her vagina being "cut" and could see blood everywhere in the room. Noisy conversations nearby made the environment even more hostile. The baby was born in poor health and was immediately taken to intensive care. Neither Pará, in the delivery room, nor Yva, in the corridor, had any idea what was happening. They were unable to speak to one another. Neither spoke Portuguese fluently, and even if they had been able to understand the hospital staff, nobody attempted to explain what was going on with the newborn baby. A few minutes after

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having her vagina cut, Pará fainted. She woke up alone with a blood transfusion tube in her left arm. There was no sign of her baby or her mother. Pará described this experience to me as a “scene from a horror film.”¹

Kerechu, a young woman, mother to three children, also had her first child in hospital. She would have preferred to give birth in the village, but she had felt “weak.” Furthermore, a medical doctor had previously told her that she should have a hospital birth because she was “at risk as an adolescent.” Fifteen at the time, she asked her husband to call for an ambulance when she started feeling the first contractions. After some hours of waiting and then travelling to the nearest public hospital, Kerechu entered the building, where she quickly gave birth to her baby. Even so, there was still enough time for the male physician who assisted her to perform an episiotomy, or as the Mbyá say, “cut her.” Recalling the hospital birth, Kerechu told me that she had never been the same again. Ever since her vagina was “cut,” she has felt extremely “weak,” and sometimes she is unable to walk for long. She often feels listless and believes that she may become stronger once she eventually stops menstruating.

Episiotomy is not recommended as a routine practice for women having spontaneous vaginal birth. Nonetheless, it is one of the most common surgical interventions in modern obstetrics, despite the absence of scientific evidence to justify the procedure being performed outside of an emergency (Amorim et al., 2017). At the beginning of the 2000s, a comprehensive study revealed that the episiotomy rate in Brazil was 90% (RSE, 2002). This number has been falling due to the “humanization of childbirth” movements (RSE, 2002) but remains higher than the 10% expected by the World Health Organization (WHO, 2018). Across the municipalities of Southern Brazil, where Pará and Kerechu live, episiotomies have been carried out in more than 70% of vaginal births over recent years (Cesar et al., 2022).

Among Guarani-Mbyá women, episiotomy surgery is more than a non-recommended medical intervention. It causes “weakness.” The incisions made to the vaginas of Guarani-Mbyá women affect their body-spirits (*nhe'ê*) and deprive them of the energy they could dedicate to their swidden, basket weaving, childcare and travelling to visit relatives across the vast and geopolitically fragmented Guarani-Mbyá territories in the countries of Argentina, Bolivia, Brazil, Paraguay, and Uruguay. Whilst C-section rates in Brazil are known to be lower among Indigenous women than non-Indigenous women (Souza et al., 2021), episiotomy rates have yet to be studied. Episiotomy is a difficult procedure to transform into statistical data since it is frequently absent from the medical records and, when registered, there is no way of identifying whether the woman “cut” was Indigenous or not. No accurate quantitative data is available and hence an ethnographic approach seems to be the best tool to obtain a picture of what happens to those Indigenous women who end up giving birth in hospitals.

In this article, I explore the connections between the medicalization of childbirth and environmental devastation through Guarani-Mbyá understandings of life and the living. I argue that the cuts made to Guarani-Mbyá women’s vaginas in Brazilian hospitals are experienced and situated on the same cosmopolitical level as the cuts made to their ancestral territories by fences that demarcate soybean plantations and cattle ranches. What I call an extractivism of vitalities occurs precisely through both bodies and territories. In exploring this issue, I highlight connections obvious to Indigenous women: their bodies and territories are inherently linked by vital forces that are shared and modulated through different qualities of relations between humans and other-than-human beings.

“CUTS” BECOMING NUMBERS: ETHNOGRAPHY IN VILLAGES AND IN HOSPITALS

This work began 22 years ago. It is part of a long-term, in-depth, and ongoing ethnography that encompasses and intertwines four generations of Guarani-Mbyá women and my entire career as an anthropologist. The fact that my friends-interlocutors have witnessed my own pregnancies and children growing up has contributed to shaping our relations of trust, conversations and, in the process, my specific research interests. Since my first stays among the Guarani-Mbyá, being a woman and a

mother placed me in a position allowing me to address topics such as menstruation, childbirth, midwifery, seclusion, and everything related to these events. In an earlier text I described that it was while breastfeeding my first child in a Guarani-Mbyá village that the topic of having strong or weak breast milk drew my attention to bodily substances, including their intensities and their transformational capacities (Prates, 2019). Some women had offered to breastfeed my child and, wishing to reciprocate, I said I could also breastfeed theirs. To my naïve surprise, they said no because my breast milk was stronger than theirs and would kill any Guarani-Mbyá children. The other way round, however, was not dangerous and my baby would not suffer any harm if breastfed by them. Breast milk, along with blood and semen (the “blood of the men”), are bodily substances that potentialize relations, strengthening or weakening the person's vitality.

Despite emic understandings of vital forces being central in my ethnography since I began working with the Guarani-Mbyá, the subject of nonconsensual episiotomies has gained emphasis in recent studies, particularly from 2020 onward. This is related to the fact that the institutionalization of childbirth is greatly affecting a new generation of Guarani-Mbyá women, who are the daughters, grandchildren, and great-grandchildren of my old friends-interlocutors. During my long-term stays in the villages, which mainly spanned from 2003 to 2010, most women gave birth or had given birth at home. The privilege of working with them over such a lengthy period has allowed me to follow the unfolding of the intricate relationships between Indigenous and biomedical knowledge, which, depending on the village's configurations, can be either more or less asymmetrical. Being advised to go to hospital is a new biomedical practice that relates to a trend toward classifying young Guarani-Mbyá women as “adolescents,” making their pregnancies fall automatically under the “risk” category, without any other criteria than being less than 19 years old (Prates & Silva Yva Mirim, 2026). Among the Guarani-Mbyá, by contrast, women are considered adults once they menstruate and become pregnant.

Episiotomies and other biomedical interventions experienced by Guarani-Mbyá women in hospitals, such as the vaginal examinations (VE), are a highly sensitive theme. The women are shy and feel ashamed to talk about the “cut” and avoid openly discussing this procedure, even among themselves in accordance with Pará and Jerá. While I was working on the project “Indigenous Peoples Responding to Covid-19” (PARI-c), which encompassed Indigenous persons from various collectives, in 2020, the nonconsensual episiotomies suddenly came to light. Hospital birth was one of the central themes of a case study focused on pregnancy and childbirth during the pandemic (Prates et al., 2022). Among the team, there were a few young Guarani-Mbyá women who, after listening to testimonies from Indigenous belonging to different collectives, felt comfortable sharing that the “cuts” were also an issue for them. However, while Indigenous women from other groups addressed topics such as the necessity to improve the quality of medical care offered in hospitals, the Guarani-Mbyá women questioned the necessity to go to the hospital: “Why do we really need to go to the hospital? Why did any of us ever need to give birth in a hospital?”

I visited my Guarani-Mbyá friends-interlocutors in 2023, and through lengthy and caring conversations on the basis of relations of mutual trust, I checked some data gathered during PARI-c project and gained a deeper understanding of what being “cut” implies. This artisanal work thus ended up providing a statistical overview of the recurrence of episiotomies and of what happens in the everyday life of birthing outside of Indigenous territories. Based on my fieldwork in two different villages, *Teko'a Porã* and *Teko'a Nhamandu*, geographically distant from each other but part of the same kinship network, 90% of Guarani-Mbyá women with whom I talked and who had given birth in hospital in the last 5 years had suffered nonconsensual episiotomies. In these two villages, there are around 65 women with children and a little more than half of this total have given birth in the hospital. Nineteen of the 20 women with whom I talked had been “cut.” Pará once told me that every Guarani-Mbyá woman who goes to hospital to give birth will come back to their village with a “cut vagina.”

Even a few cases of nonconsensual episiotomies among the Guarani-Mbyá would be anthropologically relevant. It is a serious problem for my interlocutors and I am interested in grounded ethnographic theories. By presenting these figures and especially what they entail, I aim to highlight and explore the cosmopolitical relations between bodies and territories. The methodological approach used here is

ethnographic and the data derives mostly from three distinct research projects conducted between 2017 and 2023.² In addition to the research in villages, I also conducted fieldwork in two public hospitals, including semi-structured interviews with 16 health professionals. The research in both institutions lasted nine months and was conducted concomitantly. Among the professionals I interviewed, there were medical doctors, nurses, psychologists, and social workers.

EPISIOTOMIES IN A LIVING WORLD

Episiotomy is the biomedical term for the surgical incision made in the perineal region, located between the woman's vagina and anus, during physiological childbirth. According to the WHO (2018), episiotomies are procedures of restricted use and should only be carried out in very specific situations, such as cases of fetal distress or risk of the mother dying. The procedure shortens labor and is usually performed during the expulsive stage, although it is completely unnecessary in the majority of births. The act of "cutting" the vagina is, moreover, accompanied by the need to suture it afterward. Anthropologists and health professional authors argue that both procedures, when performed routinely, constitute a patriarchal ritual of genital mutilation (Diniz et al., 1998; Kitzinger, 1984).

The cutting of the vaginas of Guarani-Mbyá women marks more than their bodies. When Kerechu tells us that she felt weak and therefore had to give birth in hospital, and that, when giving birth in hospital, she was cut and from then on never felt the same again, she is speaking about her body-spirit (*nhe'è*). She felt pain, a burning sensation in her genitals and for days was unable to walk. This weakening, in the sense of being unable to perform everyday tasks, persisted intensely for many months after the episiotomy. Yet it is encompassed by a more profound weakness in the relations and encounters that allow the strengthening of the Guarani-Mbyá person on this existential plane. Being weakened is not limited to the effect on a self-enclosed biological entity, such as the body as conceived by biomedical logic. When analyzed alongside its etymological meaning, the expression *che py'a kanguy* translates as "I am weak in the viscera/I am weak in the heart." The weakness cited by Indigenous interlocutors thus belongs to the order of embodied affects: to be weak is to be affected by something encompassing, both physical and spiritual.

I describe episiotomies as nonconsensual because all my Guarani-Mbyá interlocutors stated that they had not known they would be "cut." If they expected it might happen, it was because another woman, previously "cut," had warned them of the possibility. Moreover, even if they were or had been asked by the medical team, neither the moment of childbirth nor the colonial language is the appropriate context in which to obtain such consent. An older Guarani-Mbyá woman, who gave birth to her eight children in the village, many of them alone, asked me rhetorically in one of our conversations about the "cuts": Why cut the mother if the baby will come out anyway? It is a pertinent observation since many doctors justify episiotomy as a means of preventing a larger perineal tear. However, research shows that this surgical incision is in the large majority of cases deeper and more extensive than most tears produced by the spontaneous passage of the baby (Diniz & Chacham, 2004; Ramar et al., 2025)

During my conversations with Guarani-Mbyá women about the "cuts," they referred to another serious problem: the countless "touches" (VE) performed during labor in hospitals. As an ancient practice considered by many professionals to be an essential part of reproductive health care in general and childbirth in particular, the vaginal examination has been widely addressed as one of many forms of obstetric violence by critical scholars (Branco et al., 2024; Shabot, 2021). The objective of the "touches" is to assess whether labor is progressing by checking cervical dilation. However, VEs must be avoided and limited as much as possible to prevent adding more pain and discomfort to birthing women and to limit the risk of infection (Moncrieff et al., 2022).

Many public hospitals in Brazil are designated teaching hospitals. This means that medical students are trained in these institutions. When enrolled in gynecology and obstetrics internships, these trainees are required to perform examinations on women patients. Generally, their first consultations are assisted and supervised by university medical professors. In these cases, the vaginas of women users

of Brazil's public health system, including those of Indigenous women, are effectively their practical school.

One of the medical doctors I interviewed during research in public hospitals, a topic that will be addressed later, who was more critical of gynecological care, told me that some of her colleagues performed the vaginal examination just to see whether they had time to have a coffee in the institution's bar or whether the birth would occur during their shift. "There is no medical justification for this. On the contrary, vaginal examination should be minimized to avoid infection," she remarked. She added that although the practice of collective examination had been reduced greatly, it is still common for university medical professors to arrive with two or three students to examine a patient in labor. All the students perform the "touch" examination on the woman—who, we should not forget, is in pain giving birth. After the examination by the students on the same woman, the professor, checking to see whether the students' conclusions are correct, also inserts his or her fingers into the woman's vagina to verify the degree of cervical dilation.

From the viewpoint of the Guarani-Mbyá women wise in the art of caring for others, VE is unnecessary, even unrecommended. The woman in labor must not have their vagina touched and it is unimaginable to cut them. Birthing a person is more than a physiological event among Indigenous peoples. Actions such as raising a baby from the soil or bathing them, as among the Guarani-Mbyá, are what effectively mean giving birth to a human being (Clastres, 1985; Martin, 2026; Prates, 2021). Aside from some massaging of pregnant women's bellies, the women who care and bathe babies only touch a birthing woman with their words and chants and through the tobacco smoke from their pipes.

Episiotomies, vagina suturing and examination, perpetuated over women's bodies during biomedical childbirth, are part of wider patriarchal forces that affect women from different backgrounds globally. It is framed upon gender inequalities and power over birthing bodies (Rich, 1977). Scientific literature from a broad range of disciplines, such as law, social and health sciences, has been examining and categorizing intentional acts of humiliation and disregard for pregnant, in labor and postnatal stage women as obstetric violence. This is considered one of the most expressive ways of how patriarchy operates (Kosi, 2025; Samaritter et al., 2024).

OF VITAL FORCES AND BIRTHING BODIES

The COVID-19 pandemic mobilized Indigenous peoples in general for different reasons, and the Guarani-Mbyá women, particularly, to discuss hospital birth. As the biomedical presence in the everyday life of the villages slowed down and the attendance of biomedical settings was discouraged, some pregnant women who had been advised by health professionals to deliver in a hospital ended up birthing their babies in the villages. Such was the case of Jerá, who had her first two children in the hospital and her third, because of the pandemic, in the village under the care of her mother. For the Guarani-Mbyá with whom I work, COVID-19 was a moment of pause and deep reflection about what it means to live in a perishing world. For a while, they expected the "end of the world" but never doubted that the pandemic was primarily an event targeting the "White" (Juruá) people, who destroy forests and construct many tall buildings. Cities made up of concrete cause hotter soils and increase the potency of the winds. COVID-19 was circulated by strong winds and caused by the anger of other-than-human beings, mainly animals, in revenge on those who killed them without any kind of diplomatic negotiation with their *ija* (protector beings).

When the pandemic reached the world, then, the Guarani-Mbyá strengthened their connections to the divinities to make their body-persons stronger. Praying, singing and dancing in the ceremonial house (*opy*), along with strict attention to what was said, were maximized actions. The fact that they were not severely impacted by the virus and no deaths were registered among the network of kin to whom I have attachments was proof that their vital forces, activated by the relations they were fostering, were strong enough. The "windstorm" created an opportunity to reflect and avoid hospital births.

Among the Indigenous peoples of South America, processes of health, illness and well-being are generally expressed through emic categories of vitality, modulated by notions of strengthening and weakening (Barbira-Freedman, 2026; Nuckolls, 2010; Uzendoski & Calapucha-Tapuy, 2012). Moreover, they operate through registers different to those commonly accessed by biomedical metrics with their ontological separation of bodies from places and other-than-human beings and their emphasis on individual biology. For these peoples, illness and death are never the consequence of “natural causes” but the outcome of treacherous encounters with deceptive beings (Taylor, 2000). A vast literature demonstrates that vitality—or vital forces—despite being manifested under different names, configurations, understandings and intensities among the huge diversity of Indigenous collectives, is always present, animating beings of diverse kinds (Barreto, 2025; Benites, 2018; Conklin, 2001; Santos-Granero, 2019; Stolze-Lima, 2006; Viveiros de Castro, 1996).

Among the Guarani-Mbyá, the term used to refer to the vital force that animates a human person is *nhe'è*. It is the presence and engendering of *nhe'è* in the body, more specifically in the bones, that characterizes “real” humanity (Viveiros de Castro, 1996) and maintains the connection between Guarani-Mbyá people and the divinities. *Nhe'è* is not an essence enveloped by bodily/material flesh. Rather, it is a being that exists, on this plane, through and in relation to a body, strengthened or weakened by relationalities interwoven with substances and encounters between humans and other-than-human beings. It is *nhe'è* that sustains and raises up the Guarani-Mbyá person. Beginning to walk and speak are signs that *nhe'è* has become settled in the child's body, confirming their “real” humanity and distinguishing them from other beings, such as animals. From pregnancy onwards, when the baby's bones begin to form, *nhe'è* starts to be “accustomed” among kin. It is the divinities Nhamandu and Nhandecy Kuery who send *nhe'è* to this plane. The settling of *nhe'è* in a body is a process that, although stabilized in the child's naming ritual, coinciding with the start of walking and speaking, remains susceptible to instability throughout life. Rejoicing (Pissolato, 2007), dancing, walking, drinking “mate” (yerba mate), smoking tobacco and eating foods sent by the divinities are among the essential actions for strengthening *nhe'è*. Illnesses, scares, harsh words and foods considered “dead” (Macedo, 2019), among other factors, weaken *nhe'è* and, consequently, cause the Guarani-Mbyá person to waste away.

All beings that coinhabit this world possess a “spirit.” This is not a privilege of Guarani-Mbyá people. Humanity is the underlying condition of all beings (Barreto, 2025; Viveiros de Castro, 1996). *Nhe'è*, however, constitutes only those persons considered “real” humans, immanent to Nhanderu and Nhandecy Kuery. The *ijá*, in turn, known in the anthropological literature as “owner,” “masters” or “protectors,” are a category of beings that mediate each and every relation between Guarani-Mbyá persons and other-than-human beings (Benites, 2023; Fausto, 2008; Macedo, 2019). Rivers, wind, soil, mountains, animals, plants and certain objects generally possess *ijá*. The “whites” possess *ijá*, too. There also exist the shadows or “spirits” of the dead, which threaten the existence of the living. The world in which my interlocutors live is a living world, and the concept of the “inanimate” has no relevance within the Guarani-Mbyá cosmos. The pandemic, as earlier mention, made all these relations explicit.

Guarani-Mbyá women's bodies are made and constituted gradually by the relations and vitalities of other-than-human beings. Here the *ijá* play an important role. Long before girls have their first menstruation, a direct investment is undertaken. Animal greases, such as those found in the common opossum, are rubbed on the lumbar region of young women with the intention of facilitating labor in the future. Since the Guarani-Mbyá attribute this animal with the capacity to give birth without pain and difficulty, its grease acts as a substance vitality that enhances Guarani-Mbyá bodies (Prates, 2021). For this to be successful, however, it is necessary to negotiate with the protector of the opossum collective, the *mbykuré ija*. There is no extraction of vitality without permission. Diplomacy must be used to constitute a Guarani-Mbyá humanity that, even while it differentiates itself from the other beings with whom it coinhabits the world, also depends on them to constitute itself as such.

It is these kinds of relations that potentialize and strengthen Guarani-Mbyá women's ability to know what to do and how to bring a child into this world. In their understanding, no touch or intervention is necessary. What the woman birthing needs is observation, attention and counselling since her body

has long been prepared for this moment. Odor and noise must be avoided so that they do not become vehicles for the intentions of predators seeking to cause disease or even the death of the woman or baby. Blood from childbirth attracts other-than-human beings through its scent and when it drips onto the ground, it must be covered immediately with ashes.³ Fire ashes, like the pipe's smoke, are the antithetical element of blood.

THE DIRTINESS OF HOSPITAL CHILDBIRTH

Obtaining data on episiotomies was not among the objectives of my ethnographic fieldwork in hospitals, conducted between 2017 and 2018. During this study, I had no idea that this particular surgical procedure was a problem for Guarani-Mbyá women, and I was even less aware of how often it happened. Furthermore, from the interviews with health professionals, I had wrongly assumed that Indigenous women did not receive many interventions during birth. Medical doctors and nurses very often emphasized, with some enthusiasm, how "Indigenous women know how to birth." They mentioned that they even "allowed" them to squat to deliver, explaining these were patients who acted "instinctively." After a young Guarani-Mbyá mentioned the "cut" during the COVID-19 research, however, 2 years after concluding the hospital ethnography, I decided to revisit my field notes and recorded interviews.

Episiotomies were only mentioned once, tangentially, merely to highlight the main "problem" of assisting Guarani-Mbyá births in hospitals: hygiene. Revisiting this material made me realize that while I had attempted to explore themes such as the presence of a companion and the need for special diets that accommodate Indigenous women's avoidance of meat, salt, and fat in the weeks following childbirth, the hygiene issue kept cropping up in the conversations. According to them, the Guarani-Mbyá women were sent for a shower as soon as they arrived at the hospital. This was presented to me as a criterion for admission. Two interlocutors—a nurse and a social worker—told me the following:

The smoke ... the women turn up here with their hair reeking of smoke. The staff don't like it. So we ask them to take a shower. There's also the matter of their feet: really dirty feet that the women place on the sofa. They don't sit on the sofa like we do. Many of the women squat on the sofa. It's tricky. It's a lack of hygiene, and we have to tell them that
(Nurse)

Very often they have lice. That was another issue that often caused problems because they would recommend that the mother [the Indigenous woman in labour] use a cap when she entered the maternity ward. Frequently, they didn't understand why they had to use the cap, and this situation would develop in a way that had to be managed differently, and the entire team became involved. They [the Indigenous women] have a real communication problem, you know? They don't speak Portuguese. So how do we get them to take a shower or agree to wear a cap over their hair? It's not just the hospital staff who complain; it's the other women patients too. So it's a nuisance. (Social Worker)

For the Guarani-Mbyá, pipe smoke⁴ is a protective element that enhances their connection with the divinities. It provides the means to protect oneself from beings that try to capture the human condition. The vitalities emanating from the tobacco smoke are essential to strengthen the person during childbirth. Indigenous women have their heads protected with blown tobacco smoke just before getting into the car or ambulance that will take them to hospital. Imagine going from being protected in the village to facing the hostile hospital environment, and, on arrival, being obliged to take a shower. There is no "health" without tobacco for the Guarani-Mbyá. The women's "dirty" feet, for their part, are "dirty" from soil. Guarani-Mbyá women are accustomed to walking barefoot in their villages and,

for them, the soil is not dirty. As for the lice, if someone has them, there is someone else to pick. Lice are not a sign of dirtiness for Indigenous interlocutors.

The only time nonconsensual episiotomies were mentioned during the interviews was as a pretext to remark—once again—on the alleged lack of hygiene of the Guarani-Mbyá women.

They don't speak much, do they? They bow their heads; you try to explain what they have to do but sometimes I don't know if they pay any attention. They're always silent. And they arrive "smoked", you know, like we say. From the viewpoint of hygiene and disease, there's no problem smelling of smoke. But it bothers us. Something that causes repeated problems is the episiotomy cut getting infected because they don't take proper care of themselves, they don't wash the cut thoroughly and it becomes infected. So they're discharged from the hospital but sometimes have to take antibiotics in the village. Sometimes we already give them antibiotics to take away because we know the cut will get infected. (Medical Doctor)

The interlocutor cites episiotomy not to reflect on the procedure as a necessity or, conversely, an unnecessary form of medical intervention, but rather to hold Guarani-Mbyá women responsible for their lack of "proper care of themselves." On the basis of what this medical doctor stated, though, we can infer that episiotomy is a standard surgical procedure performed during childbirth. Infection is thus the consequence of an unnecessary "cut." The main issues for the Guarani-Mbyá women are the "cut," the "touches," the noisy environment and the disregard of their need to follow food restrictions after birth. For the health professionals, in turn, the main issue involved in assisting Guarani-Mbyá childbirth is the mother's "dirtiness."

The knowledge of birthing, transmitted from generation to generation, embodied and highly valued by Guarani-Mbyá people, is considered by Indigenous interlocutors to be an important force in their *reko* (mode of living). The pertinent question, therefore, is why, with all this ancestral wisdom and the constant complaints about what happens in hospitals, do some women still give birth in these alien places?

CUT TERRITORIES

Yvy Rupa, the ground on which we currently tread, originally had no fences according to the Guarani-Mbyá. My interlocutors say that "cutting the land" (*yvykyty*) is a practice of the "whites," who do not respect the *ija* and do not know how to live together with others. "They are petty and want the land just for themselves," the shamans often say. Wicker (1990) also recorded this emic category of *yvykyty* among the Guarani people living in Paraguay some decades ago. Most of the Guarani-Mbyá territories in southern Brazil are today surrounded by soybean plantations and cattle ranches. Their own territories have fences on their borders, as do all lands that surround them.

Living on small islands amid the monochromatic green and fenced tracts of farmland, the streams that flow through their villages are contaminated by pesticides and other pollutants. Moreover, little or no planting on their own is possible. Maize, manioc and sweet potatoes, among other vegetables, are essential to strengthen the Guarani-Mbyá person and are gifts sent by divinities. Last time I visited Yva, she remarked sadly that "swiddens are getting weak, then our bodies too." She speaks of a world that needs to be alive, with a diversity of relations, for it to be strong. This is not just a question of poor nutrition and low immunity in biomedical terms. Yva draws attention to the coexistence and connections between habit-abilities (Garcia, 2010) involving humans and other-than-human beings, including the divinities. Edible plants such as maize are crucial to maintain Guarani-Mbyá strength and essential to the ritual performance that reveals children's names, the *nhemongarai*. Their names are their *nhe'è*.

Several variables contribute to determining whether a birth takes place in a hospital or a village. Among them seems to be the extraction of the vitalities that keep alive both people's bodies and the bodies of the territory and other-than-human beings. An extractive process that causes environmental-territorial devastation has made a huge impact on the medicalization of Indigenous women's lives. "Midwives are disappearing," people say, and this is a major concern for my interlocutors. Those who bathe babies are not trained overnight (Prates, 2023). They must have a deep knowledge of plants, herbs and cosmological aspects in order to care for other women during childbirth. In addition to the role that intergenerational knowledge transmission plays in everyday life, "midwives" are women who have birthed babies themselves, alone or with the help of close relatives. Not in hospitals. With very small forests or none at all, just a few swiddens and villages located close to urban centers, with all the problems this entails, including "dead food," remaining strong has proven challenging.

Guarani-Mbyá women also attribute the weakness of the younger women to injectable contraceptives. Until fairly recently, a specific tree bark was used to prevent conception and end an unwanted pregnancy. Today, this tree is rarely found. Moreover, this is not a medicine that can be given just once. It needs to be taken repeatedly if pregnancy is to be avoided or to force the woman's menstruation to descend. Only a few women know how to prepare this remedy since it is not simply a matter of finding the tree and removing the bark. You have to know the right chant and words for the tree to allow some of its bark to be turned into medicine. As we saw earlier, it is important to negotiate with protective beings (*ijá*). Otherwise, if the bark is extracted without permission, it may even kill the person who takes the remedy. The tree *ijá* will take revenge. If there is no one with the wisdom to negotiate with the protective spirit over the capture of the vitality, or indeed if the tree itself no longer exists, then the young women need to resort to injectable hormones. Pará told me that hormonal contraceptives make women swell up. Their bodies become hot, filled with accumulated blood and fat in their flesh. As she explained to me what happens to women's bodies, Yva drew an analogy between contraceptives and the pesticides dumped in the rivers. She says both cause swelling. At first, they seem to make everything stronger and hotter, but over time, the person weakens and their joy is killed. The same happens to rivers, which end up becoming extremely ill.

The different factors that weaken some women and lead them to go to hospital can develop into another affliction, sometimes even more pronounced, namely the weakness caused by "cuts" (episiotomies) and "touches" (VEs). Most women go to the hospital because they or those who could care for them are feeling weak. However, they end up coming back from the hospital with their vaginas cut. There seems to be no way out.

SWIDDENS AND CHILDREN

The two villages I am discussing are located close to major federal highways in Brazil. Among my interlocutors, there is an ambivalent understanding that living near roads is good but also a source of many of their problems. Villages with easy access are better assisted by government provisions and living there facilitates travelling to visit relatives and to the markets where artisanal work such as baskets, bracelets and small wooden crafted animals can be sold. On the other hand, it is due to this "easy access" that the Guarani-Mbyá are more exposed to the way the "whites" live. The underlying cause of villages being situated close to major highways, at least the two villages I address here, is the impossibility of occupying their ancestral territories, located in rural areas. Most of these territories were transformed into huge plantations or farms, and a few became designated "natural reserves." Guarani-Mbyá have been occupying other territories recognized by them as ancestral too, situated near cities, but whose environmental conditions are poor. The colonial settlers have extracted all they could from the vitalities of other-than-human beings. These recovered lands, however, are usually not under judicial dispute. And this fact, in turn, is highly valued by the Guarani-Mbyá, who avoid confrontation with the "whites" as much as they can.

In one of these villages, *Teko'à Porã*, 60 people live on 7 hectares of land. The only stream that flows nearby seems to be entirely contaminated by pesticides, its waters cloudy white and tasting strongly of chemicals. It is in this polluted water that women and children very often wash their clothes and cool off on hot days. Water for bathing, drinking and cooking is brought weekly by the city council. But some weeks the water does not arrive. Most of the Guarani-Mbyá women living in the village give birth in medical settings. Over the last 5 years, there were at least 15 women who had a child in hospital and 14 of the women were “cut.” According to Kerechu, their bodies are “no longer the same.” If we compare this village with another located relatively far from an urban center, yet close to a major highway, there are some clear differences.

Teko'à Nhamandu, unlike *Teko'à Porã*, has around 200 hectares and is inhabited by approximately 45 people. Although surrounded by soybean monocrops and beef cattle farming too, the Guarani-Mbyá living there have been able to plant maize and other vegetables. The spiritual and political leader, Yva, is a recognized wise woman and knows how to care for childbirth. Six births, half of the total number, have taken place in the village over the past five years. The other six took place in the hospital, and four women were “cut,” while the other two had C-sections. In addition to swiddens, there are also some wild animals, such as capybara (*Hydrochoerus hydrochaeris*), deer (*Ozotoceros bezoarticus*), and armadillo (*Dasypus hybridus*), which enter the Indigenous territory and are sometimes captured. The presence of these animals is a sign that the divinities are looking after the collective. In both villages, the Brazilian Special Secretariat of Indigenous Health (SESAI) undertakes health care visits monthly. Although biomedical care is provided in equal fashion, births are much more frequent in *Teko'à Nhamandu*. According to Yva, Pará, and Kerechu, the bodies and territory of this *Teko'à* are stronger than those of *Teko'à Porã*. The difference between them lies in the size of the territory, the possibility of planting crops and the existence of ‘midwives.’ The relations and good encounters that strengthen body-spirits (*nhe'è*) and territories alike are alive and pulsating in Nhamandu.

Yva Rupa, the ground on which we all step, was created by the divinities; piercing and taking off its skin weakens Guarani-Mbyá existence on this plane. When swiddens are prepared and births take place in the village, however, the connections with Nhanderu and Nhandecy Kuery (the divinities) are strengthened. Burying the placenta in the soil while it is still warm protects the newborn and close relatives from deceptive beings. It also fertilizes the ground and nourishes the intrinsic relations between Guarani-Mbyá bodies and their territories—and consequently with the divinities. Swiddens that grow strongly and yield *porã* food—a term with the moral connotation of good/beautiful – nourish both people and soil. *Teko'à*, a term commonly translated as “village,” including in this article, is more than a territory: it is an existential space that unites the conditions for living in immanence with the divinities. Cultivating swiddens and raising children in a *teko'à* are profoundly significant actions that contrast with the weakening of relations inherent to the existence and proximity with the “whites.”

FINAL CONSIDERATIONS

Territories around the world are valued in terms of what they can supply to the economic market. A rich bibliography on extractivism and neo-extractivism has addressed this issue in relation to Indigenous peoples in South America (Ødegaard & Rivera, 2019). The political concept of body-territory has emerged primarily from Indigenous women's movements opposed to extractive practices like mining. To cite some examples, in 2016, the Women's Earth Alliance (WEA), in collaboration with the Native Youth Sexual Health Network (NYSHN), both based in North America, published an important report entitled *Violence on the Land, Violence on our Bodies: Building an Indigenous Response to Environmental Violence*. The study looked to demonstrate how extractive industries have engaged in environmental violence, leading to the chemical exposure of bodies and territories, as well as domestic violence, drug and alcohol abuse, murders and disappearances, and sexually transmitted diseases. In Central and South America, for their part, representatives of Indigenous community feminism such

as Julieta Paredes (2010) and Lorena Cabnal (2019) have deepened the equivalence between body and territory, based on a counter-colonial critique (Bispo & Pereira, 2023) of the anthropocentric ideas of property and the individual. All these initiatives have resonated strongly with organized Indigenous women's movements in Brazil, such as the Indigenous women's March (*Marcha das Mulheres Indígenas*), which takes place on a triennial basis. Guarani-Mbyá women have been timidly starting to join this initiative.

The extractivism to which I refer, although set against the broader backdrop of the political discourse of the body-territory, draws on Guarani-Mbyá notions of vitality. One of the main intended contributions of this article is to broaden the conceptualization of extractivism, highlighting the connections between bodies and territories from rooted lived experiences. Moreover, the choice of the term extractivism is not coincidental. Extractivism is the action of taking away by force, without permission, and is widely employed in the literature on territorial and environmental exploitation. However, it is not typically used to address Indigenous bodies and hospital births. Highlighting the feedback loop between extracting what the soil can provide to fuel the capitalist economy and what women's bodies can birth, no matter what the cost, makes visible the existential conditions that weaken Guarani-Mbyá women.

At least two kinds of extraction seem to be happening in this circle: one directed toward the vitalities that animate humans and other-than-human beings on a macroscale, perpetrated through practices involving the extraction of "natural resources," including animals and plants, and the scarring of the land through fences and pollution; and another, on a microscale, focused explicitly on Indigenous women's bodies during birth. In this sense, to examine what occurs in hospitals solely in terms of obstetric violence without considering what leads Guarani-Mbyá women to use these institutions—even though they would prefer to give birth in the village—would be to disregard asymmetries and reinforce a colonial framework that perpetuates inequalities. Nonconsensual episiotomies are among the consequences of the territorial damage that for centuries has made Indigenous modes of caring difficult or even impossible. This is accompanied by the epistemicide of Guarani-Mbyá midwifery knowledge, which contributes to perpetuating and aggravating the situation over the long term.

The "cuts" made in the vaginas of Guarani-Mbyá women have to be understood within the framework of relationalities and modulations between strengthening and causing to waste away, driven by extractive actions on the life of a world that is itself alive. To expose what takes place in hospitals without imagining and considering non-medicalized methods of giving birth is to fail to take seriously the roots of a structural problem, one that creates dependencies on a health system that reinforces conditions of vulnerability. Episiotomies are part of what the "white" way of life imposes on Guarani-Mbyá women. It is no coincidence that they are always referred to as *cortes* (cuts) in the colonial Portuguese language, even when the conversation is taking place in Guarani. Such cuts inscribe within their flesh broader relations of weakening.

Guarani-Mbyá midwifery practices are diffused in the social fabric. This is an embodied knowledge and most women who have given birth in villages would feel confident to care for others. As happens among most of the Indigenous peoples of lowland South America, there is no such figure as "midwife" (Barra, 2022; Dumont et al., 2026). This term has arrived with colonial contact and the process of medicalizing childbirth. In recent decades, there have been more and more initiatives designed to "train" Indigenous midwives to meet the standard biomedical criteria of birthing care. The Guarani-Mbyá I know that care for childbirths do not mind being called midwives; however, they dislike any training offered to them.

Recognizing Indigenous midwives as part of the SESAI may be a good way forward. However, there is no consensus among the Guarani-Mbyá about this being the best solution to avoid hospital births. To address childbirth care, it is crucial to take into consideration a network of human and other-than-human relations and make visible connections that are commonly fragmented between places, bodies, living beings and immaterial things. Placing the extraction from territories and bodies on the same level, through macro- and microscales grasped from caring ethnographies, contributes, I hope, to addressing Indigenous women's struggles in their own terms.

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CONFLICTS OF INTEREST STATEMENT

The author declares no conflicts of interest.

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ENDNOTES

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³Belaunde (2005) and Colpron (2006) have explored the role that blood plays in Indigenous cosmologies.

⁴A clay or wooden container filled with tobacco, called *petyngua* in Guarani.

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