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Women and traditional knowledge in health care: understanding traditional healing practices in Brazil

Mulheres e seus saberes no cuidado à saúde: compreendendo as práticas populares de cura no Brasil

Las mujeres y sus conocimientos en salud: comprender las prácticas de curación populares en Brasil

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Abstract *Several international agreements acknowledge public participation, equity, and democracy as necessary conditions to achieve Health Promotion. For this purpose, if we accept the validity of distinct systems of knowledge, we realize the relevance of an approach to healthcare based on a pluralist epistemology, which sustains the legitimacy of traditional knowledge in its own processes of production, transmission, and application. In this study, we aim to investigate the notions and understandings of traditional healing practices in a city near Curitiba, in Southern Brazil. A qualitative sociological approach was adopted, incorporating semi-structured interviews, participant observation, and Discourse Analysis of female practitioners. In addition, we want to understand the social function of these practices in contrast with biomedicine-based operations of Health Care Networks in the Brazilian Unified Health System (SUS). We observed that the role of women is central in these practices, who are responsible for their application and transmission. And the knowledge developed through these healing practices engenders a particular view about family and society. Therefore, these women are empowered by increasing their symbolic capital through their knowledge of health care.*
Key words *Medical Anthropology, Religion and Science, Primary Health Care*

Resumo *Neste estudo, buscou-se compreender o papel e a função social das práticas de mulheres benzedeiras, raizeiras, erveiras, rezadeiras, curandeiras, parteiras em sua relação com a biomedicina, e mais detidamente com as Redes de Atenção à Saúde (RAS) do Sistema Único de Saúde (SUS). Trata-se de pesquisa sociológica qualitativa por meio de entrevistas semiestruturadas, observação participante e análise do discurso de mulheres que utilizam práticas de cura para a comunidade em um município da região metropolitana de Curitiba. Os resultados possibilitam perceber que há um distanciamento entre as práticas populares de cura com o avanço da atenção à saúde biomédica, e que o declínio destes saberes populares parece ter ocorrido no processo da modernidade com o apogeu da técnica e da biomedicina. Amplia-se ainda a relevância das vozes femininas, que são representantes ativas nos cuidados à saúde, dominando técnicas, práticas e saberes que historicamente lhes conferiram prestígio social ou mesmo identidade comunitária. Identificar as mulheres que fazem práticas de cura e ouvir suas interpretações sobre o modelo de atenção à saúde institucionalizado conduz à perspectiva da participação popular na essência democrática da promoção da saúde.*
Palavras-chave *Antropologia Médica, Religião e Ciência, Atenção Primária à Saúde*

Resumen *Este estudio tuvo como objetivo comprender el papel y la función social de las prácticas de las mujeres curanderas, herbolarias, curanderas de oración y parteras en su relación con la biomedicina, y en mayor detalle con las Redes de Atención a la Salud (RAS) del Sistema Único de Salud (SUS) brasileño. Se trata de una investigación sociológica cualitativa mediante entrevistas semiestructuradas, observación participante y análisis del discurso de mujeres que utilizan prácticas de curación para la comunidad en un municipio de la región metropolitana de Curitiba. Los resultados permiten percibir que existe una brecha entre las prácticas de curación popular con el avance de la atención biomédica en salud, y que la decadencia de este conocimiento popular parece haber ocurrido en el proceso de modernidad con el apogeo de la tecnología y la biomedicina. También está aumentando la relevancia de las voces femeninas, que son representantes activas en el cuidado de salud, dominando técnicas, prácticas y conocimientos que históricamente les han dado prestigio social o incluso identidad comunitaria. Identificar a las mujeres que realizan prácticas de curación y escuchar sus interpretaciones sobre el modelo institucionalizado de atención de salud conduce a la perspectiva de una participación popular en la esencia democrática de la promoción de la salud.*
Palabras clave *Antropología Médica, Religión y Ciencia, Atención Primaria de Salud*

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Introduction

Several international agreements, such as the Declaration of Alma-Ata (1978), the Ottawa Charter (1986), the Sundsvall Statement (1991), the Declaration of Mexico (2000), the Declaration of Santafé de Bogota (1992), and the Jakarta Declaration (1997), acknowledge public participation, equity, and democracy as necessary conditions to achieve Health Promotion (HP). The Ottawa Charter, for example, includes public participation as a cornerstone of HP: "Health promotion is the process of enabling people to increase control over, and to improve, their health"[1] (p.1). The Declaration of Alma-Ata also emphasizes that "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care[1]. The Declaration of Santafé de Bogotá advocates that, for the development of health care, one of the key values is to encourage "[...] dialogue between different cultures, so that the process of health development is incorporated into the whole cultural heritage of the region"[1] (p.4).

Given the relevance of public participation, equity, and democracy for HP, traditional knowledge and traditional healing practices and how they coexist with techno-scientific knowledge should be considered. Promoting a dialogue between these types of knowledge is, for example, one of the goals of Brazil's National Policy of Popular Education in Health (PNEPS-SUS), which understands HP as a field of knowledge and practice to promote quality of life[2]. Moreover, PNEPS-SUS requires the use of resources from different areas to promote this dialogue, based on a wide perception of the health-disease process and its determinants[3].

When seeking an active participation in HP, it is essential that popular health education activities are based on dialogue, emancipation, solidarity, partnership building, co-responsibility, and individual and collective politicization[4]. Since these educational activities seek to encourage public participation, it is important to adopt a methodology that recognizes the diversity of knowledge. The same idea is described in the guidelines of the Brazilian Unified Health System's (SUS) National Health Promotion Policy, which state that traditional knowledge should be considered when planning HP programs. Also, these programs should favor participative methodologies that engage everyone implicated by SUS (health professionals, managers, and users)[5].

Tesser recognizes, however, that these knowledges, techniques, and practices often undergo a process of scientification and commodification that breaks them down into isolated specialties and detaches them from their cultural background and traditional rationality[4]. Thus, Olivé[6] states that it is essential to preserve, promote, and value traditional knowledge in its roots.

Scientification and commodification are features of biomedicine, which is a science defined as a logical system structured around medical principles, as well as a particular conception of the health-disease process, diagnosis system and therapeutic intervention[7]. The partition of biomedicine into several specialties leads to mechanization, technicization, and a fragmented conception of the body. As a result, it makes subjective aspects of the disease invisible, since it is difficult to point them out on the body and measure them according to biochemical standards and conventional diagnoses[8,9]. So, Olivé[6] argues for an approach based on a pluralist epistemology, which recognizes different conditions for valid knowledge, thus supporting the legitimacy of traditional knowledge in its own processes of production, transmission, and application. Therefore, traditional healing practices can be defined as a form of traditional and interdisciplinary knowledge that is spontaneously reproduced in everyday life[10].

Traditional healing practices hold long-experienced knowledge that is lived out on a daily basis. Preserving this knowledge over time requires a lot of dedication and long periods of observation of nature, since it is most often carried out through conscious and unconscious mechanisms that are passed on through rituals[11,12]. If we want to understand them, the individuals who own these traditions need to be heard in order to "dig out the remnants and heirs [...] of these practices, practitioners, traditions, rationalities. Such heirs and such practices (rare as they may be, and for that very reason) deserve to be preserved and fostered"[4] (p.1741).

Moreover, a focus on gender is inescapable in this case, since women play a key role in HP, which is also supported by international agreements. The Adelaide Statement (1998), for example, highlights women's right to self-determination and to formulate public health and cultural conservation policies. The Sundsvall Statement (1991) breaks new ground by declaring the need to include women's skills and knowledge in all processes, including the formulation of health-related public policies[1].

Borges recognizes that the healing practices performed by women contribute to establishing social bonding and are associated with the community's desires, knowledge, and concerns[11]. In addition, caregiving would be implicitly considered as innate to women, since it is a practice historically related to them[13]. Machado[14] supports this statement by noting that traditional healing practices are most often a specialty of women, who master the secrecy of words and gestures, the attention to rites, the natural disposition to giving, and the affinity for offerings. The body of knowledge developed by women in the performance of health care engenders a particular feminine view about family and society. Also, these women are empowered by increasing their symbolic capital through their knowledge[13].

Therefore, this study focuses on women who perform healing practices for the community in Colombo, a city in the metropolitan area of Curitiba, Paraná, Southern Brazil. We aim to investigate the social function of these practices, observing the diversity in their notions and understandings. We also want to understand their relationship with biomedicine, represented by the Health Care Networks (RAS) of SUS.

Methodology

This sociological research adopted a social qualitative approach and aimed to investigate the traditional healing practices of women in *benzedeiras and rezadeiras* (women who use both word and gesture to perform healing); *erveiras*, *raizeiras*, and *curandeiras* (women who perform healing by using medicinal plants); *parteiras and cuidadora*s (women who help in childbirth). We also seek to understand if and how these women, owners of traditional knowledge and healing practices, establish a relationship between their knowledge and the RAS, defined by Decree No. 4,279/2010 as "[...] organizational arrangements of health actions and services, of different technological densities, which seek to ensure, through technical support, logistics and management systems, the entirety of health care"[15]. Hence, we employed semi-structured interviews and participant observation in a sociological field study.

The study was conducted in a city with a population of 249,277 (2021) and a land area of 197,793 km². Its Human Development Index (HDI) is 0.733, indicative of a high level of development. In 2020, the average infant mortality rate was 8.21 deaths per 1,000 live births, and hospitalization rate for diarrhea was 0.4 for every 1,000 inhabitants[16]. There are 134 health facilities, 26 of which are primary health care units[16].

To begin the study, we mapped the territory linked to one of the city's Healthcare Units and identified potential participants with the help of community health workers. After the first three interviews with women who define themselves as practitioners of traditional healing practices, these participants recommended other women with similar profiles to be part of the investigated group. Then, we followed a non-probability sampling known as "snowball", until we reached data saturation[17,18]. We reached a total of six women to be interviewed. Four of them were *benzedeiras* and two of them were healers that used medicinal plants for their practice (*curandeiras*).

The interviews were conducted in their homes, which were also where the healing practices took place. This made it possible not only to carefully observe the composition of these spaces, but also to conduct the interviews at the place of health care itself. The sociological analysis of the interview content was conducted using Discourse Analysis, with these interpretations supported by participant observation. The study was approved by the Human Research Ethics Committee of the Federal University of Paraná, opinion 1.938.031.

Results and discussion

The healing practices are manifold, as well as their meaning to the women who practice them. Also, there are multiple ways to become *benzedeiras*, *rezadeiras*, or *curandeiras*. Among the study's participants, two of them were Catholic and affirmed they have been granted what they call a "divine gift". Thus, they would have an obligation to help others by welcoming and healing everyone who comes to them. The participants claimed that their gift also manifests itself through divine intuitions, allowing them to practice the art of healing through prayers and invocations to the sacred figures of Catholicism. It is noteworthy that an older, more experienced *benzedeira* can pass down her knowledge to another woman of her choice, granting the gift to someone else. From this perspective, the practice of *benzeção* (blessing) is intrinsically linked to the existence of a gift that guarantees the learning of healing practices, whether by su-

pernatural means or by the oral transmission of knowledge[19,20].

Two other *benzedeiras* also attribute their knowledge to the divine, associating them with Spiritism and Umbanda. These traditions emphasize the incorporation of spiritual entities, which are responsible for the healing. However, healing can still be performed without it; when that happens, healers perform the healing themselves, following the teachings of the religion. It is worth noting that Umbanda, a Brazilian religion influenced by different social and religious groups (African, Catholic, Kardecist, and indigenous), traditionally uses leaves and herbs in rituals of *benzeção*, smoking, and other healing procedures, such as the indication of teas and baths to "protect the soul" and cure to ailments that are not of a physical nature. The leaders of the *terreiros*, commonly called *pais* or *mães-de-santo*, as well as those initiated in the religion, learn about the power of plants to cure different illnesses, and about other elements that are considered sacred[21].

The other two women interviewed perform healing practices with elements of nature but do not associate them to a religion. They associate their practices with learning inherited from the native peoples instead, with an emphasis on the intergenerational nature of this knowledge, which is transmitted by their grandmothers and mothers through oral tradition.

Therefore, the origin of these knowledges is evidently quite diverse, marked by unique life trajectories, intergenerational exchanges, and different social contexts. There is no pattern in either the form or content of learning. The knowledge linked to the elements of nature, for instance, can be transmitted intergenerationally among women of the same family, but it can also be incorporated by means of a divine gift, as Catholic healers claim. On the other hand, the women healers linked to Spiritism, and especially to Umbanda, affirm that the spiritual entities are the ones who provide the prescriptions, but that their practices can be enriched through collective experiences with other women in Umbanda circles. Thus, an interconnection between the knowledge attributed to the "divine" gift and the socially transmitted knowledge can be noted, which, in turn, allows for a certain fluidity of content that can circulate through different religious or cultural contexts.

Regarding the social transmission of knowledge and practices, the female bias is striking in our study reports, showing the influence of gender. The knowledge about healing practices is related to motherhood and care, activities that are socially associated with the female universe. Furthermore, a tendency to essentialize cultural characteristics linked to women to talk about their natural aptitude for this type of practice has been observed[13].

I've met women all the time, I've never seen any man pray, not these things of blessing, I've only seen evangelicals, who come to pray for us, but evangelicals, right, Catholics, who do something, men I've never seen. [...] Because women are weaker, they feel sorrier for people, right? I think women have a softer heart [laughs] I think so, a softer heart, right? (I3).

[It is] More [often] women [...] They understand more, they are interested in having their children cured, and the fathers don't care, they want to work (I4).

I inherited [the knowledge on healing practices] from my grandmother [...] My father, who is her son, was never interested in this. [...] it was passed among women and that caught on, right, women, because I do not think men are interested in this [...] women have more... how can I put it... gift, right! Maternal gift, gift of charity, gift of wanting to help. Men are more technical; women have more patience (I6).

Within this scope, we observed that the women who participated in the study were aware that the trajectory or stance of their husbands directly influenced their healing practices. Domestic conflicts arising from their partners' alcohol dependence or the fear that they would seek financial independence by leaving home to work were cited as determining elements for the development and evolution of healing practices in the social context researched.

They said, when I got older, I was going to be a good "benzedeira", and I really was! But I started after my husband was treated for drinking, he drank a lot, so I lost twelve years of cachaça with him [...] then after he stopped for good, that's when I started to tend to people at home (I1).

[On refusing an opportunity to work with a doctor, with a signed contract, officially working as a midwife]: *I said no... I don't think so...my husband won't like it* (I4).

Another relevant aspect is the non-standardization of care. Each individual who is cared for receives a prayer, guidance, or prescription according to their specific needs, which makes for personalized care. These practices include massages, teas, herbal preparations, *garrafadas*, syrups, application of burning coals, *benzeduras*, prayers and recitations, sewing on cloth, sympathies, herbal baths, water glass, plant ex-

tracts or animal horns, rock salt, mother's milk, rituals based on the lunar cycle, or even guided by what they call "intuition".

I do, yield sewing, in a little white cloth with a needle and white thread [...] [we] do the sewing and the praying, and as it [the cloth] forms, it is a rip or twist, it does this right here, forms into a knot (I1).

[On a sympathy for kidney stone removal] *It's a meter and a half of tape, then you do it, measure the person's back, then it comes to us on the spot, the way to do it, do the prayer* (I1).

Then they sit here, I pray "Our Father, Hail Mary, Holy Mary", then they show me everything they already have, they show me before I lay my hands on them [...] They show me if it's something spiritual, if it's something spiritual bad, they give me a sign, if it's a disease, if it's pain, where the pain is in the person, they show me before I lay my hand on them! Then I start praying, I put my hand like this, I pray "Our Father, Hail Mary, Holy Mary and our protection is in the name of the Lord" and then I finish, bless the person, if it's for me to do massage, I say "you need massage" and explain where the problems are, they say: "that's right, exactly what you said' (I2).

There is a plant, which is like this, a little flower, which is very plump, that when the child has earache, you heat it, this little plant, it extracts a bit of water, juice, you put it on a spoon and drip it in the ear. Breast milk too, you can put it in your eye, you can put it in your ear, it cleans the eye, it clears up, it gets that cream out of the eye. Arruda [equivalent to rue], you let it sit in the dew, a branch of rue in clean water, inside the glass in the dew, and the next day you wash all the time with that rue, the eye, because it "dews", then that dew is good for cleaning (I5).

You must do nine remedy baths, all home remedies. You have to do the bath from the neck down, throw it in running water, you can't look back, because what is in the person goes away, this I occupy gives part of spiritualism, is the baths, guiné, arruda, rosemary, garlic clove, rock salt, mastic tree, holy palm, sword of Saint George and white rose, these remedies I teach the person to cook and take the bath from the neck down (I2).

Diagnoses are made taking into consideration the physical, mental, emotional, and spiritual conditions of the sick person[22], using strategies for analyzing and interpreting the signs that vary according to the *benzedeira*. Many diseases are treated, such as: *barriga pensa* (cystocele), fractured limbs, dislocations, *rasgaduras*, "*boca torta*" ("crooked mouth"), kidney stones, various pains, "indigestion", *quebrante* (caused by fright or evil eye), "open chest", and other diseases belonging to the nosological categories of this belief system. Treatments are diverse and range from movements and the use of materials such as plants, roots, thread, and pieces of cloth, to prayers able to produce healing through auspicious affirmations and/or invocations[23]. Treatment for *machucaduras* and *rasgaduras* (which include sprains, dislocations, and back problems), for instance, are similar: they require a piece of cloth to be sewn on while a ritual speech is recited, followed by a prayer. Moreover, the statements report, above all, the women's perception of the difference that exists between their practices and the biomedical knowledge of the RAS. Some points stand out: the referral system among women and independence from the RAS, considering the particularities of each healing practice; the unpaid activity, motivated by a sense of divine mission; and the use of elements from nature rather than synthetic medicines.

The resistance and permanence of these practices go through the reallocation and re-signification of popular knowledge and traditions in a society constantly transformed by information, technique and science[24]. *Benzedeiras* face difficulties related to the disuse of medicinal plants in the RAS, which are neglected in favor of synthetic medicines. They also mention that they suffer from value judgments about their practices, made from certain sociocultural and religious standards, which cause them to modify their practices. The new generations' disinterest in traditional healing practices contributes to the forgetting of this knowledge.

Through discourse analysis, a criticism of the conventional system established by the RAS, which places popular practices in a subordinate position, can be inferred. The participants' statements require recognition and legitimacy, especially when we consider their *modi operandi*, dynamics and the efficacy of their system, including the perception of efficacy aligned to symbolic efficacy[25].

A factor that can be considered in this comparison is the flow of referrals, which operates within the logic of reference and counter-reference in the context of the SUS. In this system, users are referred to different services in the RAS, each with its own specialty, to ensure the completeness of health care. This type of flow of referrals can also be observed in the healing practices of these women. Through their own referral system, they facilitate the circulation of people in a parallel circuit that operates inde-

pendently of the RAS. These flows and connections between therapeutic systems have been well discussed in the literature, often referred to as "therapeutic itinerary"[26]. Within this framework, individuals navigate among different *benzedeiras*, who, similarly to the conventional system, can offer specialized and personalized care. However, unlike what occurs in the RAS, which is predominantly based on biomedicine, these practices are open to alternative epistemologies[10]. As part of their therapeutic itineraries, these practices may involve referrals to the RAS. According to the *raizeira/erveira*'s description, referrals and return visits within the logic that organizes these traditional healing practices should guarantee that the patients' needs are adequately addressed and resolved.

She was just a benzedeira. So, whenever someone came to her in need for something more, she would refer them to me. And when someone came to me in need of a garrafada that she made, I'd refer them to her (I1).

As mentioned, traditional healing practices, rooted in mythical and religious elements, are socially understood as granted gifts[22]. This understanding prevents the healers from charging for their services. However, the interviews revealed cases of spontaneous retribution, in which the healers were gifted objects such as candles, clothes, shoes, and food.

Sometimes people want to pay, so I say, "No, I don't charge anything". Those who charge are not worth it, right? No, God is watching. My mother benzia so many people, poor thing, and never charged anyone (I3).

They also recollected the rewards they received just by being recognized as healers by their community. This community prestige serves them as a reward for their gift, which they perceive as a life mission.

Another point that emerged in the interviews was the women's dissatisfaction with the RAS, who expressed concern over the availability of synthetic drugs for home treatment exclusively. According to them, there were changes in the dispensing and prescription rules in the RAS, which excluded the delivery of medicinal plants in the Basic Health Units, a practice that had occurred for years. According to Ribeiro[27], the inclusion of medicinal plants in health care started in the mid-1980s with the creation of the first phytotherapy programs in public health. These programs were sustained through community gardens, municipal pharmacies for the manipulation of herbal medicine, and agreements with private pharmacies; that was until the National Program of Medicinal Plants and Herbal Medicines in SUS was launched in 2008.

In the health clinics, there used to be medicinal plants, which you received in packets to make a tea [...] *they distributed the dehydrated plants* [...] (I5).

The absence of medicinal plants in the RAS, mentioned by the women, translates into limited access to alternative options of treatment for the interested population, which leads to an exclusive dependence on synthetic medicines.

Many years ago [...] [the treatment with phytotherapies] was administered at the health clinic, where they could prescribe herbs [...] They gave herbs... because many people have insomnia, passion fruit tea induces sleep, lettuce is for sleep. Many people go to treat depression, very common today, rosemary, it helps, it aids, it is an antidepressant. So it helps a lot with the diseases, along with the medicines. You can use teas and herbs (I6).

In the interviewee's statement, she emphasizes the use of teas and herbs by the RAS, demonstrating that synthetic medicines are not the exclusive means of treatment and that there are other ways of treating situations and illnesses within their system of representation of illness and healing practices[28]. In some cases, there is a connection between native categories and biomedical diagnosis, as seen in the examples of insomnia and depression. The use of herbs in these cases is considered an autonomous care strategy in relation to biomedicine.

What I know I will carry with me for my whole life, it is knowledge. Sometimes, I even resort to a little tea [...] of sweet herb, a little chamomile tea... Look there, full of fennel growing—you can go there and come back with fennel in hands. You don't even have to buy it, and chamomile, you can plant it at home [...] parsley is diuretic, it's good for the kidney [...] It's a root also, you can cook the root, and it's good for the children's teeth [...] Sometimes it may seem silly, but it's a treasure (I5).

Moreover, traditional knowledge appropriates information from conventional pharmacology. Medicinal plants, for instance, are sometimes given names associated with commercial synthetic medicines. Examples include "vegetable insulin" (*Cissus verticillata*), "Atroveran" or "Novalgina" (*Achillea millefolium*), "Melhoral infantil" (J*usticia pectoralis* var. *stenophylla*), and "Doril" or "Penicillin" (*Alternanthera brasiliana*):

There are various remedies growing out there. I have "Melhoral infantil" planted myself. I have planted "doril" myself (I6).

On one hand, this reveals the *benzedeiras*' understanding that the active ingredients present in synthetic medicines are derived from medicinal plants. On the other hand, it also reveals that these medicines have become so popular that they influenced how medicinal plants present in nature are named. Thus, we can see the occurrence of exchanges between what[29] called "the folk" ("lay" people's) arena and the professional arena of care.

Final remarks

The rise of technique[30] and biomedicine[7] has culminated in a decline of popular knowledge and a distancing from traditional healing practices. However, in the context of health, different worldviews coexist alongside biomedicine, and it is crucial to take actions that preserve and maintain such practices. This is especially important in a culturally diverse society like Brazil.

It is worth emphasizing the relevance of female voices, since they are active representatives in health care and possess knowledge, techniques, and practices that have historically given them social prestige or even community identity. Identifying the women who perform healing practices (*curandeiras, benzedeiras, rezadeiras, parteiras, raizeiras, erveiras* and *cuidadoras*) and listening to their interpretations of the institutionalized health model allows a perspective of popular participation in the essence of democratic HP.

In this sense, we point out some experiences of stimulation of traditional healing practices: a) insertion of 250 *benzedeiras/benzedores* as Non-Formal Health Agents (ANFS) in the Family Health Program (PSF) in Sobral (CE)[31]; b) contributions of *benzedeiras* to the *Farmácia Viva* – Medicinal Plants and Herbal Medicines Program in Nova Lima (MG)[32]; c) acts of *benzedura* performed in a Health Center in Brasília (DF), with biweekly attendance on Fridays[33]; d) project "*BENZA DEUS!* Curitiba's *Benzedeiras:* Modernity and Tradition", which registered the Traditional *Benzedeiras* as Intangible Cultural Heritage in Curitiba (PR)[34]; e) Wisdom Apprentice Movement (MASA), a social movement formed by representatives of traditional healing practices in the south-central region of Paraná, who collectively seek recognition and redistribution of rights[35]. These examples show that in places where there is institutional openness or initiatives for the preservation of traditional healing practices and recognition of the subjects who hold this local knowledge, it is possible to stimulate and empower these practices in communities.

Santos proposes the emergence of a new rationality in health, since traditional knowledge can be interpenetrated by scientific knowledge[10]. The construction of a new rationality requires an epistemological rupture, which fosters popular participation in building the basis of a health care that recognizes the cultural authenticity of these practices, as well as their social relevance.

This study enables an approximation to the reality of traditional healing practices based on a division of labor by gender, age, economic status, and religious belief. If, on one hand, we observe the consolidation of the role of *benzedeiras, raizeiras* and *erveiras*, which brings along a diversity and breadth of scope in their practices and prayers as consequences of eclectic processes of religiosity, local knowledge, and intergenerational knowledge; on the other, we also observe a substitution of these practices by a symbology of modernity, represented by biomedicine and hospital devices.

The survival of traditional healing practices demonstrates that these practices are not in opposition to biomedical approaches but rather fill important gaps within the health care system. These gaps include: a historical-environmental gap, which refers to ensuring the memory and reproduction of a community self-care system rooted in local biodiversity; and an affective-symbolic gap, which refers to the support for maternity care and women's security in the process of child-rearing, through the symbolic or ritualistic nurturing and empowerment provided by confident elder women, who symbolically strengthen the motherhood of young mothers.

However, modern *benzedeiras* are discredited in their role of empowering and maintaining the care system of their communities. It is essential to rescue and value the role of *curandeiras* and *benzedeiras*. Doing so not only guarantees the preservation of intergenerational knowledges and processes, but also fosters the generation of hypotheses and scientific advancements. By promoting a coexistence of different health care systems and acknowledging the value of traditional healing practices, we can create a space of civilizing resistance within communities that have been weakened by the loss of their own care systems, limited knowledge of biodiversity, and reduced autonomy in the processes of birth and maternity. Historically, *curandeiras* and *benzedeiras* have been the guardians of this knowledge.

Collaborations

MR Mussoi idealized the text, participated in the bibliographic research, research data collection, writing and final review. RCF Giordani idealized the text, participated in the bibliographic research, writing and final review. M Hoffmann-Horochovski participated in the writing and final review. CR Silva participated in the writing.

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