Revista ARACÊ
ISSN: 2358-2472

HEALING KNOWLEDGE – THE QUILOMBOLA PHARMACY AND THE USE OF MEDICINAL PLANTS IN CHILD CARE

https://doi.org/10.56238/arev7n4-199

Submitted on: 17/03/2025 **Publication date:** 17/04/2025

Antonio Nacílio Sousa dos Santos
PhD student in Social Sciences
Institution: Federal University of Espírito Santo (UFES)
Address: Horizonte, Ceará – Brazil.
E-mail: naciliosantos23@gmail.com

Francisco Souto de Sousa Júnior
PhD in Chemistry
Institution: Federal Rural University of the Semi-Arid (UFERSA)
Address: Mossoró, Rio Grande do Norte – Brazil.
Email: franciscosouto@ufersa.edu.br

Alan Judson Zaidan de Sousa
Graduating in Medicine
Institution: Pitágoras Health Sciences Faculty
Address: Codó, Maranhão – Brazil.
E-mail: alanjudson_zaidan@outlook.com

Joner Ney Vieira da Silva
Master in Physics Teaching
Institution: Federal University of Pará (UFPA)
Address: Mãe do Rio, Pará – Brazil.
E-mail: jonerney@gmail.com

Enes Buck Mutiua Cantala Xavier
PhD student in Health Biotechnology
Institution: Federal University of Espírito Santo (UFES)
Address: Vitória, Espírito Santo – Brazil.
E-mail: enesbuckxavier@gmail.com

Maria Edvânia da Silva
Master in History and Historical Culture
Institution: Federal University of Paraíba (UFPB)
Address: Araripe, Ceará – Brazil.
Email: ed-vania-silva@hotmail.com

Liana Nolibos Rodrigues
Master in Maternal and Child Health
Institution: Franciscan University (UFN)
Address: Santa Maria, Rio Grande do Sul – Brazil.
E-mail: liana.rodrigues@ufsm.br

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Fernanda Beatriz Alves
Master in Health Promotion
Institution: University of Santa Cruz do Sul (UNISC)
Address: Santa Cruz do Sul, Rio Grande do Sul – Brazil.
E-mail: nandabzalves@yahoo.com.br

Daniel de Oliveira Baptista
PhD in Social Anthropology
Institution: Federal University of Minas Gerais (UFMG)
Address: Belo Horizonte, Minas Gerais – Brazil.
E-mail: daniel_baptista@yahoo.com.br

Marcio Harrison dos Santos Ferreira
PhD student in Agroecology and Territorial Development (PPGADT/UNIVASF)
Institution: Federal Institute of Piauí (IFPI/Paulistana Campus)
Address: Paulistana, Piauí – Brazil.
E-mail: marcio.harrison@gmail.com

Witter Duarte Guerra
PhD in Biofuel Science and Technology.
Institution: Federal University of Uberlândia (UFU)
Address: Uberlândia, Minas Gerais – Brazil.
E-mail: witter_guerra@yahoo.com.br

Carla Emanuele Lopatiuk
Medical Student
Institution: Campo Real University Center
Address: Ponta Grossa, Paraná – Brazil.
E-mail: carla.emanuele2201@gmail.com

Elicéia da Silva Almeida
Master's student in Health Sciences
Institution: Integralize
Address: João Pessoa, Paraíba – Brazil.
Email: eliceiapp@gmail.com

Adnaldo Junior Brilhante Lacerda
Master in Chemistry
Institution: Federal Institute of Education, Science and Technology of Mato Grosso (IFMT/Campus Pontes Lacerda).
Address: Cuiabá, Mato Grosso – Brazil.
Email: baldergato@hotmail.com

Márcia Marin de Liz
Undergraduate student in Pharmacy
Institution: Cruzeiro do Sul University.
Address: Lages, Santa Catarina – Brazil.
E-mail: marciamarin2020@icloud.com

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Jeymson Xavier da Silva
Specialist in Auditing and Controllership.
Institution: Facuminas Institute.
Address: Itaitinga, Ceará – Brazil.
E-mail: mazolafilho@hotmail.com

ABSTRACT
This article proposes a critical reflection on the traditional quilombola knowledge related to the use of medicinal plants in child care, understanding them as practices of resistance, healing and intergenerational transmission of knowledge. In the midst of a history marked by erasures, criminalizations, and delegitimization of traditional medical systems, quilombola communities keep alive ancestral forms of care that articulate body, territory, spirituality, and health. In this sense, the study has as its object of research the quilombola living pharmacy, focusing on the ways in which mothers, grandmothers, midwives and root women manage natural resources to treat diseases and strengthen children's health. The research starts from the following question: How are quilombola medicinal knowledge mobilized in childhood care and what tensions are established between this ancestral knowledge and hegemonic biomedical discourses? Theoretically, we made use of the works of Zhang (2002), Grmek (1991), Lima and Moura Junior (2024), Pessoa and Maton (2024), Melo (2021), Vanini (2010), Farmer (2003), Kleinman, Basilico, Kim and Farmer (2013), Scheper-Hughes (1993), Lévi-Strauss (1966; 1978; 2004), Fabian (1983; 2014), Turner (1991), Shiva (1999), Brito et al. (2024), Mendes and Cavas (2018), Rodrigues, Paneto and Severi (2018), Sperry et al. (2018), Ravazoli et al. (2018), Oliveira et al. (2024), Almeida (2011), Cunha (2018), Wagner (1981), among others. The research is qualitative from Minayo (2007), descriptive and bibliographic according to Gil (2008) and the data analysis was carried out from the comprehensive perspective of Weber (1949). The findings of this research reveal that the quilombola medicinal knowledge mobilized in child care articulates physical and spiritual healing practices, sustained by intergenerational bonds and by a logic of collective and territorialized care. It was identified that the quilombola living pharmacy goes beyond the technical use of plants, incorporating prayers, affections and intentions, as forms of resistance to biomedical medicalization. The practices of the root women and midwives reaffirm the contemporaneity of this knowledge and denounce the epistemic erasure promoted by scientific colonialism. It was also observed that the use of plants is accompanied by symbolic and ethical criteria, such as the way of harvesting, preparing and transmitting knowledge. Finally, it was found that defending this knowledge is to claim not only health recognition, but also cultural, historical and political autonomy.

Keywords: Quilombola Knowledge. Child Care. Healing. Body-Territory.

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BETWEEN ROOTS AND PRAYERS: QUILOMBOLA MEDICINAL KNOWLEDGE IN CHILD CARE AND THE DISPUTE AGAINST EPISTEMICIDE – INTRODUCING

Traditional quilombola medicine cannot be understood only as a set of healing practices, but as a living expression of an ancestral epistemology deeply rooted in the relationship between body, territory and collective memory. Since the colonial period, black communities formed by escaped enslaved people have created spaces of resistance where care for life was also a form of insurgency. "Quilombo (Kilombo) [...] represented in the history of our people a milestone in their capacity for resistance and organization" (Nascimento, 2006b, p. 117b). And as Fernandes (2016) explains, "[...] the quilombos resisted in their royal sieges for about a hundred years [...], facing 27 wars" (p. 42). Thus, traditional medicine flourished as a form of integral care and existential resistance.

> The quilombo extrapolates the notion of the place of runaway blacks. This conception is rooted in a white slave tradition that conceives blacks as animals that live hidden in the forests, surviving on what it can offer them. As if in the quilombo there were no possible forms of economic production and organization of life. More than a place for escaped blacks, the quilombo presents itself, in its uprisings against the imperial state, as a political territory capable of confronting seigniorial power and the logic of exploitation and domination that it represented. (Fernandes, 2016, p. 42)

The origin of the quilombos, although associated with the escapes from slavery, reveals complex forms of organization and re-elaboration of alternative ways of life to the colonial system. "These quilombos were of various sizes [...] they were armed groups [...], the large ones were already much more complex" (Moura, 1986, p. 17). And not only did they resist physically, but also culturally: "[...] quilombola communities were formed in territories where they learned to live in/and from the forest" (Castro, 2006, apud Guedes, 2011, p. 64). Soon, the medicinal tradition was cultivated in this fertile soil of freedom, where women, children and the elderly transmitted knowledge as a political and spiritual heritage.

Colonization, however, imposed not only slavery, but the systematic erasure of this knowledge. Even today, ancestral practices such as prayer, herbal baths and the use of roots are targets of delegitimization. "While health services deny and/or delegitimize the demands of the quilombola community [...], its inhabitants (re)create the way of caring" (Brito et al., 2024, p. 17). As one praying woman reports: "[...] she had an animal's eye [...], I blessed her, I taught her a medicine [...] it was a catinga vine, a mucuracaá leaf [...], lard and then she can no longer go out to be serene" (Santos, 2017, p. 158).

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> We know that the history of our country is based on almost four centuries of enslavement of the peoples coming from Africa. This process naturalized the systematic erasure of the traditions of the various black peoples who arrived here, from the prohibition of the use of their native languages to the imposition of Christian names, among other various forms of violence. [...] The rites and every way of existence of black peoples, and also of indigenous peoples, bothered the white and Christian colonial logic. Several persecutions were established for ways of life that did not obey this logic (Fernandes, 2024, p. 42).

This delegitimization reflects epistemic racism, which disqualifies non-Western knowledge. "White-Western rationality [...] it is based on an ideal of modernity that is based on patriarchy, sexism, racism" (Brito, 2024, p. 102). And as Carneiro (2005) denounces: "[...] epistemicide mortally wounds the rationality of the subjugated or kidnaps it, mutilates the ability to learn" (p. 97). Therefore, silencing is not mere carelessness: it is a strategy of domination, which marginalizes other ways of producing knowledge and taking care of life.

Biomedical hegemony[1], in turn, excludes these practices from official health protocols. "Cooking and praying like this is not useful, what is useful is medicine [...], the person says he is not using anything" (Sobonfu, 2024, p. 96). Even so, traditional care continues to be a space of mutual recognition and community affirmation. "Community forms of care produce relationships of recognition [...], the other as an experience belonging to the territory" (Brito et al., 2024, p. 15). Therefore, it is in the domestic and spiritual space that knowledge resists and flourishes.

> Community care practices produce relationships of recognition that are mediated both at the time of their practices and in the transfer of this knowledge among the residents. Autonomy, experience and recognition are circulated in the exercise of care practices. The other as an experience belonging to the territory composes with other quilombola bodies that are in the territory and make it their health space (Brito, Santos, Fernandes & Parra-Valencia, 2024, p. 15).

It is in this scenario that the present research is justified. Because, in addition to the existence of theoretical gaps in traditional quilombola medicine, there is a political urgency to make such practices visible in the face of the advance of neoliberal and biomedical rationality. "The importance of the research lies in the little literature on the therapeutic use

[1] Biomedical hegemony, historically consolidated as the dominant model of health care, imposed a technical-scientific rationality that disregards the cultural, spiritual and territorial contexts of the subjects. This model, centered on the fragmentation of the body and the medicalization of life, has relegated traditional knowledge to a condition of invisibility or folklorization. Thus, practices such as popular phytotherapy, healing rituals and the knowledge of midwives and root women are systematically devalued by health institutions. As Luz (2007) points out, biomedicine has established itself as hegemonic knowledge by unilaterally defining what is valid or invalid as care, operating not only an epistemological exclusion, but also a political imposition of what should be recognized as legitimate science. See: LUZ, Madel Terezinha**.** Natural, rational, scientific: cultural legitimacy and institutional power in medicine**.** 6. ed. Rio de Janeiro: Editora Fiocruz, 2007.

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of medicinal plants among quilombola women" (Guedes, 2011, p. 26). Furthermore, "[...] the cultivation and use of plants has an important meaning [...], as it concerns the preservation of biodiversity and the promotion of care practices that differ from biomedical hegemony" (Almeida, 2024, p. 11).

The relevance of this investigation is not only academic, but also social and cultural. Because recognizing traditional modes of care is to strengthen public policies that are sensitive to local realities. As Almeida (2011) argues: "[...] the healers are specialists who maintain, through their prayers, formulas and symbolism, the secrets and knowledge about plants" (p. 158). And as Fabian (1983) reinforces: "[...] indigenous and African cosmologies need to be understood as legitimate fields of knowledge production, and not as folklore or superstition" (p. 44).

In the field of public health and childhood, this recognition becomes even more urgent. Quilombola children are the target of standardized public policies that ignore the plurality of knowledge and modes of care present in their territories. "Healers are sought out in cases of colic and evil eye [...], they use specific prayers and rituals for each case" says Aqualtune (2022, p. 73). And as Ferreti (2003) observes, "[...] the religiosity of the popular classes is pointed out in some studies as having a key role as a therapeutic space" (apud Melo, 2022, p. 74).

In view of this, the general objective of the research is to analyze how quilombola medicinal knowledge is mobilized in child care. And as specific objectives, it is intended to identify the tensions and articulations between this knowledge and the discourses of hegemonic medicine, in addition to understanding how such practices are resignified in the daily life of communities. According to Cunha (2018), "[...] to resignify the quilombo is to restructure the historical readings of the past, making them converge to the elaboration of the present that is dignified and fair to the communities" (p. 45). And, as Wagner (1981) reminds us, "[...] culture is invention: a continuous process of recreation of meanings" (p. 22).

> The idea of culture, then, is essentially a means of making something visible; it is like turning on the light in a room that was dark. Culture does not reside in visible behavior or customs, but in the ideas and values that make those behaviors and customs seem sensible and meaningful. Culture, in this sense, is not a collection of things or actions, but a way of inventing them. It is the very act of invention, the projection of meaning on the world[2] (Wagner, 1981, p. 14).

[2] Our translation.

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The research question that guides this study is: "How are quilombola medicinal knowledges mobilized in child care and what tensions are established between this ancestral knowledge and hegemonic biomedical discourses?"element. This question emerges from attentive listening to the territories and from the criticism of the single rationality. "We do not want to deny science, our struggle is to denigrate it [...], to make it black, plural, situated" (Brito, 2024, p. 102). And as Shiva (1999) points out: "[...] biopiracy[3] is also a form of epistemic colonialism, as it steals not only the resources, but the meanings that traditional peoples attribute to them" (p. 44).

Therefore, talking about practices such as the use of plants, prayers, infusions and collective care is not to rescue a folkloric past, but to project a fairer, more inclusive and territorialized future of care. "You heal the hidden parts. You stop the child who leaks" (Bandeira, 2024, p. 13). And as Farmer (2003) warns: "[...] the structural violence that prevents access to health is inseparable from the denial of local knowledge and community forms of self-care" (p. 41).

For all these reasons, this research is inscribed as a political gesture of listening, recognizing and valuing the knowledge that heals. Because, as Paulo Freire would say, "[...] no one is born made, it is by experiencing ourselves in the world that we make ourselves" (2001, p. 14). And as Scheper-Hughes (1993) reaffirms: "[...] there is no life that is not permeated by pain, but there are worlds in which pain is welcomed, shared and cared for in community" (p. 201).

ANCESTRAL PATHS AND EPISTEMOLOGIES OF CARE: A QUALITATIVE AND COMPREHENSIVE APPROACH TO QUILOMBOLA KNOWLEDGE

This research was conducted under a qualitative approach, as it sought to understand the meanings attributed by quilombola communities to the use of medicinal plants in child care. As Minayo (2007, p. 21) points out: "[...] qualitative research works with the universe of meanings, motivations, aspirations, beliefs, values and attitudes". Therefore,

[3] Biopiracy is not restricted to the misappropriation of genetic and biological resources from traditional communities, but is also a forceful expression of epistemic colonialism. This is because, by extracting ancestral knowledge about the use of medicinal plants and transforming them into patents or marketable products without due recognition and return to native peoples, the hegemonic system reaffirms the logic of domination that delegitimizes local knowledge. This process implies the translation of this knowledge into the molds of Western science, emptying its symbolic and spiritual meanings and converting them into merchandise. As Vandana Shiva (1999) denounces, this type of appropriation represents a continuity of colonialism, by displacing the knowledge of communities from their contexts and reconfiguring them under the language of scientific innovation and Western intellectual property. See: SHIVA, Vandana. Biopiracy: the plundering of nature and knowledge. São Paulo: Editora Escrituras, 1999.

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it was an investigation that respected the symbolic and relational complexity of the object, refusing any statistical reductionism. Stake (2011, p. 26) adds that:

> The qualitative study is interpretative. It focuses on the meanings of human relations from different points of view. Researchers are comfortable with multiple meanings. They respect intuition. [...] Qualitative study is experiential. It is empirical and is directed to the countryside. It focuses on the observations made by the participants and takes into account what they see rather than what they feel. It strives to be naturalistic, not to interfere or manipulate to obtain data. Its description offers the reader of the report an indirect (vicarious) experience. It is in line with the view that reality is a human work.

In addition, the nature of the research was descriptive, as we sought to present, with details and sensitivity, how the management of medicinal plants by mothers, grandmothers, midwives and root women in quilombola communities takes place. According to Gil (2008, p. 28): "[...] descriptive research aims to describe the characteristics of a given population or phenomenon". And, in this case, the observed phenomenon involves daily practices crossed by ancestry, spirituality and resistance.

From the technical point of view, it was a bibliographic and documentary research, based on books, dissertations, scientific articles and institutional documents. As Prodanov and Freitas (2013, p. 119) point out, "[...] bibliographic research is developed from material already prepared, consisting mainly of books and scientific articles". In addition, we also used ethnographic records and experience reports that allowed us access to sensitive and dense narratives. Stake (2011, p. 23) states that "[...] qualitative research is interpretive, experiential, situational and personalistic", which evidences the methodological choice adopted.

> The bibliographic research is developed from material already prepared, consisting mainly of books and scientific articles. [...] The main advantage of literature search lies in the fact that it allows the researcher to cover a much wider range of phenomena than he could research directly. [...] Bibliographic research is also indispensable in historical studies. In many situations, there is no other way to know past events than on the basis of secondary data. [...] To reduce this possibility [of errors], it is convenient for researchers to be sure of the conditions in which the data were obtained, to analyze each piece of information in depth to discover possible inconsistencies or contradictions, and to use different sources, carefully comparing themselves (Gil, 2008, p. 51).

In addition, the research was based on a comprehensive analysis, inspired by the thought of Max Weber (1949), who proposed the interpretation of social actions based on the meanings that the subjects attribute to them. This analytical option was fundamental to understand not only the "what" is done, but the "why", the "how" and the "for whom" it is

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done. As Gil (2008, p. 21) points out: "[...] understanding is the methodological way to penetrate the universe of human meanings and intentionalities".

The selection of bibliographic sources followed the criteria of thematic relevance, epistemological diversity and updating. Priority was given to works that address quilombola knowledge, medicinal plants, child care, epistemologies of the South, anthropology of health, decoloniality, and spirituality. In addition to the classic texts, recent research, dissertations and articles published in journals of academic excellence were used. For Prodanov and Freitas (2013, p. 74), "[...] The bibliographic survey must be planned and executed rigorously, because it is in it that the theoretical basis of the research resides".

During the reading of the materials, we carried out analytical files, interpretative notes and construction of emerging categories that would dialogue with the research problem. As Minayo (2007, p. 73) recalls, "[...] qualitative analysis requires a reflective and systematic process, which goes far beyond the simple repetition of information". Thus, we seek to build situated understandings, crossed by the voices of the subjects, by historical silencings and by the powers of resistance.

The epistemological stance adopted was one of recognition of the validity of traditional knowledge as legitimate forms of knowledge production. In this sense, we dialogue with decolonial thought and with the proposal of a science committed to epistemic plurality. As Flick (2009, p. 34) points out: "[...] qualitative research does not start from neutrality, but from the reflexivity of the researcher in the face of the reality studied". This reflexivity was central for the study not to reproduce hierarchies between knowledges, but to promote an encounter of knowledges.

From an ethical point of view, we are committed to respecting and valuing quilombola ancestral knowledge, understanding it as intangible heritage and as expressions of care integrated into community life. The research, even though it was bibliographic, respected the principles of recognition, listening and reciprocity. As Stake (2011, p. 24) proposes: "[...] qualitative research is a form of involvement that requires sensitivity, empathy and responsibility towards the other from the researcher".

That said, it is important to emphasize that the methodological path did not take place in a linear way, but through a circular and dialectical movement between theory and empiricism. As Prodanov and Freitas (2013, p. 126) point out: "[...] Methodology is the path of knowledge, and this path is built in the very act of research." Therefore, we welcomed the uncertainties, reformulated questions and continued listening to the texts as if listening to

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living narratives, because we knew that in them there was much more than technique: life, knowledge and memory pulsated.

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Traditional quilombola medicine manifests itself as a link between ancestral memory and contemporary modes of resistance. It is much more than technique: it is a gesture, it is presence, it is spirituality rooted in the territory. As Grada states: "[...] there are plants that my mother doesn't know the name, but she knows what they're for [...] she says that's what it's for, she brings it home to plant" (Brito, 2021, p. 88). And this is not by chance: it is an expression of a knowledge that is transmitted with time and care. According to the Experience Report in Amapá[4], "[...] in addition to knowledge about which plants to use, religiosity, faith, and attunement with nature are highly correlated during the process of preparing these medicines" (Vieitas et al., 2021, p. 296).

> That said, it is worth considering that an important dimension to be observed and understood is that of spirituality, often present in the ways of preparing and using plants. Spirituality is related to the search for meanings and meanings, for explanations about life that transcend the existence of the physical and material world. It concerns the invisible [...] that which is considered sacred, manifests itself in the relationship between the 'I' and the 'something greater' that heals. It is not limited to the sphere of the religious or religions, although it also passes through them. It goes further, it includes the mystique and the shared dream, the values combined in respect for what is not explained by human rationality. In this sense, the understanding of the healing processes by plants can go through the relationship with the divine and the invisible, more than with biochemistry, and care through rites that involve faith (Almeida, 2024, p. 83).

Thus, it is not possible to dissociate plant and territory, leaf and community. The relationship with nature is affective, ancestral and political. "The practice of care, it strengthens the care of knowing that the other is well [...] normally we are using tea for prevention" (Grada, apud Brito, 2021, p. 101). And as Monken and Gondim reinforce: "[...]

[4] The experience report carried out in a quilombola community in Amapá evidenced the centrality of medicinal plants as a form of daily and spiritual care, especially in dealing with children. In the record, the women reported the use of baths, teas, ointments and smokes, always associated with prayers and knowledge transmitted orally by the older ones. The practices, according to the document, are guided not only by the effectiveness of the herbs, but also by respect for nature and ancestry. In addition, the report reveals that knowledge about the right time to harvest, prepare and apply plants is part of a pedagogy of care sustained by community bonds and a deep connection with the territory. These practices, although often ignored by formal health services, are still alive and reconfigured in the daily lives of families, demonstrating resistance and protagonism of quilombola women. See: ALMEIDA, Elinalva Oliveira de et al. Use of medicinal plants in a quilombo: an experience report in the state of Amapá. *Pan-Amazonian Journal of Health*, Belém, v. 6, n. 1, p. 57-60, jan./mar. 2015. Available at: https://doi.org/10.5123/S2176-62232015000100007. Accessed on: 17 Mar. 2025.

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involving people who carry out popular practices (herbalists, midwives, healers, healers, informal caregivers...)" (Monken & Gondim, 2006, p. 40).

In this universe, women play a fundamental role as guardians of care and life. Midwives, roots, healers and grandmothers are the foundations of a medicine rooted in everyday life. "Oh it was already my family, right [...] my grandmother taught it, she was a midwife, then I already learned" (Ester, apud Brito, 2021, p. 89). Dona Raimunda, for example, "[...] it is also the main guardian of the memory and history of this social group" (Guedes, 2011, p. 123). Therefore, care is a practice of memory, and memory, a practice of resistance.

The transmission of this knowledge is oral[5], daily, collective. As Sobonfu says, "[...] it comes like this from generations, right, from grandparents, from grandparents it passed to their children and to their children it passed to their grandchildren" (Brito, 2021, p. 88). And as Santos (2015) adds: "[...] quilombola peoples have experiences in their relationship with the territory that generate vital forces" (p. 47). Therefore, these practices are not limited to the biological body, but activate care networks that include plants, knowledge, dreams, and affections.

> During the course of the research, we were able to observe the processes of transmission of knowledge about the use of plants, marked by oral transmission over the generations, as we see in the participants' statements: 'So it is a knowledge that everyone has, it comes from generations, right, from grandparents, from grandparents it passed to their children and to their children it passed to their grandchildren and so the generations' (Sobonfu). [...] In addition to generational issues, knowledge is presented in a communal way, going beyond the limits of the family circle and care takes on a space that goes beyond human care and this process only makes sense in the relationship, where the leaves are not equivalent to the medicines that after their use can be discarded. [...] In this sense, there is no imposition on care, it takes place in listening, exchanging and recognizing the other and nature as part of oneself (Brito, 2024, p. 88-89).

Because cures and recipes are also revealed in dreams. It is the invisible making itself present in the healing. "When I woke up, I tied the sheet to my head, that's it, then my

[5] The transmission of knowledge about the use of medicinal plants in quilombola communities occurs predominantly orally, in a continuous process of sharing between generations, marked by listening, observation and affection. This knowledge is learned in practice, in contact with the elders – grandmothers, mothers, midwives and root women – who teach not only the name and function of herbs, but also the gestures, times, silences and prayers that make up care. Contrary to the written and systematized logic of hegemonic science, traditional knowledge is preserved and reinvented through orality, resisting attempts at erasure and reaffirming the role of women as guardians of the therapeutic memory of the territory. As Guedes (2024) points out, this knowledge is not fixed, but dynamic and situated, being transmitted "[...] in the time of relationships" and founded on trust and lived experience. See: GUEDES, Ana Célia Barbosa. Quilombola women and the use of medicinal plants: an ethnobotanical approach in traditional communities**.** 2024. 176 f. Dissertation (Master's Degree in Development and Environment) – Federal University of Paraíba, João Pessoa, 2024.

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headache passed" (Ida, apud Brito, 2021, p. 100). And as Glowczewski points out: "[...] the spaces of dreaming are expressed in rituals, myths and dream experiences that produce relationships with ancestral spirits" (Glowczewski, 2015, p. 89).

This wisdom, however, coexists with institutional denial. Traditionalism is often made invisible or ignored by official health services. "The doctor does not like to prescribe medicine [...] it does not encourage. He doesn't talk about tea" (Vanini, 2010, p. 70). And how do women react? "We heal with tea at home. [...] Because you go to the doctor, he doesn't give medicine either. So I have a tea" (Participant identified as RI 38[6], apud Vanini, 2010, p. 70).

> At the post, the doctor does not like to prescribe medicine. [...] He says that flu is not a disease, he does not talk about tea. That's the problem. It was to tell us: make this tea here, which is good, and it's ready. He doesn't encourage it. [...] We didn't even get to see them, because someone who had the flu on the way back from us, oh I went to the doctor but the doctor only gave medicine for fever [...] so it's no use for you to go, then you do it at home, I didn't take anyone to my house, everyone got the flu, there are four of us, we coughed and everything, we cured it with tea at home [...] (Marisa, 2010, p. 70).

The knowledge of plants is not only empirical, it is also spiritual. "It concerns the invisible [...] respect for that which is not explained by human rationality" (Wong Un, 2016, p. 36). And this requires, as Grada observes, "[...] a way of also taking care of the plant [...] does not want to attack, because boiling water with the plant causes it to die" (Brito, 2021, p. 89). Care is relational, circular and full of listening.

Not only is the plant cared for: the entire territory participates in the process. "Care is related to prevention [...] we usually try to drink the right teas before the pain" (Grada, 2021, p. 101). And as Rojas-Andrade, Nina and Fernandes (2023) reinforce: "[...] this ethics of care expands to nature and the living territory, which makes up a place of collective experience between humans and non-humans" (Rojas-Andrade et al., 2023, p. 8).

Therefore, care is always collective and the territory is a protagonist. "The territory is crossed by internal and external forces [...] who exercise power over the territory" (Monken

[6] The name of the participant with the acronym "RI 38" aims to preserve her identity and ensure the ethical confidentiality necessary for research involving reports of people in traditional contexts. This practice is common in ethnographic and qualitative studies, especially when one seeks to respect the privacy of the subjects without erasing the strength of their testimonies. In the specific case, the acronym indicates that it is Individual Report number 38, collected in the fieldwork of Vanini (2010), allowing the reader to locate the origin of the speech without directly exposing the person. This strategy ensures that the voices of quilombola women are heard with respect and legitimacy, protecting them from possible undue exposure, in accordance with the ethical norms of research in the humanities and social sciences. See: VANINI, Talita. Knowledge and practices of healing: an ethnography of traditional midwives of the Ribeira Valley. 2010. 148 f. Dissertation (Master's Degree in Social Sciences) – Federal University of São Carlos, São Carlos, 2010.

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& Gondim, 2006, p. 42). Healing only happens because life pulsates between plant, person, land and dream. "It's not just about surviving [...] but of the exercise and legitimation of knowledge that is reconfigured by showing inventiveness" (Brito, 2021, p. 100).

> Dreams appear in the accounts of the quilombo residents as this expression of connection with the vital forces of the territory, as a great fabric of collective space-time, as forces that connect and spread in a network that connects and feeds back the doings of common life, between: daily healing practices, work in the fields, balcony conversations, relationships with plants. [...] Rita, when dreaming, affirms the collective space with her ancestral learnings, to take care of herself she must be connected to the stories, experiences and ancestral knowledge that inhabit the territory. [...] Ancestral knowledge is not fixed and immutable, it is vital energies that transform and update the subject in his or her history and spirituality (Lima & Moura Junior, 2024, p. 13).

And even in the face of daily epistemicides, these practices continue to move. As Vello says: "[...] the treatments are intended to be universal [...] forgetting that there are singularities present as pulsating and vibrant life" (2019, p. 234). Therefore, quilombola care is resistance, because "[...] it is not only the practice of picking up the plant, but the care of it that needs to be involved with us" (Grada, 2021, p. 101).

In this way, what midwives, prayers, mothers and grandmothers teach us is that care needs time, bonding, territory. "Care requires being present [...] the time spent caring for the land, for the plants" (Brito, 2021, p. 101). And as Guedes (2011) points out: "[...] the elders preserve the collective memory as a commitment to the present" (p. 124).

Therefore, there is no traditional medicine without listening, without bonding and without body-territory[7]. "Care in quilombola communities is expressed in the zeal for the place, in the care of plants, animals, territory and nature" (Santos, 2015, p. 47). And as Ribeiro (1996) reminds us, Axé "[...] it is the invisible, magical-sacred force [...] it needs to be transmitted" (1996, p. 51). That said, we affirm that it is through cultural crossings that this Axé becomes a knowledge that heals.

[7] The notion of body-territory, widely mobilized by black and indigenous women, expresses the inseparability between the physical, emotional and spiritual body and the space where one lives, cultivates and resists. In quilombola communities, taking care of a child's body is also taking care of the territory where he grows up, as both are deeply interconnected by practices of care, belonging, and ancestry. The body is not seen as something isolated from nature, but as a living extension of the land, rivers, plants and stories that inhabit it. As Segato and Ribeiro (2014) state, the body-territory is "[...] the first territory to be defended" and its violation also represents the violation of the collectivity. In this sense, the use of medicinal plants in child care reaffirms this unity and resists the attempts at fragmentation imposed by biomedical and colonial rationality. See: SEGATO, Rita Laura; RIBEIRO, Silvia. Territory-body and epistemologies of the South: women's resistance to violence as reexistence**.** In: PAULA, Ana Lúcia; CORRÊA, Marilene de Paula (ed.). *Bodies, territories and knowledge: multidisciplinary reflections of women in Latin America*. Rio de Janeiro: Heinrich Böll Foundation, 2014. p. 19-30.

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> This integration considers that all elements, whether animate or inanimate, have a vital force that needs to be taken care of. Many African traditions are based on the presence of this vital force, which for the Yoruba, as presented by Ribeiro (1996, p. 51), is called Axé, which '[...] is the invisible force, the magical-sacred force of every divinity, of every animate being, of every thing. It does not appear spontaneously. It needs to be transmitted', a force that is present in the animal, vegetable, mineral and spiritual kingdoms. [...] This relationship takes us back to the care practices present in the quilombola community, this vitality is concentrated in the plants, spreads and is linked to the vital forces present in the land where it is planted, in the person who will harvest, with the union of the other elements that make up the care and the energy of those who are receiving the care (Brito et al., 2024, p. 90).

Quilombola knowledge is not in books, but in the body, in listening, in repetition and in affection. They are woven in orality, which is more than speaking: it is living memory. As Hampâté Bâ reminds us: "[...] the heritage has not yet been lost and resides in the memory of the last generation of great depositories, of whom it can be said that they are the living memory of Africa" (2010, p. 167). And Tierno Bokar reinforces: "[...] Writing is the photograph of knowledge, but not knowledge itself. Knowledge is a light that exists in man" (apud Hampâté Bâ, 2010, p. 167).

Thus, the spoken word carries ancestral strength, as it dwells in trust between generations. And, for African peoples, "[...] the word is an entity [...] lying would not only be a moral defect, but a ritual interdiction" (Hampâté Bâ, 2010, apud Brito, 2021, p. 84). As Oliveira (2018) states, ancestry is "[...] a relationship between elements of the visible and invisible world" that is realized by the "[...] rites, values and customs" transmitted orally.

Storytelling is one of the main vehicles of transmission. The "djele", [8]according to Hampâté Bâ, "[...] they are like blood that circulates through African societies bringing life" (2010, apud Brito, 2021, p. 85). That is why, in the words of Clastres, "[...] every culture is ethnocentrist in its narcissistic relationship with itself", but the West has transformed this difference into domination by "[...] to establish a scientific discourse that subjugates other forms of knowledge" (1979, p. 15).

[8] The term "djele", of Mandinka origin, designates the guardians of memory and speech in West African societies, responsible for orally transmitting ancestral knowledge, the stories of peoples and fundamental ethical teachings to the community. This figure, also known as griô, occupies a place of deep respect in the communities, being recognized for his pedagogical and spiritual role. In the context of Brazilian quilombola communities, the tradition of the "djele" resurfaces in the figure of midwives, root-healers and healers who, through orality, listening and lived experience, transmit not only healing techniques, but a collective and ancestral way of existing. As Santos (2010) points out, "[...] The word of the djele is a thread of continuity between past, present and future, woven with the rhythm of the voice and the wisdom of listening", being, therefore, a symbol of the pedagogy of ancestry. See: SANTOS, José Jorge de Carvalho. The reinvention of the griots: oral tradition and public policies of culture in Brazil. *Afro-Asia Magazine*, Salvador, n. 41, p. 41-70, 2010. Available at: https://doi.org/10.9771/aa.v0i41.5663. Accessed on: 17 Apr. 2025.

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In quilombola communities, the grandmother is not just a member of the family: she is a living library. "My grandmother taught, she was a midwife [...] everyone was at tea [...] I learned" (Ester, apud Brito, 2021, p. 89). And as Candau recalls, "[...] generational memory is also a founding memory [...] an awareness of belonging to a chain of successive generations" (2016, p. 142).

The transmission of knowledge is also a daily practice. Children learn by observing, helping, asking. "The one who helps me is one of my daughters [...] I put everything on paper and say: look, this is how you do it" (Guedes, 2011, p. 161). And, as Guedes reports, "[...] women are concerned with transmitting it to their daughters, granddaughters, nieces, friends and neighbors" (p. 161). Below we have the representation of the strength and role of orality and daily life in the traditional educational process, but it also demonstrates the affectivity, the generational bond and the female protagonism in the preservation of knowledge.

> In Santa Rita de Barreira[9], as reflected in previous pages, knowledge about the manipulation of plants for medicinal purposes has been built up over the years, especially among women, who are concerned with transmitting it to their daughters, granddaughters, nieces, friends and neighbors. Thus: '[...] Who helps me is one of my daughters, that Barbura, I fix everything and call her, and put it on paper, you know? I put everything on paper and say: look my daughter, this is for... It's for when I don't have it... she has already gone from this world to another, you will do it, she has everything written down, she worries about learning, she does it [...] I sent my daughter to bring some medicine, she brought everything... then after a while this man who made the medicine told me that he doesn't feel anything anymore, my daughter, he's pink that I want you to see, he took it, took it, took so many bottles for diabetes'" (Guedes, 2011, p. 161).

In childhood, medicinal knowledge is absorbed naturally, because it is part of life. "The acquisition of skills such as the preparation of medicines and the recognition of medicinal plants occurs during childhood, influenced mainly by parents" (Lucena et al., 2012, apud Pellegrino, n.d., p. 43). And according to Thompson, "[...] the child learns the

[9] The community of Santa Rita de Barreira, located in the state of Ceará, is a quilombola territory marked by a strong tradition of collective care, where the use of medicinal plants and the knowledge of older women occupy a central place in community life. In this locality, knowledge about herbs, baths, teas and blessings is passed down from generation to generation, sustaining healing practices that articulate spirituality, territory and resistance. The women of Santa Rita de Barreira act as guardians of this knowledge, wisely handling what nature offers, always with respect for the invisible forces that inhabit the body and the world. According to Lima and Moura Junior (2024), it is in this context that care is understood not only as assistance, but as a relationship, memory, and struggle for autonomy in the face of historical attempts at cultural erasure. See: LIMA, Lídia Ferreira de; MOURA JUNIOR, Milton Pereira de. Healing practices and experiences of young quilombolas: an analysis from the perspective of the anthropology of health. *Brazilian Journal of Social Sciences*, São Paulo, v. 39, n. 1, p. 1–21, 2024. Available at: https://doi.org/10.1590/10.1590/3391062112024-0101. Accessed on: 17 Apr. 2025.

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first tasks from his mother or grandmother [...] with the transmission of knowledge, social experiences are also transmitted" (apud Guedes, 2011, p. 165).

And although the formal school often ignores this pedagogy of everyday life, it is there, in the backyard, that knowledge pulsates. "Popular knowledge [...] are passed on from generation to generation, in our backyards and kitchens" (Contatore et al., 2015, p. 56). And, as Pessoa and Maton point out, "[...] these practices constitute forms of initiation of the child into culture" (2024, p. 3).

> These practices constitute forms of initiation of the child into the culture and symbolic social relations of the community. Childhood, in this context, is not perceived as a neutral or biologically predetermined stage, but as a cultural construction marked by rites, narratives and shared experiences. [...] The daily life of the quilombola child is full of ritualized actions: bathing with herbs, praying at birth, sleeping under songs, conversations in the kitchen and in the terreiro. These moments are experienced as passages, and in them the values, care, and affections that structure community life and belonging to the territory are established (Pessoa & Maton, 2024, p. 3).

These learning rituals involve the body, the gaze and the gesture. "The child learns because he participates, because he observes and because he does it together" (Brito, 2021, p. 88). And this coexistence is also transformation: "[...] the words, the scenes, what changes in subjectivity?" (Pessoa & Maton, 2024, p. 3). Thus, traditional medicine, in this context, is a sensitive and political pedagogy. Because it educates for bonding, for listening and for the territory. "Health care practices show us the affirmation of the collective in an experience of ancestral knowledge" (Brito, 2021, p. 88). And for Thompson, "[...] even with the changes, it is not admitted that each generation has a different horizon [...] formal education has not intervened in a significant way" (apud Guedes, 2011, p. 166).

Teaching how to heal is teaching how to take care of the other, and this is done with patience and presence. "Memory is fundamental in the process of transmitting knowledge among the members of a given group" (Candau, 2016, p. 142). Therefore, "[...] cultural practices are constructed and reconstructed by the interrelation of social, political and economic factors" (Thompson, 1998, apud Guedes, 2011, p. 161).

> Memory is fundamental in the process of transmitting knowledge among the members of a given group. Traditional knowledge is transmitted orally from generation to generation, constituting an intangible cultural heritage that instrumentalizes sustainable development (Carneiro da Cunha, 2007, p. 76).

Traditional medicine also teaches how to resist. Because "[...] the younger healers are spiritually prepared by the older ones [...] there is a whole treatment until the person can

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teach medicine" (Gomes, 2017, p. 165). And, as Hampâté Bâ reinforces, "[...] knowledge precedes writing" (2010, p. 168). Therefore, the traditional knowledge transmitted by quilombola women forms a learning field that involves the body, the territory and ancestry. "The care practices carried out by roots, healers [...] have been recognized and used by the population for time immemorial" (Contatore et al., 2015, p. 56). And, thus, knowledge is still alive because it continues to be lived.

From this context, in quilombola communities, the living pharmacy manifests itself as a system of comprehensive care that articulates ancestral practices, affective bonds, and spirituality. Lemongrass tea, for example, is prepared with fresh leaves, washed and infused for ten minutes, and offered warm to children with colic or insomnia. According to Rojas-Andrade et al. (2023), it is "[...] a relational ethics that expands to nature and to the living territory, which composes a place of collective experience between humans and non-humans". The choice of the plant, the moment of harvest and the gesture of offering the tea make up a symbolic and relational therapeutic process.

The bath with rue, guinea and lavender is applied to agitated children or with symptoms of the evil eye. The leaves are macerated and immersed in warm water, which is poured over the body at dusk, accompanied by prayers. Mendes and Cavas (2018) state that "[...] the leaf needs to be alive, it has to be fresh, it has to be strong" (p. 7), pointing out that the effectiveness of the practice is linked to ritual, faith and intention. As Tesser and Luz (2008) point out: "[...] the therapeutic process is only effective when the caregiver's symbolic system is in line with the beliefs of the community served".

> The efficacy of magical treatment implies three conditions: first, the sorcerer's faith in the efficacy of his techniques; second, the patient's faith in the sorcerer; and, third, the collective faith and expectations that provide the sorcerer and the sick person with a base of support. The patient frees himself from the tensions that paralyzed him by transferring them to the sorcerer. The sorcerer takes on these tensions and 'dramatizes' them through myths and rituals that are endowed with logical coherence and emotional force. Thus, the conflict becomes intelligible, and the cure possible[10] (Lévi-Strauss, 2004, p. 196).

To treat colds and coughs of quilombola children, syrups of thick leaf mint, cloves, lemon and honey are prepared. The mint is heated, combined with the other ingredients and administered in spoonfuls upon waking and before bed. Mãe Celina de Xangô-Berlin (apud Durão et al., 2025) reports that this recipe is shared in collective experiences, reinforcing community ties. Freire (2014) teaches that "[...] knowledge is built in praxis, in

[10] Our translation.

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collective action-reflection on the world", and this is exactly what happens when mothers teach their daughters how to dose and recognize the effects of herbs.

Poultices of castor leaf or grated yams are applied to lower fever and relieve pain that children feel in the early hours of sleeping. The preparation is wrapped in a clean cloth and placed on the child's forehead or chest. Durão et al. (2025) describe the use of these procedures as part of a logic of care centered on presence and time. Grada, a resident of a quilombo, says: "[...] the practice is more than preparing the plant, it is being together in care" (Brito, 2021, p. 122). This active presence becomes, as Brandão (2016) suggests, a pedagogy of coexistence and affection.

Also from this perspective, gargles with angico bark or malva are used to relieve throat inflammation. The warm infusion is used in mouthwash two or three times a day. Mendes and Cavas (2018) report that these practices are taught by grandfathers and grandmothers as part of a community education about the body. Luz (2007) argues that "[...] traditional medicines value integrality and operate with symbolic, affective and spiritual logics", recognizing the knowledge of the elder as a therapeutic component.

> Traditional African medicine arrived in Brazil about 5 centuries ago, and carries the culture of several peoples on the African continent. [...] It has a complex healing system, with a strong therapeutic base based on phytotherapy and the use of medicinal plants, and is undeniably more spiritualist in its approach to the phenomena of individual and group illness, and its most important healing agent is usually a priest (or priestess), through the figure of the pai de santo or mãe de santo, who operates therapeutically by intermediating spiritual entities'. [...] In addition, the therapeutics of African medicine recommend behaviors and attitudes, 'such as special diets, ways of feeling and thinking that facilitate healing, as well as offerings of prayers and food'[11] (Shiva, 1999, p. 76).

Within this context, we affirm: food also heals. Soups with picão leaf, cilantro, chives and beans are prepared to strengthen sick children. Dona Neuza reports that this practice is used in cases of weakness and worms (apud Durão et al., 2025, p. 4). Santos and Quinteiro (2018) call this the ecology of knowledge: "[...] a non-hierarchical dialogue between different rationalities, in which culinary, therapeutic and spiritual knowledge coexist". The stove is, therefore, a sacred space for the transmission of care.

Benzimentos[12] involve crosses with branches of rue or castor bean, accompanied by murmured prayers. Dona Antônia Almeida is recognized for applying these practices to the

[11] Our translation.
[12] Blessings are an ancestral practice deeply rooted in quilombola communities, being performed, for the most part, by older women who combine the use of herbs, prayers and symbolic gestures to promote healing and spiritual protection. More than a religious act, blessing is a gesture of integral care, which considers the body,

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children of her community (Guedes, 2018, p. 142). Lima and Júnior (2024) state that "[...] Blessing in childhood involves the presence of a trusted adult, who prays in a low voice while holding the child's feet." These actions activate, as Luz (2007) says, a therapeutic cosmology invisible to clinical rationality.

> The curator has one in Taquari and there is one here in the community. A woman who heals, she picks up a bush, then prays the Our Father, Hail Mary, then throws the twig over her, then if the twig gets deflated, because the twig gets withered, it dies, then she says why she was full of eyes. Oxi when it's the next day, the child is already eating it (Aqualtune, 2022, p. 73).

Bottles with[13] ginger, mint, stonebreaker or thousand-man vine are prepared for controlled use in more serious cases. According to Durão et al. (2025), these compounds are left to rest with cachaça or alcohol for 15 days before use. Care in preparation, time and dosage is part of the pedagogy of care. As Freire (2014) explains, "[...] knowledge emerges from curiosity that becomes a question, from the question that becomes a search and from the search that is also an encounter". And this knowledge requires listening and recognition.

> Dantas et al. consider the bottles as solutions basically consisting of two distinct components, the solvent and the solutes. The solvent used is usually wine, cachaça, water, honey or 'Água Rabelo'; and solute, a combination of medicinal plants, and elements of animal or mineral origin can also be added. Vegetable parts can be peels, fruits, leaves, roots or flowers, dried or fresh. The product of the mixture is macerated for at least three days. Many raizeiros, healers and healers have the practice of burying the prepared garrafada. [...] It can be seen that the religious/spiritual element still remains strongly linked to contemporary folk medicine (Passos et al., 2018, p. 250).

soul and territory as inseparable dimensions of health. The strength of blessing lies in listening, faith and the oral transmission of prayers learned from the ancestors, which gives this practice an inestimable therapeutic and cultural value. Mendes and Cavas (2018) point out that the blessings represent "[...] a form of resistance and resignification of traditional knowledge in the face of biomedical hegemony", being often ignored by formal health services, but widely recognized within communities as legitimate paths of cure. See: MENDES, Cláudia Pereira; CAVAS, Eliane Cristina. Quilombola healers: healing and resistance practices in traditional communities**.** *Revista Retratos da Escola*, Brasília, v. 12, n. 23, p. 455-470, jul./dez. 2018. Available at: https://doi.org/10.24934/retratos.v12i23.1916. Accessed on: 17 Apr. 2025.

[13] Garrafadas are artisanal preparations made from the combination of herbs, roots, bark and other natural ingredients, macerated in liquids such as alcohol or honey, widely used in quilombola communities as forms of prevention and treatment of various ailments. More than medicines, they express an ancestral knowledge that articulates elements of nature, spirituality and community experience. Its preparation involves precise criteria for choosing ingredients, maturation time and ritualistic intentions, and are often accompanied by prayers and symbolic recommendations. According to Oliveira et al. (2018), garrafadas "[...] constitute an intangible heritage that resists the disqualification of popular knowledge, reaffirming the autonomy of traditional therapeutic practices in the face of the biomedical model". Its use remains alive in many communities, being transmitted orally as a legacy of care and resistance. See: OLIVEIRA, Rafaela Gomes de; GURGEL, Ingryd de Oliveira; MORAES, Poliana Gonçalves. The cultural dissemination of garrafadas in Brazil: tradition, faith and popular knowledge**.** *Revista Interfaces Científicas – Saúde e Ambiente*, Aracaju, v. 6, n. 2, p. 143–154, jul./dez. 2018. Available at: https://doi.org/10.17564/2316-3798.2018v6n2p143-154. Accessed on: 17 Apr. 2025.

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Still in the same vein, theorists claim that dreams also guide treatments. Ida, a quilombo resident, dreamed of using a purple pine nut leaf on her head to relieve pain (Brito, 2021). Glowczewski (2015) points out that "[...] dreams are not illusions, but legitimate ways of transmitting and updating knowledge." Thus, dream practices challenge Western reason and affirm other possible epistemologies.

The way you harvest the plant also matters. Mother Celina teaches that "[...] the leaves should be harvested early in the morning, with the intention of healing and without anger in the heart" (apud Durão et al., 2025, p. 6). Sousa Santos (2007) points out that "[...] it is necessary to recognize subalternized knowledge as valid for the reinvention of life". The hand that harvests carries meaning; Silence, faith and respect make up the remedy.

> The best times to collect are in the morning, right after the dew has completely dried, and in the late afternoon on very sunny days. [...] Leaves that are pierced, dry, attacked by insects and moldy should be separated. The quality of the sheets to be used is extremely important. [...] Plants are true 'chemical substance factories' and at certain times of the day and periods of their growth, they have different amounts of the bioactive substances responsible for the desired therapeutic effects (Almeida, 2011, p. 149-150).

In this way, in the face of the knowledge that passes from generation to generation, children, in turn, learn by observing. They learn the name of the leaves, the timing of the moon, the right measure. As Brandão (2016) writes: "[...] Educating is a process of mutual invention, in which the subject transforms himself by transforming the world around him". The living pharmacy is, therefore, a sensitive and communitarian school, where knowledge is passed from body to body, without official intermediaries. It is a pedagogy of listening, presence and gesture.

Thus, to recognize the living pharmacy in quilombola child care is to admit that there are multiple ways of curing, teaching and resisting. As Clóvis, a resident of Quilombo do Agreste, says: "[...] When I was a child, I had no medicine. It was tea, bottle and prayer" (Brito et al., 2024, p. 11). Incorporating these practices into collective health is to break with epistemicide and recognize, as proposed by the National Policy on Popular Education in Health[14] (Brasil, 2013), that "[...] popular care involves bonds, history and culture".

[14] The National Policy for Popular Education in Health (PNEPS-SUS), established by Ordinance No. 2,761, of November 19, 2013, represents a milestone in the valorization of popular knowledge and the promotion of equity in the Unified Health System (SUS). Inspired by Freire's principles, the policy seeks to integrate technical-scientific knowledge with traditional knowledge, promoting dialogue, social participation and the collective construction of health care. By recognizing the importance of cultural and community practices, PNEPS-SUS strengthens participatory management and social control, contributing to the democratization of public health policies. See: BRAZIL. Ministry of Health. Ordinance No. 2,761, of November 19, 2013. Establishes the National

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Therefore, each tea, each cross with rue, each song sung while preparing a soup is also a political and pedagogical act.

When we talk about health practices in quilombola communities, we are not only describing alternative treatments, but facing a system that for a long time made other ways of healing invisible. The tensions between traditional knowledge and biomedical medicine are marked by symbolic and structural disputes in health services. As Luz (2007) states: "[...] modern medicine has established itself as hegemonic knowledge, defining what is valid or invalid as care" (p. 52). This becomes evident when practices such as blessings and the use of teas are disregarded in the consultations. According to Nascimento et al. (2013), "[...] popular therapeutic practices are often displaced from their original context and reinterpreted by biomedical logic" (p. 359), revealing a process of appropriation without real listening. Brito et al. (2024) reinforces the political and epistemic dimension of the dispute between knowledges, showing that institutional recognition is not a gift, but a field of resistance, invention, and historicity on the part of communities.

> It is very evident that the practice of community care is invisible by professionals, even when they use them. The care practices present in the community resist the processes of invisibility and delegitimization of health services. In the quilombola community, daily care practices are configured as one of the ways found for the affirmation of life, the exercise and legitimation of knowledge that exist not only to counteract the violent bias of colonialities, but as an expression of a knowledge that comes from afar and that is reconfigured showing a whole inventiveness, struggle and resistance of subjects who have never been dominated, but who go through several attempts at domination (p. 17).

These tensions become even more acute when we observe how health professionals receive – or ignore – local knowledge. Many quilombola women report that they omit the use of medicinal plants during consultations, fearing judgment. As Sobonfu shares: "[...] what works is medication, then the person to avoid it, right, the person says he is not using anything" (Brito et al., 2024, p. 15). This disqualification affects not only the practice, but the person as a subject. Werneck (2016) warns that "[...] the absence of explicit mechanisms to confront institutional racism prevents the SUS from achieving equity" (p. 89).

Institutional racism, according to Oliveira Júnior and Lima (2011), "[...] it is the collective failure of institutions to provide a professional and appropriate service to people

Policy for Popular Education in Health within the scope of the Unified Health System (PNEPS-SUS). Diário Oficial da União: section 1, Brasília, DF, n. 223, p. 70, 20 nov. 2013. Available at: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt2761_19_11_2013.html. Accessed on: 17 Mar. 2025.

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because of their color" (p. 22). This racism is expressed in small gestures, such as the refusal to listen, and in large structures, such as the absence of policies to welcome cultural practices. Grada exemplifies this violence when she reports: "[...] sometimes we seek help and it is as if we were not heard, as if our pain was not real" (Brito, 2021, p. 96).

In many Basic Health Units (BHU), the refusal to recognize the territory as a space for health production reinforces exclusion. As Silva, Sancho and Figueiredo (2015) point out: "[...] the denial of the territory and of the present health practices are constantly marked by situations of institutional racism that weaken the bonds of users to the services" (p. 74). This fragility translates into fear, silence and evasion. Ida reports: "[...] the person is embarrassed because in the corner you arrive you are well received is one thing and in the corner you arrive and are ignored is another thing" (Brito et al., 2024, p. 16).

> Popular health education promotes meetings, participatory management experiences, appreciation of experiences, knowledge and cultures, and popular and integrative care practices, such as those involving the cultivation and use of medicinal plants. [...] Medicinal plants and herbal medicines are recognized within the scope of the Unified Health System and are the object of a national policy that values popular practices of using medicinal plants and home remedies, including in family contexts. This reveals that each traditional practice, each prayer, tea or song, is not just a technique, but an act of care, resistance and cultural affirmation (Almeida, 2024, p. 104).

Even in the face of a situation of exclusionary practices, at the same time, we see growing experiences of articulation between traditional practices and the Unified Health System (SUS). The National Policy on Medicinal Plants and Herbal Medicines[15] (2006) proposes "[...] rescue and value traditional knowledge about medicinal plants" (Brasil, 2006, p. 24). This appreciation, however, is still limited. As Souza and Luz (2011) warn: "[...] the integration between medicines has become fallacious when there is an overlap of Western medical knowledge" (apud Contatore et al., 2015, p. 842).

[15] The National Policy on Medicinal Plants and Herbal Medicines (PNPMF), instituted by Decree No. 5,813, of June 22, 2006, represents a milestone in the valorization of traditional knowledge and in the promotion of the sustainable use of Brazilian biodiversity. Its central objective is to guarantee the population safe access and rational use of medicinal plants and herbal medicines, integrating popular practices into the Unified Health System (SUS). The policy establishes guidelines for the development of technologies, strengthening the production chain and recognition of associated traditional knowledge, promoting social inclusion and sustainable development. In addition, it encourages research, innovation and training of professionals, aiming at expanding therapeutic options and valuing traditional health practices. See: BRAZIL. Decree No. 5,813, of June 22, 2006. Approves the National Policy on Medicinal Plants and Herbal Medicines and makes other provisions. *Federal Official Gazette: section 1*, Brasília, DF, p. 1, June 23, 2006. Available at: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_fitoterapicos.pdf. Accessed on: 13 Mar. 2025.

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The integrative and complementary practices[16] recognized in the SUS also face resistance from sectors that still understand traditional knowledge as inferior. However, as Chechetto (2013) points out: "[...] the integration of scientific and traditional knowledge can promote emancipatory health practices" (p. 78). And according to Rossato et al. (2019), "[...] the dialogue between university and community is fundamental to break with the colonial logic of knowledge" (p. 66), especially when it comes to quilombola health.

Currently, the federal government is discussing the creation of the National Policy for the Integral Health of the Quilombola Population (PNASQ),[17] which seeks to guarantee the right to respectful and comprehensive care. This policy is inspired by previous milestones, such as the National Policy for the Integral Health of the Black Population (2009), and aims to "[...] promote equity, combat institutional racism, and expand access based on the knowledge and practices of communities" (Brasil, 2023, p. 5). This guideline signals an important change, but it still lacks effective implementation.

> Despite the advances in health policies achieved with the Unified Health System, in the case of equity it was not able to insert explicit mechanisms to overcome the barriers faced by the black population in access to health, especially the situations imposed by institutional racism. [...] In addition to the experiences of racism suffered in guaranteeing access to health, there is an invisibility of quilombola community productions in the services. This process is based on white/Western coloniality that disqualifies or, as Carneiro (2005) presents us, mortally wounds the rationality of the subjugated (Brito et al., 2024, p. 15).

[16] Integrative and Complementary Health Practices (ICPs) are therapeutic approaches that aim to prevent health problems, promote and recover health, emphasizing welcoming listening, the construction of therapeutic bonds and the connection between human beings, the environment and society. These practices were institutionalized by the National Policy of Integrative and Complementary Practices in the Unified Health System (PNPIC) and, currently, the Unified Health System (SUS) offers, fully and free of charge, 29 procedures of Integrative and Complementary Practices to the population. These therapeutic conducts play a comprehensive role in the SUS and can be incorporated at all levels of the Health Care Network, with a special focus on Primary Care, where they have great potential for action. One of the central ideas of this approach is a broader view of the health and disease process, as well as the promotion of comprehensive care for human beings, especially self-care. The indications for the practices are based on the individual as a whole, taking into account their physical, emotional, mental and social aspects. See: BRAZIL. Ministry of Health. Integrative and Complementary Practices in Health (PICS). Brasília, DF: Ministry of Health, 2024. Available at: https://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/p/pics. Accessed on: 27 Mar. 2025.

[17] The National Policy for the Integral Health of the Quilombola Population (PNASQ) was instituted by the Ministry of Health with the objective of ensuring full access to health for the quilombola population, recognizing their ethnic, cultural, territorial and ancestral trajectory specificities. The policy aims to reduce ethnic-racial inequalities, racism and discrimination in the health services of the Unified Health System (SUS), promoting equity and improving health indicators and quality of life for this population. The PNASQ establishes guidelines for the implementation of actions that consider the social and cultural diversity of quilombolas, strengthening social participation and social control in the SUS. See: BRAZIL. Ministry of Health. National Policy for the Integral Health of the Quilombola Population (PNASQ). Brasília, DF: Ministry of Health, 2025. Available at: https://www.gov.br/saude/pt-br/assuntos/noticias/2025/fevereiro/aberta-consulta-publica-sobre-a-politica-nacional-de-saude-integral-da-populacao-quilombola. Accessed on: 17 Mar. 2025.

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The reality in quilombola territories is marked by difficulties in access, turnover of professionals, and by a care model that is still centered on the disease. As Marques et al. (2014) point out, "[...] the precariousness of the structure and the curative vision of the SUS make it difficult to build bonds with the quilombola population" (p. 114). In addition, Gomes et al. (2013) point out that "[...] institutional racism operates as an invisible barrier, keeping users away from health services" (p. 82).

The experiences of black quilombola women have denounced these exclusions, but also pointed out paths. The National Policy on Popular Education in Health[18] (2013) proposes the valorization of popular and emancipatory practices. As the document states: "[...] the shared construction of knowledge is a pedagogical process that recognizes silenced voices and promotes protagonism" (Brasil, 2013, p. 18). In this sense, care becomes a space for struggle and cultural affirmation.

The absence of qualified listening in health services reinforces the epistemicide of traditional practices. As Carneiro (2005) observes: "[...] white coloniality fatally wounds the rationality of the subjugated" (p. 54). And this wound opens every time a woman is silenced when she mentions a care practice learned from her grandmother. For Santos and Quinteiro (2018), "[...] there is a historical alliance between science and power that excludes other ways of producing knowledge" (p. 28).

Despite this, quilombola communities continue to reinvent forms of care and resistance. As Freire (2014) points out: "[...] the construction of knowledge takes place in dialogue, in practice and in the transformation of reality" (p. 46). For this reason, recognizing quilombola knowledge is not a favor from the State, but an ethical and constitutional obligation. After all, as Luz and Barros (2013) recall, "[...] health is only fully realized when the culture of the other is respected" (p. 61).

> We consider here that the ethics of care presented by the actor and social actresses of the research is not limited to health care practices, it is a community ethic, ancestral to collective care, which, in the face of an epistemicidal logic, is configured as a mode of resistance and struggle against a white-Western rationality that denies

[18] The National Policy for Popular Education in Health (PNEPS-SUS), established by Ordinance No. 2,761, of November 19, 2013, represents a milestone in the valorization of popular knowledge and the promotion of equity in the Unified Health System (SUS). Inspired by Freire's principles, the policy seeks to integrate technical-scientific knowledge with traditional knowledge, promoting dialogue, social participation and the collective construction of health care. By recognizing the importance of cultural and community practices, PNEPS-SUS strengthens participatory management and social control, contributing to the democratization of public health policies. See: BRAZIL. Ministry of Health. Ordinance No. 2,761, of November 19, 2013. Establishes the National Policy for Popular Education in Health within the scope of the Unified Health System (PNEPS-SUS). *Diário Oficial da União: section 1*, Brasília, DF, n. 223, p. 70, 20 nov. 2013. Available at: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt2761_19_11_2013.html. Accessed on: 17 Apr. 2025.

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> and tries to deprive the other of their knowledge productions. [...] The knowledge presented in the narratives shows the inventiveness of a people in the face of a reality marked by colonialities, which even in the face of a structurally racist project of modernity manage to preserve knowledge and reinvent it not only as a response to this system of domination, but as another way of operating life guided by an ethics of care (Brito, 2024, p. 101).

Thus, guaranteeing the integral health of the quilombola population requires not only public policies, but also an epistemological shift. It is necessary for the SUS to stop seeing popular knowledge as exotic or accessory and incorporate it as a legitimate part of care. As summarized by Contatore et al. (2015): "[...] real integration requires the recognition of the cosmologies proper to each medical rationality" (p. 843). Thus, moving towards equity requires listening, dialogue and, above all, the courage to transform structures that have historically produced silences.

Thus, when we think about quilombola childcare practices, it is essential to recognize that these forms of knowledge do not follow the Western logic of Cartesian reasoning, but operate through what Lévi-Strauss called "savage thinking."[19] This thinking, far from being primitive or irrational, builds coherent systems based on symbolic classifications. As he himself states: "[...] savage thought is logical insofar as it operates by classifying, ordering, and grouping the elements of the world according to relations of similarity and difference" (Lévi-Strauss, 1966, p. 83). Therefore, when a grandmother chooses a specific leaf to bathe a child with a fever, she not only practices functional knowledge, but also activates a symbolic network that relates warmth, freshness, protection and ancestry. Also according to Lévi-Strauss, "[...] each plant is, at the same time, medicine and sign" (1978, p. 114), which reveals that, in the quilombola universe, treating is not only fighting symptoms, but reorganizing meanings.

Nevertheless, it is necessary to recognize that this knowledge does not act in isolation, but coexists with the discourses of Western medicine. Kleinman, when proposing the concept of plural medical systems[20], states that "[...] the experience of illness is shaped

[19] Reference to the author's work that bears the same name.

[20] The concept of plural medical systems, proposed by Arthur Kleinman, recognizes that different cultures organize their own health care systems, in which multiple ways of understanding, treating and experiencing illness coexist. According to this perspective, biomedicine is only one among several possible medical systems, and not a universal truth. In popular and traditional contexts, such as in quilombola communities, therapeutic plurality is a daily reality, in which blessings, teas, medical consultations and spiritual practices coexist and complement each other. Kleinman (2013) points out that "[...] the experience of illness is shaped by culture, and different medical systems reflect different visions of the body, the person, and healing," which requires health professionals to be sensitive to intercultural and respectful of local practices. See: KLEINMAN, Arthur. Disease, care and cure: anthropological and cultural aspects of the experience of illness. In: KLEINMAN, Arthur; BASILICO, Matthew; KIM, Jim Yong; FARMER, Paul (ed.). *Reimagining Global Health: An Introduction*. Rio de Janeiro: Editora Fiocruz, 2013. p. 29-45.

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by culture, and different medical systems reflect different views of the body, the person, and healing" (2013, p. 34). Thus, quilombola child care is not opposed to biomedicine on principle, but seeks to affirm its own logic. Scheper-Hughes reinforces this idea by stating that "[...] modern medicine tends to ignore the cultural context of pain and healing, treating the body as an isolated object" (1993, p. 67). That is why, for many quilombola families, tea and prayer are inseparable – because they heal the body and protect the soul.

> The proposal to document the healing of the body and soul originated from our experiences in fieldwork [...] Man's relationship with the search for mystical paths for his own healing was clear, showing that the use of plants in the doors, as guardians, in the manufacture of small amulets, in the preparation of baths for children, incense and teas, reveals the most transparent of the ways that the community uses to heal the body and soul in an almost always instinctive way, uniting the magical with the effective medicinal properties (Almeida, 2011, p. 69).

Even so, these practices suffer a systematic devaluation when they enter public health services. Paul Farmer warns us that "[...] the suffering of marginalized populations cannot be understood without an analysis of the structures that keep them in poverty and exclusion" (Farmer, 2003, p. 51). And it is precisely at this point that ancestral knowledge is put in check, as quilombola subjects are expected to adapt their customs to clinical protocols. According to the author, "[...] the choices that people make in health are shaped by the structures of oppression and by the history of institutional abandonment" (2013, p. 88), which forces us to understand that the replacement of tea by pills is not only a therapeutic option, but a historical imposition.

This imposition, by the way, is part of a broader process of epistemological erasure, denounced by Vandana Shiva. For her, "[...] Western science has transformed knowledge into a commodity and delegitimized all other forms of knowledge" (1999, p. 45). This means that for a plant to be considered medicinal, it needs to be validated by a laboratory – ignoring centuries of empirical use by communities. Shiva also denounces that "[...] epistemic colonialism manifests itself when local knowledge is appropriated, renamed and sold as scientific innovation" (1999, p. 53). Therefore, when a healer teaches her granddaughter how to prepare a discharge bath for quilombola children, she is also resisting this process of expropriation and silent colonization of knowledge.

> Therefore, what is at stake is not necessarily the conservation of biodiversity, but rather the monetization of the common goods existing in nature, that is, the transformation of these goods into merchandise. [...] It is important to highlight that the intellectual rights over biodiversity would not belong to traditional peoples, who have contributed to its conservation, but to large pharmaceutical companies that want to appropriate common goods to monetize these resources. From this

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> perspective, in the name of biodiversity conservation, these companies will be able to control various natural resources, especially medicinal plants and knowledge related to the preparation of herbal remedies, and will then be able to commercialize them (Guedes, 2024, p. 176).

The act of teaching a discharge bath to quilombola children, for example, far from being just an intimate or routine gesture, is also a vigorous form of resistance against epistemic erasure and the transformation of knowledge into merchandise. By preserving these practices in the midst of the onslaught of hegemonic science, quilombola women reaffirm the power of a knowledge that is not measured in patents or clinical trials, but rather in affection, ancestry, and lived experience. As Almeida (2011) states: "[...] The ritual of bathing has as a collective symbology its purifying and transforming virtue. Being associated with the act of immersing, which gives it an initiatory value [...] the smell baths are dedicated to the divinities and used for protection, healing and balance of the spirit" (p. 193).

Therefore, the transmission of the preparation of a bath is not neutral: it carries the political gesture of those who refuse to see their knowledge reduced to a laboratory object. In addition, Guedes (2024) reminds us that "[...] the affective bonds and the parental, neighborly, and patronage relationships mirror the style of community life, making the healers, who are also healers, responsible for the transmission of traditional knowledge and for the treatment of quilombola children" (p. 165). Thus, teaching how to harvest, prepare and take an herbal bath is not only teaching care – it is also teaching a belonging, a symbolic territory and a way of existence that refuses to be silenced.

Johannes Fabian, when reflecting on time in anthropology, shows how the knowledge of the other has always been situated in a distant, frozen past, as if traditional peoples were not contemporaries of modernity. He states that "[...] the denial of contemporaneity[21] is one of the mechanisms by which the West legitimized its superiority" (1983, p. 143). Therefore, to affirm quilombola knowledge in the use of medicinal plants in children in the present is to break with this colonizing chronological logic. Fabian adds: "[...]

[21] The concept of contemporaneity, formulated by Johannes Fabian, denounces the historical tendency of Western anthropology to represent traditional peoples as belonging to an "other" time, distant, archaic and alien to modernity. This denial of shared time – or existential simultaneity – functions as a mechanism of epistemological exclusion, preventing the researched subjects from being recognized as contemporary interlocutors, bearers of living and current knowledge. According to Fabian (1983), breaking with this colonizing chronological logic is fundamental to building horizontal relations in the scientific field, in which the "other" ceases to be just an object and is recognized as a legitimate producer of knowledge. In the context of quilombola communities, to affirm contemporaneity is to recognize that their knowledge and practices exist in the present and are part of the construction of plural and possible futures. See: FABIAN, Johannes. Time and the Other: how anthropology makes its object. New York: Columbia University Press, 1983.

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it is necessary to give back to the other his place in the now, so that he is not only an object of study, but a political interlocutor" (2014, p. 162). Therefore, defending the use of plants in child care is not only a health issue, but a claim for time, voice and agency.

> Pointing out that we will tell our own story and build our narratives does not mean that something unprecedented in our journey, as black people, is happening, in reality what happens is the resumption of our historicity from ourselves. [...] We speak the language of the colonizer, but we make our own use, our own ruptures, we tell our story, we build our own narratives (Brito, 2024, p. 37).

As Scheper-Hughes teaches us, the body is a space of cultural, political and affective inscription. And the body of the quilombola child is cared for with gestures, words, broths and baths that are part of the family's daily life. She writes: "[...] the human body is socially produced and culturally interpreted, being the place where power relations are dramatized" (Scheper-Hughes, 1993, p. 226). Therefore, prohibiting the use of a tea or discrediting a prayer is, in a way, disallowing an entire experience of the world. Kleinman adds that "[...] it is not just about treating children's diseases, but about understanding meanings" (2013, p. 76), and this is exactly the challenge for the SUS in the face of quilombola medicinal practices.

Farmer points out that the absence of public policies that respect cultural diversity reinforces the cycle of inequalities. "The structure of global health often functions as an instrument of exclusion" (Farmer, 2003, p. 116), especially when it ignores local contexts. Thus, even when there is access to health units, many mothers stop attending them for fear of being judged for their traditional practices. And it is no wonder: "[...] structural violence is present when institutions fail to meet the real needs of the populations" (p. 159), which forces us to think that the problem is not only in the lack of resources, but in the refusal to recognize other knowledge.

By bringing up "Wild Thought", Lévi-Strauss dismantles the idea that indigenous and quilombola knowledge is only instinctive or empirical. He states that "[...] there is a logic behind the use of plants, even when their efficacy cannot be proven in biochemical terms" (2004, p. 92). And this logic is based on deep observations of nature and symbolic relationships that give meaning to the lived world. Therefore, the use of a certain root to relieve a child's fever or a leaf to ward off puerile fear is not random. As he adds: "[...] therapeutic practice is anchored in a coherent system of beliefs and classifications, which connects man, plant and cosmos" (1978, p. 117).

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Meanwhile, Shiva (1999) denounces that "[...] the West has created the illusion that modern science is universal, when in fact it is deeply localized and culturally situated" (p. 63). And in doing so, it has made invisible the knowledge built by peoples who live in a deep relationship with the land. This invisibility is reflected in public policies that prioritize industrialized medicines, but do not offer support to community living pharmacies. As she states: "[...] the monocultures of knowledge lead to the monoculture of the mind, impoverishing the diversity of thought and practices of life" (p. 89), which directly threatens the plurality of experiences of child care in quilombos.

Fabian, when discussing the relationship between time and knowledge, argues that "[...] when we remove the other from the present time, we transform him into a vestige of a dead past" (1983, p. 45). And this is precisely what happens when quilombola knowledge is treated as folklore and not as legitimate knowledge. This operation disqualifies not only the practice, but an entire way of life. Therefore, as he insists: "[...] it is necessary to recognize that the knowledge of the other is in progress, it is alive, it is now" (2014, p. 198), which requires ethical and committed listening from the State and institutions.

Kleinman, in turn, argues that health care should be guided by an interpretative model that takes into account the subjects' narratives. He states: "[...] Professionals should ask the patient: what do you think you have? What do you think caused this?" (2013, p. 45). This active listening is what is often lacking in the SUS when it comes to the quilombola population. As Scheper-Hughes (1993) points out, "[...] medicine becomes violent when it ignores the meanings that individuals attribute to their pain and their cure" (p. 243), which reaffirms the urgency of a more culturally sensitive and humanized care.

Thus, it is essential to recognize that the use of medicinal plants, blessings and soups in quilombola child care are not obsolete practices, but contemporary forms of resistance and production of life. Farmer states: "[...] resisting structural violence requires valuing the voices that have been historically silenced" (2003, p. 221). And as Shiva reminds us: "[...] rescuing ancestral knowledge is also rescuing ways of living that do not destroy the planet" (1999, p. 108). Therefore, walking alongside quilombola knowledge is not only an ethical action, but also a political, health, and environmental urgency.

CONCLUSION

Throughout this study, it was possible to understand that quilombola child care is not limited to the use of medicinal plants as an empirical practice, but is configured as a

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relational, ancestral worldview deeply rooted in the territory. Every tea prepared, every bath with herbs, every blessing performed by a grandmother or a midwife represents more than a therapeutic act: it is a reaffirmation of the dignity of a people and the legitimacy of its epistemology. In this sense, the quilombola living pharmacy emerges as a space of healing, resistance and identity affirmation.

In addition, it was evident that this knowledge is not isolated in a folkloric past, but is current, alive and dynamic. They circulate orally, are reupdated in backyards, kitchens and in the bodies of children cared for with hands that carry stories. And even in the face of the pressures of hegemonic biomedicine, these practices persist, reinvent themselves and dialogue with everyday reality, always seeking comprehensive care that welcomes the body, the spirit and the territory.

It is important to recognize, however, that these forms of care coexist with symbolic, political and institutional tensions. The exclusion of traditional knowledge in public health services reveals a colonial project that is still in progress, which insists on hierarchizing knowledge and silencing what does not fit into Western technical rationality. The speeches of quilombola women, so often crossed by the fear of judgment, denounce that epistemicide is not an abstraction: it is experienced on a daily basis, in consultations, in UBS, in protocols.

Despite this, community care practices continue to be woven with affection, memory, and resistance. Teaching a daughter how to prepare a syrup, picking leaves at dawn, or reciting a prayer in the baby's bath are not just gestures of transmission of knowledge: they are acts of historical continuity. They are pedagogies of bonding that form subjects aware of their belonging and their ancestral strength. They are also, and above all, ways of saying that knowledge is not a monopoly of a science, but a common good in constant collective construction.

Therefore, to reaffirm quilombola child care as legitimate is also to claim another model of health: a model that listens, that welcomes, that dialogues with the ways of living and healing of traditional peoples. This requires from institutions an epistemological displacement and an ethical openness to other ways of producing life. It is not a matter of replacing knowledge, but of recognizing that there are other ways of knowing – and that these forms have the right to exist.

The experience of the living pharmacy has shown us that healing there is not an isolated act, but a community and spiritual process. It is the territory that heals, it is the plant

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that listens, it is the dream that guides. And, therefore, taking care of a child is also taking care of the collectivity, the forest, the stories and the deities that inhabit quilombola life. As so many women taught during the research, care does not rush: it requires time, silence and presence.

Thus, this research did not intend to give voice to quilombola communities – because they already speak. What we did was listen, record and walk together. What is expected, from here, is that public health care is capable of doing the same: listening with respect, recognizing with humility and dialoguing with justice. Because there is no equity possible without valuing the knowledge that heals, and there is no fair future if the territories of knowledge are forgotten.

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