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"Passed from generation to generation": Care practices of *quilombola* women

"Vem passando de geração para geração": as práticas de cuidados de mulheres quilombolas

"Pasado de generación en generación": las prácticas de cuidado de las mujeres quilombolas

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Abstract: Aim: to investigate how sociocultural care practices were constructed among women in a *quilombola* community. **Method:** qualitative, descriptive, anthropological research, developed with *quilombola* women. The data, produced from the focus group technique, were submitted to thematic content analysis, according to the operative proposal. **Results:** the care developed and shared during the different life cycles of *quilombola* women were presented. Menarche, pregnancy, childbirth, the puerperium and menopause were shown to be processes that demand specific actions and are made from the existing resources within the family and community context. **Conclusions:** the care practices were developed from the historical values present in the cultural universe of this *quilombola* community. They represent actions passed on from generation to generation among women, who are represented as the main caregivers within the home and family context, but also among the individuals who are cared for by them.

Descriptors: Women's health; African continental ancestry group; Culture

Resumo: Objetivo: investigar como foram construídas socioculturalmente as práticas de cuidado entre mulheres de uma comunidade quilombola. **Método:** pesquisa qualitativa, descritiva, com vertente antropológica, desenvolvida com mulheres quilombolas. Os dados, produzidos a partir da técnica de grupo focal, foram submetidos à análise de conteúdo temática, conforme a proposta operativa. **Resultados:** foram apresentadas os cuidados desenvolvidos e compartilhados durante os diferentes ciclos de vida da mulher quilombola. A menarca, gravidez, parto, puerpério e a menopausa foram evidenciados como processos que demandam ações específicas e

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são realizadas a partir dos recursos existentes no contexto familiar e comunitário. **Conclusões:** as práticas de cuidados foram construídas a partir dos valores historicamente presentes no universo cultural desta comunidade quilombola. Elas representam ações repassadas intergeracionalmente entre as mulheres, as quais são representadas como os principais cuidadores dentro do contexto domiciliar e familiar, mas também entre os indivíduos que são cuidados por elas.
Descritores: Saúde da mulher; Grupo com ancestrais do continente africano; Cultura

Resumen: Objetivo: investigar cómo eran las prácticas de atención construidos socioculturalmente entre las mujeres de la comunidad quilombola. **Método:** investigación cualitativa, descriptiva, antropológica, desarrollada con las mujeres quilombolas. Los datos, producidos a partir de la técnica del grupo focal, fueron sometidos a análisis de contenido temático, de acuerdo con la propuesta operativa. **Resultados:** han sido presentados los cuidados desarrollados y compartidos durante los diferentes ciclos de vida de las mujeres quilombolas. La menarquia, el embarazo, el parto, el puerperio y la menopausia se evidenciaron como procesos que demandan acciones específicas y se realizan con los recursos existentes en el contexto familiar y comunitario. **Conclusiones:** las prácticas de cuidados fueron construidas a partir de los valores históricamente presentes en el universo cultural de esta comunidad quilombola. Representan acciones transmitidas intergeneracionalmente entre las mujeres, que son representadas como las principales cuidadoras en el contexto de la casa y familiar, pero también entre las personas que son atendidas por ellas.
Descriptores: Salud de la mujer; Grupo de ascendencia continental africana; Cultura

Introduction

The remaining *quilombola* follow Brazilian history and are located in practically every state in Brazil.[1] The term *quilombo* derives from the word *kilombo* and in the past meant a warrior camp in the forest resulting from collective resistance against slavery. *Quilombos* were mainly inhabited by refugee slaves, but they also comprised individuals from other ethnic groups uprooted from their communities.[2]

Quilombos are now considered spaces in which ethnic-racial groups with a presumption of black ancestry reside.[3] In these communities, as in other groups,[4] intergenerational values, beliefs, and customs have been perpetuated, which influence how individuals perceive and interpret their bodies as well as their own health, and develop their care practices.

Care practices, in this case, consist of individual or collective social actions, encompassing popular and scientific beliefs. They are developed in interpersonal relationships and portray the

values and principles of a group.[5] Women have historically been assigned the role of provider of such care, thus caring for themselves, their families and other members of the family network.[6]

The care practices developed by women are linked to the three health care subsystems: informal, popular and professional. The family subsystem encompasses popular culture and common sense, represented by care related to home remedies, rest, emotional support, and religiosity, among others. Associated with the family subsystem, there is the popular subsystem, which includes the care actions developed by healers, *benzedeiras* [Portuguese: traditional term for a lady who gives religious blessings and is a midwife]. The professional subsystem refers to biomedical care, which treats individuals based on their illnesses.[7]

Each subsystem has its own characteristics, as well as differing concepts, knowledge and care practices in relation to the health and disease process. Throughout life, women move between these three subsystems, because the types of care that integrate these subsystems are not mutually exclusive, but overlap.[7]

In this sense, the present study was conducted from a master's dissertation,[8] which was guided by the research question "How were the sociocultural care practices constructed among *quilombola* women?", with the aim of investigating how the care practices among women from a *quilombola* community were constructed from a sociocultural perspective.

Method

This is a qualitative, descriptive research with an anthropological aspect, developed with *quilombola* women. The research scenario was a *quilombola* community; located 65 kilometers from the host municipality in the interior of Rio Grande do Sul, Brazil. Access to the community is via an unpaved road.

At the time of the study, the community used water from an artesian well that was constructed 10 years previously and had electricity that was installed four years ago. They

developed subsistence cultivation of vegetables and owned a bakery, which was maintained by women, where they produced bread to be sold. There is also a warehouse and a school; however these do not belong to the community.

There were no health services near the community and they did not develop leisure activities either. Twice a week, a single commercial bus transported residents to the host city.

The selection of participants was intentional, considering of women over 12 years of age (an age group that includes the onset of adolescence), such that 13 participants from 14 to 56 years old were included.

Data were produced in February 2014 using the Focus Group (FG) research method, applied by a female mediator and a male observer. The technique was developed during three meetings, and the present article presents the findings from one of these meetings. In order to promote discussion about the focus theme, the participants were invited to develop an album about the care practices developed throughout the female life cycle, based on the techniques of clipping and collage of images, and mediated by the following statement and question: "We are all women and we experience our care from birth. If we had an album showing our lifelong care practices, what would it look like? "

During elaboration of the album, the participants were also asked: "In your opinion, what is important to take care of women's health?" For the development of the album, the participants were divided into small groups. Each group produced one or more pages of the album relative to a specific period of the female life cycle.

In this way, care practices developed in the different life cycles of women were presented, such as adolescence, adulthood and old age, as well as certain female events, such as menarche, the pregnancy-puerperal period and menopause. For exhibition of the album pages, the women organized themselves according to the chronological occurrence of these events in the female cycle.

The participants' discourses were recorded on digital devices and then transcribed. The data were subjected to thematic content analysis, according to the operative proposal.[9] The anonymity of the participants was ensured with identification via an alphanumeric system. The ethical aspects referred to in Resolution 466/2012 were respected. The research project that originated this study was approved by the Research Ethics Committee on December 13, 2013, through Resolution Process Number 494.051 and CAAE 25345113.7.0000.5346.

Results and discussion

During adolescence, girls begin to be involved with their first care practices. In this phase the body changes begin and they experience intense hormonal alterations, as well as events that profoundly mark their lives, such as the menarche and coitarche.

The study participants highlighted that adolescence was marked by: detachment from childhood games and established friendships; the manifestation of their first affections, loves and desires for boys; the first kiss, dating and sexual intercourse; in addition to the emergence of concerns about body aesthetics. Adolescence was also characterized to a certain extent with family expenses and the future, thus giving rise to the desire to enter the job market.

Among the care practices, women cited mainly those related to aesthetics. They reported that during adolescence, they were more concerned with body image and resorted to resources that could allow a guarantee of care.

> *We put on makeup* [cut out and pasted images that illustrate makeup]*. Because you will remind yourself that you will get old in your teens. You will have wrinkles. Then you'll have to start using powder, blush. Not to mention that teenagers love it too.* (M4)

It is possible to identify the existing care with aesthetics and, especially, with physical beauty. Care practices developed to maintain beauty represent care that participants believe

should begin in adolescence, perpetuating throughout the female life cycle, and with implications for the future.

The same care practices, focused on body image, were also identified in a study[10] developed with female *quilombola* adolescents. These practices are justified as a concern with physical beauty and involve a "body worship cult"[11] that is not restricted to adolescents, but also includes women from other age groups. Body image, which one wants to "take care of", represents a cultural and multidimensional construction that encompasses women's perceptions, feelings and behaviors regarding their physical attributes.[11]

Associated with body care, they also highlighted the first physical changes experienced during this period and the menarche itself. Among older women, this event was experienced during a period in which mother and daughter had little dialogue and the girl-woman's right to know and understand her own body was denied.

> *We didn't know what a period was, because what were our mothers? They hid it from us, we didn't even see it in the bathroom, I didn't know about it.* (M6)

On the other hand, another slightly younger participant reported her experience with the menarche and her relationship with her mother. It is possible to see that menarche and other women's events were no longer veiled and were discussed within the family environment, allowing the revelation of some care practices developed by mothers towards their daughters, mainly through advice.

> *When I was 12, I started menstruating, but I was already warned: "...your cycle will start". My mother explained it well. It was just more strict. She didn't tell me that I had to use* [contraceptive methods]*, but she scared me also. I think a lot of moms do this: "...if you take a pill, I'll know too* [if you have sexual relations]*, because you are starting to put on weight, it will create body. I will notice that you are taking the pill. If you get a condom from the Health Clinic, my friend will tell me". I think this was also prejudicial. Today there are mothers who are still living in the past, who do this.* (M4)

> *Today a mother comes and already talks with a daughter. Before, if we asked our mother, she would answer: "…when you get married, you'll know". You had to find out for yourself. So they got married very early, then they regretted it. I myself had a son when I was 17 years old, and if mother had said, '…look, my daughter, you take care of yourself"* [...] *I might not have had a son so young.* (M7)

Until recently, some subjects, especially those related to sexuality, were considered taboos and repressed by parents in the family environment. It was observed that menarche is one of these veiled themes within the family, because it is recognized as a rite of passage to adulthood,[12] in which the girl awakens to sexuality, thus leading to the possibility of an early pregnancy.[13]

In the second account, one observes the fear created by the mother in her daughter, claiming that the loss of her virginity could be revealed through physical changes apparent in her body. Culturally, sexuality reserves many myths and beliefs transmitted on an intergenerational basis that lead to distress among adolescents.[13]

It is even possible to infer that, within the context of this community, female sexuality is shrouded in the conception of a guarantee certificate,[14] which must be preserved by the girl-woman, since it mythically symbolizes a motive of honor for her and her family. Thus, the participant's discourse also shows that the experience of sexuality among girls tends to be somewhat repressed by the family.

Regarding the dialogue about sexuality in the family context, authors[15] have underscored that many parents feel difficulty in addressing issues related to sexuality with their children, because they believe that this attitude could serve as a stimulus for early sexual initiation. Possibly, this was also the belief, which prevailed in the past among the mothers of *quilombola* women.

However, in a context in which the adolescent needs to maintain her sex life under a veil, it is believed that the barriers imposed on intrafamilial communication not only lead to early

sexual initiation, but also to the possibility of an unplanned pregnancy. From the participants' perspective, it appears that dialogue represents a fundamental tool in the development of care practices that encompass adolescence.

During the group, the participants also awoke to the fact that, even with dialogue, many *quilombo* adolescents continued to become pregnant. Thus, they pondered on other reasons that determined the occurrence of this phenomenon. Among them, they mentioned the use of contraceptive methods, and it was possible to verify that care practices related to safe sexual intercourse were not and continue not to be common among these women.

> *Nobody accepts it if we say it was carelessness, because if you say it is carelessness, people say: "...how was it carelessness, if there are various methods for taking care of yourself? There's a free pill, there's a free condom". It's free but you also feel ashamed. I had my first baby at 13. How could I not feel ashamed to go to a Health Center and ask for a pill, a condom? Ask my mother? Imagine I was going to ask my mom for a pill. There was no way and there is the pill too, but you have to register and have to prove that you don't have the means to pay.* (M4)

> *These days I happened to be there* [at a municipal health service] *and the attendants themselves looking at the condom box up there and commenting: "...look at the idea of putting it up there. What teenager will get here and be brave faced enough to get a condom in front of everyone?" As much as you want to, you don't get it out of shame. There are always people watching. The ladies who work there themselves keep commenting.* (M8)

The excerpts from the discourses highlight the difficulties faced by women in accessing contraceptive methods. Among the main reasons mentioned for not using these methods are the feeling of embarrassment; the location chosen by the health service to make them available which, according to the participants, is inappropriate; and the bureaucratization imposed by the institution, which, according to the participant, requests proof of the lack of financial resources to purchase the contraceptive.

It is also possible to perceive the responsibility that, culturally, has been bestowed upon these women, since adolescence, in relation to care practices focused on safe sexual practice.[16] As in other communities,[10] men are not responsible for development of care practices and when they are experiencing adolescence, together with a girl of the same age and with the same immaturity, inexperience and unpreparedness, this responsibility is still attributed to the girl.

In addition to all the myths and taboos surrounding sexuality, at this stage, beliefs about menstrual blood and its supernatural powers also emerged in the group debate.

> *My mother always said not to wash my head, and even so I insisted and washed it.* (M1)
> *This one from* [region near community] *died. By the time they left here with her to go to town, she was already dead. Because when you wash* [your hair]*, you bust your head.* (M7)

In their view, during the menstrual cycle, women should have some restrictions on hygiene, especially with regard to hair washing, as they considered that menstrual blood could have supernatural powers. They even knew women who had disregarded this care practice and it had implications for their own health, even leading to death.

Thus, it can be seen that beliefs involving this period or menstrual blood continue to be perpetuated in countless societies.[6] These reports corroborate the literature,[17] which indicates that beliefs and care practices are born simultaneously within the same social context, influencing each other and causing women to adopt certain behaviors.

With regard to menstruation, in the popular context, there are still beliefs, myths and taboos that have been perpetuated throughout history and restrict women to certain activities.[18] For *quilombola* women, menstrual blood appears to have malignant powers, being a dreaded substance that, depending on the conduct adopted by the woman during this period, may emerge from the uterus to another region of the body, such as the head, leading to negative

outcomes, as indicated by M7 on stating that hair washing during the menstrual period, could lead to death.

During this phase, *quilombola* women also adopt care practices aimed at relieving colic. They resort to teas, but also to industrialized medicines.

> *When you have colic, it is always good to have a cup of tea.* (M1)
> *I take Buscopan.* (M2)
> *I take Atroveran. Sometimes I take almost a whole bottle in three days to see if it goes away.* (M4)
> *My grandmother, when I feel it, straight away tells me to have orange tea. (M8)*

It is possible to verify that, among the older women, the use of teas stands out, while among younger women the use of industrialized medicines is common. Thus, it is considered that the boundary that separates popular knowledge, as in the use of teas, from scientific knowledge, used in the formulation of industrialized medicines, is tenuous, and it is possible to combine them, thereby creating new knowledge and care practices. Although there is, in some situations, a conflict between the two knowledge systems, it is considered that they complement each other and can be reinvented according to the needs of each individual or group.[19]

Regarding adolescence, adolescent pregnancy was also highlighted. According to the women, girls experience their first pregnancy while still in their adolescence.

> *In adolescence, not only us, ok? This was our case, but almost all of them married here in their teens. Almost all had little presents* [children] *in their teens* [laughter]. (M4)

Teenage pregnancy has emerged in this and other reports as being common in the community. Therefore, it is presented as a natural event for adolescents, since it was experienced by grandparents and mothers alike, who hope it can also be experienced by their daughters.

It appears that the socioeconomic and cultural context, as well as the values and principles transmitted within these,[20] are able to define the attitudes, behaviors and choices made by individuals. Thus, the cultural traditions themselves existing in the *quilombola* community can contribute to girls choosing to experience pregnancy during adolescence.[21]

Moreover, in their view, the fact that, especially, mothers did not accept discussion with their families about issues related to sexuality, was crucial for them to opt for early marriage and/or pregnancy. They believe the possibility of dialogue that is currently present may change the habitual choices made by *quilombola* adolescents.

In the transition to adulthood, they pointed out that women who did not become pregnant in their teens experienced their first pregnancy as adults. According to them, the care practices related to the gestational process, developed in the past, have gradually changed. Pregnancy that initially did not require so much care was now considered a condition that required constant "treatment".

> *Nowadays, you get pregnant, you have to go to the doctor. "...oh, I'm going to the doctor, because otherwise I'll lose my child". We used to do everything before. Today they get pregnant; they don't do anything else, because their son is going to come out from down there.* (M6)

This discourse manifests the change in relation to the view on pregnancy. The cultural vision created around pregnancy is that it should not be seen as a female physiological event, characterized by transformations in all organic systems, but as a pathological state that needs to be controlled and treated by health professionals.[18]

Pregnancy, viewed under this pathologizing and biologicist paradigm, determined the emergence of new care practices. Among them, the need for regulation and medical treatment, as expressed in the content of the participant's discourse. Surrounded by the biomedical and diseased pregnancy culture, some *quilombo* women have failed to perform numerous activities of daily living, believing that these could endanger the vitality of the fetus.

In the same manner as pregnancy, midwifery has also undergone numerous changes. Childbirths that culturally occurred in the *quilombola* community and were assisted by mothers and other women in the family began to occur in the hospital environment, with the intervention of health professionals and without the help and presence of significant people for the women.

> *I gave birth to them all, not to say they were all, the first one I got by caesarean section and the last one. All the others were delivered with mom at home. In the last delivery* [in hospital]*, the serum dropped off my arm. I had nobody with me. The nurse came: "...ah, did you remove the serum?" "...I didn't. It fell out", and she took a needle and stuck it in my arm. I raised my foot, kicked her, and ran away from the hospital. I stopped there at my sister's house. The next day I went* [to the hospital]*, because my belly was so big, stiches burst, got infected, they had to open all over again. Then, yes, I suffered, it seemed like I was going to deliver another one.* (M6)

> *I gave birth together with mom. I didn't go to town. I delivered in my mother's office. I called the mother of that girl there. She was my midwife, and my mother and another neighbor who lived next door. That was how we get children. The girl I already got in the city, but I also arrived at the hospital, the nurse said to me, "...take off those clothes" and I said I wasn't going to take my clothes off.* (M7)

The deliveries that were assisted by mothers and neighbors, in the home and family context, underwent several modifications. Care practices aimed at childbirth that, for a long time, were developed by the women of the family, began to be performed and, most of the time, imposed by individuals unknown to them, who disregarded the subjectivity, uniqueness and grandeur of the moment. They tried to subordinate them to their power through impersonal postures, rigid norms and unnecessary interventions. Thus, such changes in the birth scenario were traumatic for these women.

With the birth of babies and the need to perform first care practices, it was observed that the scientific knowledge of health professionals were imposed on women as absolute truths, which should be incorporated into the daily care of newborns (NB).

> *At the hospital, they* [health professionals] *explain for us: "..look you have to breastfeed! They are not going to suck bottles! Breastfeed!"* (M1)
>
> *They* [nursing staff] *say a lot that we have to give breast milk, and not to give tea or cow's milk.* (M7)

Breastfeeding is a care practice imposed and demanded on women by health professionals. The guidelines reported by the participants, although important and appropriate regarding the feeding of the newborn and the early introduction of other liquids, evoke, according to the authors,[22] a veiled accusation that makes women responsible for the success of breastfeeding and that generates, in their imagination, feelings of guilt when the NB refuses or is otherwise unable to breastfeed.

This highlights the importance of rethinking the way breastfeeding has been taught, in order to present it as a choice that should be made exclusively and consciously by women. Breastfeeding needs to be seen as one of the many possibilities in a woman's life and not as unique and obligatory.

Despite this context of impositions created by health professionals, it was still possible to verify that many of the care practices passed on by the most experienced women, such as the use of umbigueira [a string around the belly to protect the child from negative energy or spirits] and ingestion of teas continue to be propagated in the community. Although, for the most part, remain hidden by the women.

> *I put on an umbigueira. Once, the nurse cursed me. I put it on my granddaughter, she said I can't, she made a scandal, but at home, I always use it.* (M1)

> *I used to drink a lot of mint and herbs tea, which was good for a stomach ache in the child. The doctor doesn't let us, not even give water, but it is all hidden.* (M5)

The use of a band around the belly button, called "*umbigueira*", and the provision of teas are common in child care, and although they are care practices not recommended by health professionals, they continue to be perpetuated among women. Regarding the use of the umbilical band, it is considered that this is a culturally common practice, although it is ineffective and even harmful in some cases. In the same way, tea represents a very important and significant cultural element in childcare practices.[23] Both practices comprise a knowledge that, although empirical, is extremely respected, since it was transmitted by women considered to have experience, such as their grandparents and mothers.

For decades through to the present day, scientific medicine and the biomedical model coexist alongside popular care practices, the former seeking to impose their knowledge as the only means capable of providing the necessary care for individuals.[19] In the context studied, it was verified that despite the imposition of health professionals' knowledge, the traditional care practices and beliefs remain alive in the history and culture of the *quilombola* community.

The value attributed to the knowledge transmitted by mothers and grandparents can be observed.

> *The only thing my mother taught me* [about puerperal maternal care]*, I don't know where she learned: "…wash and drop a few drops of alcohol, then those stitches will fall out". This she taught me and this I did. I showered, washed myself, and rinsed with that water and alcohol. She said the stitches were going to fall, but I don't know if they fell. I didn't wash my head, but I took a bath every day. I was also careful not to get cold and come close to the fire. I don't know why they* [mothers] *said this: "…can't go close to the stove". To this day, anyone who has surgery can't either. It's been passed on from generations. Everything my mother gave me, I passed it to her* [daughter] *when she gave birth.* (M1)

The same care practices that were widespread in the past between mothers and daughters continue to be passed on to granddaughters. From the cultural point of view,[6] they indicated beliefs about cold and heat, which in this case not only reflect temperature but a symbolic force that can have negative effects on the health of these women. From this perspective, it is inferred that aspects present in the natural environment, such as cold and heat, could cause or expose these women to diseases.

Moreover, there are individuals considered to be a source of counseling and health care.[6] In the community, it is observed that these are represented by women with long experience in certain female events, such as grandparents and mothers, as well as women who helped in the upbringing of various children.

> *I asked my mother and my great grandmother, who also helped take care of my children.* (M1)
>
> *When I had any questions, I would ask my mother.* (M10)

The women cited are considered as references in health care, mainly due to their life experiences. They advise the younger or less experienced women about caregiving practices that have already been validated by them and that are socially accepted and respected within the *quilombo*. From an anthropological perspective,[6] in the most diverse contexts, there are individuals considered as knowledge holders, who help those considered as less experienced in various situations.

Finally, with regard to old age, the women reported that there is a concern with food and about cold and heat. In the discourses, a conception of infantilization of old age even emerged,[24] showing that, at this phase in life, individuals demand more care practices.

> *God forbid the old person has no health, you have to be more careful with food, I think.* (M1)
>
> *Usually, the person after getting old, she becomes a child again. Same thing as a baby.* (M2)

> *What do I take care of? I take care of everything. The food, the cold, the heatt.* (M11)

The prominent care practices linked to aging refer to the importance of food for maintaining health, and also reinforce the concern about exposure to heat and cold,[6] considered as factors that expose the elderly to diseases. Regarding the conception that, in old age, the person "becomes a child again", authors[24] emphasize that this conception has been highlighted from a perspective of affection and care towards the individual, on reaching the third age. However, it is often an attempt to deprive them of the possibility of running their own life and history, and of developing caregiving practices independently.

Women also highlighted one of the most significant female events in this phase, the climacteric, which is part of the aging process. Some discomforts associated with the climacteric were highlighted, especially the hot flushes, which demand care practices.

> *The only thing I got now after I entered the menopause is these hot flushes. Horrible! I do not make tea. I drink cold water, turn on the fan and move on.* (M6)

> *We are very well and in a little while, it seems that it starts to sprout in the clothes, in the face. It seems like it burns, in a little while it's dripping and in a little while it starts to pass.* (M7)

The climacteric is a very unique female experience that can vary considerably from one woman to another within the same group. Linked to this event and the changes generated from it are the perceptions, feelings, and experiences that each woman feels in a very personal way.[25]

In relieving discomfort, *quilombola* women seek simple and ready to hand options, discarding the need for help by medication, which is widely used among women in other contexts.[25] Regarding the medicalization of the female body in this and other phases of the female cycle, one of participants expressed their conception.

> *It used to be a lot of tea, now they take medicine. The medicine is the first to get us sick, intoxicated. Doctors, today, are the first to give medicine, intoxicate us with medicine. That's why the tea comes again. Before there*

> *was no disease either. Now you breathe and have already caught a disease. There's disease of all kinds that we don't even know about.* (M6)

It is observed that the participant does not accept the use of medication as the main treatment path due to the occurrence of a clinical change. According to the literature,[18] medicalization of the female body has been inserted in society as a social device, with the purpose of standardizing, managing and regulating women's events, reducing them to organic processes that require medical intervention. In this sense, medicalization involves the process of transforming "normal" and physiological aspects of life into objects of medicine.

Final considerations

As limitations of the study, we identified the fact that the observer of the FG technique is a man and the theme of the study involved health care among women; this may have caused discomfort to participants at some point. Another limitation considered is the possibility of memory bias, since research covered information that required women to resume their memories.

This study showed that care practices, as highlighted by *quilombola* women, are imbued with innumerable values, symbols and meanings. They were elaborated during each of their pathways and life processes, diversifying according to beliefs and knowledge existing in each epoch and historical context. These practices were also based on prior knowledge and mainly on the experiences of other *quilombo* women.

Thus, it is emphasized that the care provided by these women should not be understood in isolation, but by aggregating the social, cultural and economic aspects that belong to this context. In addition, it is necessary to broaden the perspective on these women, who throughout history have structured and perpetuated these practices with much tradition and dedication within their community.

Therefore, this study aims to add the contributions of popular knowledge to scientific knowledge, in order to allow the emergence of care practices that merge these two knowledge bases and lead to more effective health actions. Thus, it seeks to disseminate the knowledge that *quilombola* women have accumulated regarding care practices linked to the health care subculture.

From the knowledge and understanding of care practices adopted and maintained in different life contexts, health professionals will be able to approach the language and symbolic reality constructed by each culture. It is possible to produce an integral care that values the human being, together with respective principles and cultural values that effectively responds to the needs expressed by individuals.

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