



## QUILOMBOLA MIDWIVES' AND WOMEN'S CARE PRACTICES IN THE LIGHT OF INTERPRETATIVE ANTHROPOLOGY

*Práticas de cuidado de parteiras e mulheres quilombolas à luz da antropologia interpretativa*

*Prácticas del cuidado de comadronas y mujeres quilombolas a la luz de la antropología interpretativa*

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### ABSTRACT

**Objective:** To analyze the Quilombola popular knowledge about the care practices adopted at prenatal, childbirth and postpartum from the perspective of Quilombola midwives and women. **Methods:** This is a qualitative study carried out in a traditional community of Quilombola remnants in the Sertão Produtivo of the State of Bahia, located in the countryside of Northeastern Brazil, with 12 women – two midwives and ten women whose childbirth was assisted by one of the two midwives of the community – using a semi-structured interview questionnaire in February 2014. Data were analyzed with the aid of Interpretive Anthropology. The analysis yielded three categories: cultural care practices at prenatal, cultural care practices at childbirth, and cultural care practices at postpartum. **Results:** The first and second categories revealed that both postpartum women and midwives used manual maneuvers to stimulate contractions in pregnant women and to help in the proper positioning of the fetus to avoid complications. In the third category, the interviewees reported that midwives encouraged sitz baths with plants and herbs and the use of natural teas to avoid infections and postpartum hemorrhages. **Conclusion:** The cultural practices (maneuvers during delivery, teas, prayers to nature deities, sitz baths with herbs and leaves) reported by the study participants, which are passed from generation to generation, are important for the health of quilombola women who experience the pregnancy and postpartum cycle and should be valued by the team of health professionals.

**Descriptors:** African Continental Ancestry Group; Women's Health; Prenatal; Parturition; Puerperium.

### RESUMO

**Objetivo:** Analisar o conhecimento popular quilombola acerca das práticas de cuidado desenvolvidas no pré-natal, no parto e no puerpério sob a ótica de parteiras e mulheres quilombolas. **Métodos:** Trata-se de um estudo qualitativo realizado em uma comunidade tradicional de remanescentes quilombolas do Sertão Produtivo do estado da Bahia, localizado no interior do Nordeste Brasileiro, com 12 mulheres, sendo duas parteiras e dez mulheres que vivenciaram o parto assistidas por uma das duas parteiras da comunidade, aplicando-se um roteiro de entrevista semiestruturada em fevereiro de 2014. Os dados foram analisados com o auxílio da Antropologia Interpretativa. A análise explicitou três categorias: práticas de cuidado cultural no pré-natal, práticas de cuidado cultural no parto e práticas de cuidado cultural no pós-parto. **Resultados:** Na primeira e segunda categorias, evidenciou-



se, tanto pelas mulheres que vivenciaram o parto quanto para as parteiras, que são utilizadas manobras manuais para estimular as contrações das gestantes e para ajudar no posicionamento adequado do feto para evitar complicações. Na terceira categoria, as entrevistadas relataram o estímulo aos banhos de acentos com plantas e ervas, além do uso de chás naturais para evitar infecções e hemorragias puerperais, como conduta das parteiras. **Conclusão:** Conclui-se que as práticas culturais (manobras no parto, chás, orações às divindades naturais, banhos de assento com ervas e folhas) evidenciadas pelas participantes do estudo, transmitidas de geração a geração, são importantes para a saúde das mulheres quilombolas que vivenciam o ciclo gravídico puerperal e devem ser valorizadas pela equipe de profissionais da saúde.

**Descritores:** Grupo com Ancestrais do Continente Africano; Saúde da Mulher; Cuidado Pré-Natal; Parto; Período Pós-Parto.

## RESUMEN

**Objetivo:** Analizar el conocimiento popular quilombola acerca de las prácticas de cuidado desarrolladas en el prenatal, en el parto y el puerperio bajo la óptica de comadronas y mujeres quilombolas. **Métodos:** Se trata de un estudio cualitativo realizado en una comunidad tradicional de remanentes quilombolas del Agreste Productivo del estado de Bahía localizado en el interior del Noreste Brasileño con 12 mujeres, dos comadronas y diez mujeres que tuvieron el parto asistidas por una de las dos comadronas de la comunidad, aplicándose un guion de entrevista semiestructurada en febrero de 2014. Se analizaron los datos con el auxilio de la Antropología Interpretativa. El análisis ha explicitado tres categorías: prácticas de cuidado cultural en el prenatal, prácticas de cuidado cultural en el parto y prácticas de cuidado cultural en el posparto. **Resultados:** Se ha evidenciado en la primera y segunda categorías por las mujeres que han vivido el parto y por las comadronas, que se utilizan maniobras manuales para estimular las contracciones de las embarazadas y para ayudar en el posicionamiento adecuado del feto para evitar las complicaciones. En la tercera categoría las entrevistadas relataron el estímulo a los baños de asientos con plantas y hierbas además del uso de tés naturales para evitar infecciones y hemorragias del puerperio como conducta de las comadronas. **Conclusión:** Se concluye que las prácticas culturales (las maniobras del parto, los tés, las oraciones para las divindades naturales, los baños de asiento con hierbas y hojas) evidenciadas por las participantes del estudio y transmitidas de generación en generación son importantes para la salud de las mujeres quilombolas que vivencian el ciclo gravídico puerperal y deben ser valoradas por el equipo de profesionales sanitarios.

**Descriptor:** Grupo de Ascendencia Continental Africana; Salud de la Mujer; Atención Prenatal; Parto; Periodo Posparto.

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## INTRODUCTION

The pregnancy-postpartum cycle has always been associated with the social construction of motherhood, that is, the role socially constructed and assigned to women. Thus, the care for women at this stage of life was provided by older and more experienced women, or the so-called midwives, as they developed a close relationship with the pregnant woman for sharing their own life stories. Based on the knowledge they have acquired through past experiences from generation to generation, midwives use empirical techniques<sup>(1)</sup>.

Healers and priests used to be requested only in cases of complications, thus demonstrating that the performance of midwives is as old as humanity<sup>(2,3)</sup>. However, with the emergence of the biomedical model of care, the popular and cultural care provided to pregnant women was devalued as the obstetrics and prenatal, delivery and postpartum care technologies became more sophisticated<sup>(2)</sup>.

The comprehensive and humanized approach that was once used by midwives was replaced by the biomedical and hospital-centered model as medicine developed a practice of subjecting people to the hegemony established by scientific knowledge, which was acknowledged as superior and valid. Such model suggested that delivery should be assisted by professionals and not by midwives<sup>(2)</sup>.

The hegemonic model of health care has overrated scientific knowledge and devalued popular knowledge, especially in traditional communities, such as Quilombola communities, which have peculiar customs and traditions loaded with cultural meanings. Modern medicine has established the medicalization of the female body, transforming issues inherent to women, such as childbirth, into pathological events and introducing, in the latter, unnecessary surgical techniques and procedures that are often harmful to women's and fetus' health<sup>(2)</sup>.

However, in recent years, with the implementation of public policies to reduce maternal and infant morbidity and mortality, the discussion over comprehensiveness and humanization of pregnancy, childbirth and postpartum has been resumed<sup>(4)</sup>. Taking into account that childbirth is a physiological event that, for the most part, occurs without the need for interventions, the Ministry of Health acknowledges the work of midwives. The provision of care to women by midwives is a reality in many parts of the country<sup>(5)</sup>. Quilombola populations have gained recognition and are

highlighted because of their maintenance of their social, cultural and economic traditions, both in the use of land for the maintenance of their material and immaterial assets and practices for the maintenance of well-being and health<sup>(5,6)</sup>.

Studies have been carried out to emphasize the importance of valuing quilombola cultural habits and midwives within health care practiced by the peoples of traditional communities<sup>(2,7-9)</sup>. Thus, the present study is justified by the need to expand information on health demands in quilombola communities, particularly information on the importance of midwives' common/traditional/cultural knowledge for the care of pregnant women throughout the pregnancy-postpartum cycle. Such information is relevant because it makes it possible to rethink health care practices and health promotion strategies specifically tailored to the quilombola population, especially to women during pregnancy and postpartum, focusing on integrated care provided by Primary Health Care centers located in the communities and midwives, thus strengthening health issues and, consequently, reducing existing inequities in the field of collective health.

In this context, the following research question was built: What are the care practices developed during prenatal, childbirth and postpartum based on midwives' and quilombola women's popular knowledge? To help answer this question, the present study sought to analyze the quilombola popular knowledge about the care practices adopted at prenatal, childbirth and postpartum from the perspective of Quilombola midwives and women.

## METHODS

This is a qualitative study<sup>(10)</sup> carried out in the Lagoinha de São Gabriel Village, Bahia and adjacent settlements located in the Northwestern Bahia, approximately 480 Km from the state's capital, located in the Território de Identidade de Irecê, in the Sertão Produtivo of the state of Bahia, Northeastern Brazil. The Lagoinha community was acknowledged by the Palmares Foundation as a quilombola community on March 13, 2007 after its self-acknowledgement and has about 800 inhabitants. Of these, approximately 370 are women. The place mainly grows beans, corn and castor beans, among others, from which the population draws its own nourishment depending on the period and the intensity of the rains that fall in the region<sup>(11)</sup>.

Currently, the community has one Primary Family Health Care center, which is named after a midwife from the region, Mrs. Florentina F. de Jesus, who died months before the start of this research, at the age of 103. "Mama Fulô" or "Mãe Lo", as she was affectionately called, assisted in many childbirths (about 1,400) in the community and surrounding areas when she was still lucid, providing a great service to the local population. Such peculiarities of the community were informed by midwives and by the community health worker, who helped identify the participants.

Participants were two midwives who lived in the community and ten women who gave birth from the 1980s, a time when access to health services were poor in the region and they had to travel many kilometers to attend obstetrical consultations. It should be noted that today's health care is organized into health care networks and women receive prenatal care from the Unified Health System, although many of them choose who will serve them. Participants were identified with the help of a local community health worker and they were chosen randomly<sup>(12)</sup>. Eligible midwives should practice or have practiced midwifery in the community and in its surroundings. Eligible women should have given birth at home from the 1980s.

Sampling was finished after saturation of the interviews, in which the information provided by the participants did not add much to the material already obtained and did not contribute to the improvement of theoretical reflection<sup>(13)</sup>.

Data collection took place in February 2014 and was conducted using semi-structured interviews to identify the respondents (age of women and midwives, number of births given by women, number of births assisted by midwives, and religion and skin color of women and midwives). There were two open-ended questions, one for midwives ("Tell me about your job as a midwife during prenatal, childbirth and postpartum") and another one for women ("Tell me how the midwife worked with you during pregnancy, childbirth and postpartum").

Individual home visits were made to the research participants to explain the objectives, to present the questions of the interview and to clarify potential doubts, always guaranteeing the confidentiality of the information. After that, the interviews were carried out, recorded and transcribed verbatim.

Based on the convergences regarding intersubjectivities in cultural phenomena, particularly the experiences of women and midwives with regard to health care during prenatal, childbirth and postpartum<sup>(14-16)</sup>, the data were organized and three thematic categories emerged: cultural care practices at prenatal; cultural care practices at childbirth; cultural care practices at postpartum.

The data were analyzed and discussed on the basis of Interpretive Anthropology<sup>(16)</sup> as it is suitable for qualitative research with quilombola communities for allowing the identification of cultural patterns, common meanings and

shared actions among people that make up social groups in which the webs of meanings that constitute culture are intertwined<sup>(14-16)</sup>.

The research followed all the ethical precepts of Resolution 466/2012 and was approved by the president of the residents' association of the region and the Research Ethics Committee (REC) of the Bahia State University (*Universidade do Estado da Bahia*) with Approval No. 491.417.

All the participants signed the Free Informed Consent Form. In order to maintain the secrecy and privacy of the interviewees, we used names of plants (Quixabeira, Umburana, Macambira, Pitombeira, Mucunã, Cabeço-de-Frade, Jurubeba, Baraúna, Jurema and Barriguda) and birds (Asa Branca and Seriema) native to and/or typical of the caatinga biome, which is predominant in the region. Names of plants were used for the women who gave birth at home and the names of birds were used for the midwives.

## RESULTS

The interviews allowed to collect data on the identification of the women who had given births at home and midwives. The data are described below and following is an explanation of the three categories that emerged.

### Women's identification data

The age of the women ranged 32 to 53 years, and the age of the midwives ranged 70 to 80 years. Women with ages ranging 44 to 53 years experienced more births when compared to those aged between 32 and 37 years. As for religion, half of the participants claimed to be Catholic and the other half claimed to be Protestant. One of the midwives stated that besides being Catholic, she is an adept at the practices of Candomblé.

### Cultural Care Practices at Prenatal

In this first category there are statements that revealed a common action among midwives, which is called 'to fix the belly':

*"It is because she says she's getting the baby into position. Because, in case the baby is on one side, she comes and fixes the belly [...] Because now she says that if the baby is positioned under the rib, it will be hard to give birth." (Pitombeira)*

*"I put them in bed. They lay on their back, I put them in the right position, looking for the boy, where he is and his position [...] Then I put my hand on her waist and I swing them." (Asa Branca)*

This seems to be a quite common custom in the community. The women interviewed reported this practice. According to them, from five months of pregnancy women begin to visit the midwife's house for palpation and, if necessary, "to fix the belly".

*"She just got there, fixed our belly, tidied it up. Sometimes the belly was tilted backwards and when she was getting close she said that I would feel pain during childbirth but as soon as the baby was born the person would calm down". (Jurema)*

When asked about the measures taken with regard to a woman who had retained placenta, the midwife (Seriema) said that "she begged God, she prayed, she did a massage with a black oil and then the placenta was expelled". This statement demonstrates how religiosity and the use of homemade remedies are very common practices in the community. When they cannot intervene using practices based on everyday experiences, midwives turn to deities, and it is through their faith that they succeed in their prayers.

Another case that the midwife Seriema reported was a child who had the umbilical cord wrapped around the neck. She made "a maneuver and the child was born purple", that is, cyanotic. When she realized that "the child did not cry and did not breathe, she sucked the child's nose with her own mouth, removing childbirth leftovers" that blocked the airways, saving the girl's life.

Another issue that drew attention was the occasion in which the midwife Seriema said that she was called to assist a woman who was in labor and, upon arriving and palpating, she noticed that the child was "seated" (breech presentation). According to her, she placed her hand in the birth canal and made a maneuver and the child changed position (from breech presentation to cephalic presentation). After that she performed the delivery.

### Cultural care practices at childbirth

In this second category, which describes cultural care practices at childbirth, attention was drawn to a statement about breath control guidelines. According to reports:

*"She [the midwife] advised us not to hold our breath too much." (Quixabeira)*

*"She [the midwife] used to tell us not to pull the air up because if we do so the child sits." (Macambira)*

*"Just the breath she [the midwife] tells us not to pull up. You have to take a deep breath. And let go slowly so the baby does not go up". (Pitombeira)*

In providing such care, midwives reassure pregnant women, promote the relief of discomfort due to poor positioning of the fetus and strengthen the bond they have through touch, thus building a relationship of trust, which contributes significantly to a more humanized childbirth.

Regarding childbirth, several practices were developed by midwives on a daily basis, although they do not have an academic background. These practices are transmitted from generation to generation and the experience of the older ones is fundamental so that the practice of midwifery is learned by the younger ones.

*"Then I started with boys [...] Mãe Lô always invited me and I watched and helped her". (Asa Branca)*

*"She, Mãe Lô, had already taught me how to cut the umbilical cord like this [...] I was used to being with her. I helped her. Then she said: "Oh, my daughter, now I am going to pick it up and you are the one who is going to clean [...], clamp and cut the umbilical cord to become a "mother". (Seriema)*

Of the births they performed, the midwives interviewed stated that they "never lost" any mother or child, although they have already encountered some complications. According to them, in these cases they resort to divine assistance and the use of homemade remedies, such as teas, black oil, chicken schmaltz and lamb tallow, among others.

Asa Branca reports a case in which a pregnant woman "(...) delivered the child and did not expel the placenta", that is, there was no separation of placenta and the woman was suffering on the bed groaning. According to her, the problem was solved after prayers and massages in the abdomen of the woman.

One of the interviewees mentioned some homemade remedies, such as hot egg, pepper tea and soaking baths, which were made and offered by midwives to increase uterine contractions and facilitate passage of the child through the birth canal.

*"[...] they told us to take tea with pepper, to drink hot eggs to get the pain coming [...] Then the midwife asked me to prepare a bath, but I do not even know what the bath was." (Jurubeba)*

Asa Branca also states that when she notices that she needs to take the woman to the hospital, she does not allow any type of food. However, after this statement, she said that:

*"When they get bothered, I do not let them eat anything. Just a milk, a little milk, or a little tea without sugar, medicinal tea, coriander tea, cumin tea, black pepper tea. A nurse also told me that they can eat farm chicken too when they feel pain. If the pain increased, they can eat farm chicken broth." (Asa Branca)*

### Cultural care practices at postpartum

The last category shows that after delivery, the midwife usually spends a few days accompanying the postpartum and the newborn, observing possible interurrences and providing some care, such as preparing a bath with medicinal plants for the woman and bathing the child, with special attention to the umbilical cord stump. With regard to this, Asa Branca says:

*"[...] The next day, if it is near here, I will go there or they will pick me up here. I bathe the baby the first time. I come in, I bathe the baby, and if the mother cannot bathe herself, I bathe her." (Asa Branca)*

The medicinal plants used for the soaking baths that most appeared in the statements of the interviewees were aroeira, quixabeira, umbuzeiro and umburana, plants that are part of the flora of the region and, according to popular knowledge, function as anti-inflammatory agents. The bath is prepared by baking leaves and/or the bark of the stem, which after cooled are used for the hygiene of the external genitalia. Seriema said that:

*“[...] We bathed them with aroeira barks, umbuzeiro and imburana leaves, and pau de colher barks. We prepared the baths and the women bathed using them the entire postpartum, and then nobody needed to go to the doctor. I think, with those baths, the flesh would heal. There was no infection, there was nothing else. The baths and the remedies that they used for the women who gave birth here were those [...]” (Seriema)*

The midwives advise not to force the pelvic region during postpartum to avoid possible hemorrhages. To this end, they currently recommend that women avoid carrying weight and blowing fire, whereas in the 1980s and early 1990s, according to them, their recommendation was to take a shower only 15 days after giving birth and to wash the head only after 30 days.

*“[...] The midwife does not let us lift weight or blow the fire to light up and in the past she did not let us wash our heads... It would take 15 or 30 days or even longer.” (Macambira).*

Over time, these guidelines have been modified and, currently, according to Asa Branca, postpartum women must behave according to the “postpartum period” after the first child. According to her, if the woman already has a habit of bathing or washing the head from the first day after the first birth, they can do so in any other births they have, there is no problem:

*“[...] It was not like that in the old days. They could only wash their heads after thirty days. But today I bathe them the first time, but then they take showers in the bathroom as they are used to.” (Asa Branca)*

With regard to the care for the newborn’s umbilical cord stump, there have been many changes from the 1980s to the present day. Women who had children during the first period stated that the recommendation given, not only by midwives but also by older people in the community, was not to allow it to get wet during the bath, then to add sweet olive oil, chicken schmaltz, merthiolate, baby powder, iodinated alcohol or imburana barks on the site.

They all reported using a band, which could be bandage, cloth and/or cloth diaper, which was wrapped around the abdomen of the newborn, making a slight compression. According to them, it was used to prevent flies from landing on the stump and to speed up the mummification process and protect the newborn at bath time, since, according to all the women, midwives always advised them not to let the site get wet. Despite being an older practice in the community, Barriguda said that:

*“Even pipe rust, can you believe it? Pipe rust was used to heal the child’s umbilical cord stump. A band was also used to prevent it from getting wet and avoid flies landing on it. When you smoke, residues stay inside the pipe and cigarette, a sort of powder. So, that was put on child’s umbilical cord stump so that it could heal. It was sad, you know? Think about it.” (Barriguda)*

The midwife Asa Branca stated that the care she currently provides and/or guides with respect to the newborn’s umbilical cord stump is:

*“[...] I tie it up with a cord. I clean the cord and add hot water to it, alcohol and then I iron it and save it for the moment I need [...] to bathe the baby. Now, you should not let water into it before it heals, because it rots. There are those gauzes, right? Sometimes it is already ready, then I teach them how to do it.” (Asa Branca)*

## DISCUSSION

Regarding the participants’ identification data, despite being a Quilombola community, only three of them considered themselves Black. The others declared themselves to be mixed-race Brazilians. It is possible that this finding demonstrates the presence of prejudice and discrimination rooted in the culture that surrounds them, the process of devaluation of Black people, and their cultural habits and traditions, as well as their negation as a subject and an important actor in the construction of the country<sup>(6)</sup>. In all, the women went through a total of 42 deliveries. Of these, 23 were at home, 18 at the hospital and one in a birth house. The midwife Asa Branca performed 86 deliveries and Seriema performed 20 deliveries. Both participated in the present study.

With regard to the pregnant woman visiting the midwife’s house so that she could do the abdominal palpation and, if necessary, “fix the belly”, despite being a common practice, the Ministry of Health says that any massage or examination in the belly of the pregnant woman should be performed with delicacy and care<sup>(17)</sup>.

The maneuver performed by the midwife when the baby exhibited breech presentation, placing it in the cephalic position, a maneuver called the internal version, is extremely difficult to perform and requires precision and dexterity. In the case of the child who was born with the umbilical cord wrapped around the neck and the midwife made a maneuver and solved the problem, it should be noted that since midwives do not have any suitable tool to perform the aspiration they do so intuitively and instinctively<sup>(17)</sup> using the mouth to aspirate secretions or ventilate if necessary<sup>(18)</sup>. The care given to the newborn in the first hours of life is crucial for the prevention of hypoxic-ischemic injuries. In this regard, although the literature does not recommend the routine practice of airway aspiration, it may contribute to avoid complications related to lack of oxygen<sup>(8)</sup>.

In general, as emphasized in the three categories, during the provision of cultural care at prenatal, childbirth and postpartum, there is a reference to rituals with prayers, and to the use of herbal teas and baths, which is corroborated in a study carried out with midwives in the city of Barrancabermeja, in the Cimitarra River valley, in Colombia. The study showed that midwives' knowledge is evident from the preparation of the pregnant woman to postpartum, with the use of care practices based on cultural beliefs and customs, using natural resources and divine invocation<sup>(19)</sup>.

It should be noted that the Ministry of Health acknowledges and values the work of traditional midwives whose wisdom allows to perceive the intimate and familiar character of birth in different Brazilian regions. The Ministry of Health elaborated the Traditional Midwife Book<sup>(17)</sup> and scheduled trainings for midwives, including spaces for complementing their knowledge. It has, therefore, encouraged traditional midwives to be increasingly welcomed and valued by the Unified Health System in an integrated way in Primary Health Care centers with the support of health professionals so that they can defend life and promote the health of women and babies.

However, these procedures can be carried out as long as they do not harm these women. The Ministry of Health warns, in the Traditional Midwife Book, that in case any intercurrent occurs during this period, the woman should be referred immediately to the hospital in order to avoid damages to her health or to the health of the baby<sup>(17)</sup>.

However, it is imperative to point out that even with the encouragement of midwives and the training offered to them, the interviewees' statements in the current study showed that there are still actions based on empiricism that could endanger the health of women and babies. Thus, there is a need for greater integration of midwives into the Family Health Strategy and with community health workers who are responsible for the monitoring of women and children in the community, including home visits to see how prenatal care is being delivered to women at postpartum.

Therefore, it is difficult to enter midwives' cultural care system, in which there are no relationships to or characteristics shared with modern society, where hospitals are inserted<sup>(13,14,19,20)</sup>. The value of their work lies in the woman's trust in their techniques in addition to the satisfaction and assurance that the newborn will be born without any harms originating from such care.

From an Interpretive Anthropology and Health perspective, the ritual is differentiated from other norms presented by people in traditional communities, especially moral ones, and it is explained by the nature of its elements<sup>(14,20,21)</sup>. It is in the sphere of the sacred that the ritual is structured, since it has the objective of delimiting the boundaries between the sacred and the profane and organizing the rules of behavior in the presence of the sacred<sup>(14,15,20,21)</sup>.

A qualitative study based on Anthropology carried out at the Maranhão Traditional Midwives Association found that women and midwives organize themselves into networks of small communities, in which there is no payment using money, but respect for local traditional and cultural codes. Pregnant women owe a debt of gratitude for the established relationship, which does not need paper to guarantee payment, but the certainty that there will be reciprocal help<sup>(2)</sup>.

Thus, midwives' knowledge of daily experiences and rituals and natural resources such as teas and baths within a religious context traditionally developed in years of practice is transmitted orally to the successors, and both midwives and Quilombola women have resisted the hegemony of technical, pharmacological and industrial knowledge learned at universities<sup>(17,22)</sup>.

The participants' statements, both in the present study and in the study carried out in Colombia, showed that midwives perform maneuvers to detect women's dilation, fetal position, uterine contractions and fetal movements<sup>(19)</sup>. Without scientific knowledge and based on their midwifery experience, midwives perform the obstetric maneuver called the Leopold-Zweifel maneuver, which aims to externally verify, through palpation, the presence of the fetus as well as its presentation (cephalic) or breech) and its situation or position (longitudinal or transverse) in the uterine cavity<sup>(18,23)</sup>.

The oral transmission of knowledge is explained by the fact that most midwives come from lower social strata without access to minimum training, such as literacy<sup>(5,17)</sup>. Two studies emphasized the difficulty of finding systematic

records of their performance and the knowledge built by them, generating a gap in history that had been filled with the denunciations and unfavorable opinions of Medicine about their performance in labor and childbirth care<sup>(1,24)</sup>. The medical denunciations did not mention the lack of knowledge regarding the childbirth maneuvers, but the hygiene conditions in which they was performed<sup>(25,26)</sup>.

Decree 94.406 of July 8, 1987, which provides for the exercise of Nursing, included midwives in the group of Nursing professionals. However, in characterizing them, the law recognizes only graduates or holders of certificates issued by schools or teaching institutions, thus excluding traditional midwives<sup>(3)</sup>. These facts highlight the attempt to instill in traditional midwives the practices based on the knowledge of modern medicine, which now comes to exercise its hegemony and control over birth, causing what anthropologists call cultural violence and acculturation.

The transfer from home birth to hospital birth, for example, also meant a change in the position of giving birth. From vertical positions (squatting, stirrups, in order to ensure a good position for observation and medical intervention, showing the control that obstetric Medicine has exerted on the woman crouching or sitting), the woman began to give birth lying on the metal bed with the legs supported at the time of delivery<sup>(2,4)</sup>.

The subjective power exercised by health professionals, which is expressed in the way of communicating with people from traditional communities, to the detriment of the superiority of scientific knowledge about popular/cultural knowledge, leads to prejudices, stigma and marginalization regarding cultural practices<sup>(26,27)</sup>.

This demonstrates the control over birth through the power exerted by Medicine on pregnant women. Power is a way of controlling the action of others under their care and its exercise is through the interrelations established between the parties. Therefore, for this relation of power to happen, it is indispensable that the subject on whose action the power is exercised is recognized as a subject of action, and that in the face of the relation of power there is always a field of possibilities for actions, responses, reactions, effects and inventions. In this regard, violence implies the nullification of the subject's possibilities of action as force, coercion or even destruction are used as forms of action<sup>(26,27)</sup>.

A study on nurses' prejudice regarding indigenous Australians' cultural knowledge on health pointed out that health professionals should break with stigmas and prejudices and act with cultural security when coming in contact with traditional communities so that they can understand the legitimacy of these peoples, their singularities and their place in the world<sup>(26)</sup>. Similarly, health professionals should understand what is produced within quilombola communities as a practice of cultural health care and prevention of diseases in the health-disease process.

Therefore, within this cultural system of care developed by midwives and interpreted by the Anthropology of Health from the appropriation of the object that concerns them throughout their lives, there is evidence of the components related to the health of traditional societies<sup>(14,15,21)</sup>, "which correspond to the belief patterns related to causes of diseases, the norms governing the choice and evaluation of treatment, the socially legitimized roles of individuals, power relations, interaction configurations and institutions"<sup>(15)</sup>.

In the light of what has been discussed, this study contributes to distinguishing the role of midwives in the promotion of health as they are the choice of care of quilombola women during prenatal, childbirth and postpartum and given that the midwives' knowledge integrated with health services and with supervision could contribute to reduce the maternal mortality of the quilombola population.

Still with regard to promoting the health of the black population and traditional communities, the cultural care practices developed by quilombola midwives during the pregnancy-postpartum cycle show that encouraging alternative care practices is important for the maintenance of socially organized customs and soft technology developed throughout the historical construction of cultural communities.

This study has limitations with regard to the number of participants. In addition, as it is a qualitative case study that focuses on only one place, it was not possible to capture multiple views. In addition, there are few published studies that reveal the importance of popular/traditional knowledge of quilombola midwives for the health of women, especially for events involving prenatal, childbirth and postpartum. However, the qualitative approach associated with an anthropological interpretive analysis made it possible to deeply analyze the cultural issues in the participants' statements.

## FINAL CONSIDERATIONS

This study identified themes that reinforce the idea that the use of cultural practices (childbirth maneuvers, teas, prayers to the natural divinities and soaking baths with herbs and leaves), obtained from quilombola midwives's

traditional knowledge and transmitted from generation to generation, is important for the health and evolution of pregnancies in quilombola women who experience the pregnancy-postpartum cycle and find in them assistance and care alternatives to those implemented by the hospital-centered model.

Therefore, the analysis of the results originating from the experiences of midwives and quilombola women revealed that the common knowledge originating from midwives' daily experiences promotes cultural care to pregnant women, parturient women and postpartum women.

As midwives have contributed to the humanization of labor and childbirth and to the decrease in infant mortality, efforts should be made by managers and professionals so that they are increasingly integrated into the Unified Health System. In addition, health services should welcome them and respect their knowledge, beliefs and cultures, giving them the opportunity to receive training to ensure the safety of quilombola women.

## CONFLICTS OF INTEREST

The authors declare there are no conflicts of interest in the present research.

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