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CONTEMPORARY PHYTOTHERAPY IN BRAZIL: A PARALLEL WITH PAULO FREIRE'S THEORY OF ANTIDIALOGICAL ACTION

FITOTERAPIA CONTEMPORÂNEA NO BRASIL: UM PARALELO COM A TEORIA DA AÇÃO ANTIDIALÓGICA DE PAULO FREIRE

Ana Cimbleris-Alkmim[1]
Simone de Araújo Medina Mendonça[2]
Djenane Ramalho-de-Oliveira[3]

Abstract: This article aims to critically discuss sociocultural aspects that influence the practice of phytotherapy in contemporary Brazil, employing Paulo Freire's theory of antidialogical action. The evocative autoethnography methodology was used. Two constructed narratives intertwine with the four components of the antidialogical action – conquest, divide and rule, manipulation and cultural invasion – creating a dialogue between theory and practice as a decolonial problem-posing perspective is outlined. The reasons for the diminished role of phytotherapy in the official healthcare system, despite its immense potential for the country, are unveiled. In conclusion, it is imperative for a critical praxis that values Brazilian Traditional Medicine to be widespread in teaching, research and healthcare services. A limit-situation is thus denounced, containing in itself the seed of the untested feasibility to be built: a broad, ecological and socially fairer health project.

Keywords: Phytotherapy; Medicinal Plants; Traditional Medicine of the Americas; Qualitative Research.

Resumo: Este artigo pretende discutir criticamente aspectos socioculturais que influenciam a prática da fitoterapia no Brasil contemporâneo, olhando-a a partir da teoria da ação antidialógica de Paulo Freire. Para isso, empregou-se a Autoetnografia Evocativa. Duas narrativas produzidas se entrecruzam com os quatro componentes da ação antidialógica – conquista, dividir para manter a opressão, manipulação e invasão cultural –, criando diálogo entre teoria e prática à medida que se desenha uma problematização com perspectiva decolonial. São desveladas razões para a baixa expressividade da fitoterapia no sistema oficial de saúde apesar do seu imenso potencial para o país. Conclui-se que é necessário que uma práxis crítica baseada na valorização da Medicina Tradicional Brasileira se capilarize no ensino, na pesquisa e nos serviços em saúde. Assim, denuncia-se uma situação-limite, que contém em si a semente do inédito-viável a ser construído: um projeto de saúde amplo, ecológico e socialmente mais justo.

Palavras-chave: Fitoterapia; Plantas Medicinais; Medicina Tradicional das Américas; Pesquisa Qualitativa.

1 Introduction

"Phyto" is a Greek suffix or prefix that means "plants". Phytotherapy refers to therapy by plants. The growth of phytotherapy is a worldwide reality, with increasing

[1] Doctorate student in Medicines and Pharmaceutical Assistance and Master in Pharmaceutical Sciences, Federal University of Minas Gerais (UFMG). Center for Pharmaceutical Care Studies (CEAF - UFMG). Belo Horizonte, MG, Brazil. E-mail: anacimbleris@gmail.com
[2] Doctor in Medicines and Pharmaceutical Assistance, UFMG. Professor and collaborator of CEAF - UFMG. Belo Horizonte, MG, Brazil. E-mail: simoneamm@gmail.com
[3] PhD in Social and Administrative Pharmacy, University of Minnesota (UM). Professor and coordinator of CEAF - UFMG. Belo Horizonte, MG, Brazil. djenane.oliveira@gmail.com

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population interest. The low rates of side effects, the expansion of the therapeutic range, the possibility of lower production costs compared to synthetic drugs and the recognition of conventional medicine make the inclusion of phytotherapy in official healthcare systems to be repeatedly recommended by the World Health Organization (WHO) (WHO, 1978, 2002, 2013).

Since the end of the 20th century, legislative and regulatory advances in this field have been remarkable, including in Brazil (BRASIL, 2012a). In 2006, phytotherapy was strengthened by the sequential publications of the National Policy on Integrative and Complementary Practices in the Brazilian Public Healthcare System (Sistema Único de Saúde - SUS) (BRASIL, 2006b) and the National Policy on Medicinal Plants and Phytotherapy (BRASIL, 2016). The latter has the general objective of "guaranteeing to the Brazilian population safe access and rational use of medicinal plants and herbal medicines, promoting the sustainable use of biodiversity, the development of the production chain and the national industry" (BRASIL, 2016, p. 24). To operationalize this objective, in 2008, the National Program of Medicinal Plants and Phytotherapy was published (BRASIL, 2016). Since then, the National Health Surveillance Agency (Agência Nacional de Vigilância Sanitária - Anvisa) has gradually regulated phytotherapy in its different dimensions (BRASIL, 2018).

Brazil has the greatest biological diversity in the world, including numerous medicinal species, with the potential to establish "its own and autonomous development model in the medicinal plants' area" (BRASIL, 2016, p. 101). Current public policies mention the importance of traditional and popular knowledge and practices in medicinal plants, valuing the ancestral principles on which such elements are validated through the very tradition (BRASIL, 2016). After all, it would be very difficult for a therapeutic resource to be passed on for hundreds or thousands of years to subsequent generations if it was not cost-effective.

All over the world, the ancient practice of phytotherapy has been expressed in contemporary practices; however, often without its "kinship" with what was done in the past, as if they were "disconnected knowledges" (FREIRE, 2005a, p. 19). In transitioning societies, strong contradictions are revealed in the clash between emerging values - in the quest for fulfillment - and values of yesterday - in the quest for preservation (FREIRE, 2005b). This characterizes the transitional phase, conducive to conscious choices, of "knowledge transformed into action", provided that the challenges in question are critically captured (FREIRE, 2005b, p. 54).

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Therefore, considering historical and sociological aspects, a critical discussion of reality is necessary. Between the values of yesterday and today, around 82% of the Brazilian population currently uses medicinal plants products in their health care (BRASIL, 2012a). This fact demonstrates the national expressiveness of this practice. However, despite all the regulatory, environmental and cultural factors favoring phytotherapy in Brazil, it is still not fully integrated into healthcare professional practice (MAIA *et al*., 2016).

Grounded on traditional use, some herbal medicines are already produced industrially or masterfully from native plants, which can be found in commercial establishments and eventually also in the Brazilian Public Healthcare System. Still, the systematization of how the different traditional Brazilian peoples think about health and develop their diagnostic and care processes is shallow – that goes far beyond considering only which products are used for diagnostic, preventive and therapeutic purposes. In short, there is still no clear path to operationalize the offer of Traditional Brazilian Medicine in the official healthcare system, and there is no access to consultations with healthcare professionals in this approach. Interestingly, in the Brazilian Public Healthcare System, there is an established model for the provision of consultations along the lines of Traditional Medicines from China and India (Ayurvedic), which are also vastly based on the use of medicinal plants (BRASIL, 2006b, 2017). These countries are examples of how traditional health practices, besides producing individual and local impacts, can be relevant assets in the global scenario.

Paulo Freire, Patron of Brazilian Education (BRASIL, 2012b), is an important theorist of critical thinking. His extensive work, of a universal nature, has impacted Brazil, his country of origin, and the whole world for decades, including in the healthcare field (MIRANDA; BARROSO, 2004). For that reason, his thought was chosen to foment the discussion of this paper.

According to Freire, "dialogue is the loving encounter of men [and women] who, mediated by the world, 'pronounce' it, that is, transform it, and, transforming it, humanize it for the humanization of all" (FREIRE, 2021, p. 51). Anti-dialogue is the practice that is the opposite of dialogue, implying a vertical relationship. It is unloving, uncritical, hopeless, and arrogant. Anti-dialogue is deeply embedded in the historical-cultural formation in Latin America (FREIRE, 2005b, 2020). This concept is used in several works by Freire (1987, 2015, 2020, 2021). The book "Pedagogy of the Oppressed" (FREIRE, 1987) stands out, in which the author presented the theory of antidialogical

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action for the first time, describing the procedures practiced by the oppressors to maintain their dominant position.

Another concept relevant to this discussion is limit-situation, also coined by Freire (1987), which refers to an unfavorable situation to which individuals adhere without being aware of their submission because they have the impression that it is fatalism and, therefore, do not perceive themselves as having the power to change.

From a critical perspective, this article aims to answer the following question: which sociocultural aspects influence the practice of phytotherapy in contemporary Brazil? A parallel will be built between the current situation of phytotherapy in the Brazilian context and the theory of antidialogical action based on the professional and personal experience of the researchers. Beyond being a mere intellectual exercise, such reflection intends to denounce a concrete limit-situation and announce the untested feasibility to be sought, engendering possibilities for breaking with the current situation of oppression and the realization of a new reality that is fairer and healthier, which was previously not even considered.

2 Methodology

This qualitative research fits in a subjectivist epistemology. That is, it is assumedly developed from the researchers' point of view, not starting from the premise that there is an objective reality and that it can be investigated neutrally. Besides, it is situated in the critical paradigm, which assumes that there is a reality to be transformed by the research (DENZIN, 2017). It starts from the Freirean premises that postulate that the world is not, the world is a process of becoming (FREIRE, 2019) and that human beings are not only *in* the world but *with* the world (FREIRE, 2005b).

Complex thinking states that "the whole is in the part, which is in the whole" (MORIN, 2005, p. 75). Totality and partialities operate together in a complementary and, at the same time, contradictory way, based on a "dialectical intelligence of reality" (FREIRE, 2005a, p. 86-87). Thus, the individual is a part of the collective in which he participates, and the collective is a part of the subject. From this perspective, autoethnography was used as a methodology.

Autoethnography refers to writing about personal experiences and their relationship to culture. It is an autobiographical genre of writing and research that reveals multiple levels of consciousness, sewing relationships between social and cultural issues

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with one's own experiences (ELLIS, 2004). In many autoethnographic research, the critical aspect is central (DENZIN, 2018; RAIMONDI *et al*., 2020). After all, due to its intimate relationship with everyday life, this methodology is very useful for reflecting on and transforming reality. In the health area, it has been increasingly recognized and used (CHANG, 2016; RAMALHO-DE-OLIVEIRA, 2020).

Freire (2005b) reinforces the importance of developing research practices linked to life, using words rich in reality that cause the development of critical awareness, and Autoethnography fulfills such requirements. In this paper, Evocative Autoethnography was applied, which seeks to reconcile rigorous scientific research with the "beauty of form in the expression of findings" (FREIRE, 2005a, p. 72), involving creative writing with many details, aiming to evoke resonance and move the reader to action (ELLIS, 2004; RAMALHO-DE-OLIVEIRA, 2020).

The autoethnographic methodology allowed exploring the experience of one of the authors, immersed in the universe under study. In addition to routinely using herbal medicine, she is also an herbalist pharmacist and a phytotherapy teacher for healthcare professionals and the wider community. She observes contradictory aspects between the clinical benefits she and her patients obtain from phytotherapy and the frequent questioning of this practice or lack of interest shown by healthcare professionals. When teaching phytotherapy, she observes how healthcare professionals' and non-professionals' preconceptions limit their possibilities concerning this treatment alternative.

The period of autoethnographic data collection was between November 2020 and February 2022, totaling the elaboration of 12 vignettes. This production was read multiple times and analyzed by the first author, using a field notebook to support and record the reflexivity process. During this process, there was an encounter with Freire's theory of antidialogical action. Such a theory spoke vividly with the produced narratives, promoting an intersection between the lived experience and the social theory. It corroborated with the following statement, "men [and women] reach the reason for obstacles to the extent that their action is impeded. The obstacles to action are clarified by acting or not being able to act, which is not dichotomized from reflection" (FREIRE, 2020, p. 21-22).

The first author then organized the topics that emerged from the autoethnographic process, using the theory of antidialogical action as a lens. The other authors – also pharmacists – carefully reviewed this organization until a final product was reached by

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consensus. Considering the limited communication space available in a scientific article, the authors selected two vignettes to present.

To preserve the legitimacy of the reports, it was decided not to accommodate or distort the stories to illustrate point by point the theory of antidialogical action since the narratives were produced before the encounter with the theory and did not have the specific purpose of illustrating it at the time they were created. The raw and legitimate proximity between lived practice and the found theory was the motivation for writing this paper, which explores the pertinence of the Freirean theory to reveal the context of the phytotherapy field in Brazil.

Considering this research's epistemological and ontological assumptions, the rigor criteria proposed by Le Roux were adopted (2017). In the autoethnographic narratives, fictitious names were used, preserving the identity of the participants. This study was approved by the Research Ethics Committee of the Federal University of Minas Gerais under registration CAAE-25780314.4.0000.5149.

3 Results and discussion

The theory of antidialogical action comprises four components, named here *ipsis litteris* according to the original theory: 1) the conquest; 2) divide and rule; 3) the manipulation; and 4) the cultural invasion (FREIRE, 1987). Each of these components will be applied to the current situation of phytotherapy in Brazil. Autoethnographic excerpts, in a different font from the body of the text, will be intertwined with the theoretical discussion to create a dialogue between theory and practice, seeking the praxis recommended by Freire (1987).

3.1 The conquest

The **conquest** deals with how the oppressors develop "a series of resources through which they propose a false world for the 'admiration' of the conquered and oppressed masses. A world of decoys that, further alienating them, keeps them passive facing it" (FREIRE, 1987, p. 136).

The basis of the conquest is the myths spread by well-organized propaganda conveyed by the media, which are internalized by the oppressed popular masses (FREIRE, 1987). The ruling class presents its language, projects and values as if they were national language, projects and values "and does not accept refusal" (FREIRE,

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2005a, p. 156-157). The deposit of this alienating content in them is not communication in the true sense of the word (FREIRE, 1987).

The invader must mischaracterize the invaded culture and fill it with byproducts of the invading culture to oppress (FREIRE, 2021). In the health sphere, the conquest operates by convincing populations of technological and biomedical miracles, reinforcing the myth of the ontological inferiority of popular and traditional practices (FREIRE, 1987).

Since the beginnings of the pharmaceutical industry in Brazil in the late nineteenth century, appealing campaigns for modern products have highlighted that homecare practices are backward and dubious. These advertisements thus represent the "deposits", in Freire's sense, of the myths essential to maintaining the implemented *status quo*, carrying a truly domesticating force (FREIRE, 2005b).

Many of the population and a large part of healthcare professionals have the dangerous illusion that scientific development is neutral. However, the organization of services and the choice of the techniques that shall be employed carry a political vision, whether declared or not (FREIRE, 2020, 2021). The acceptance of therapeutic resources should not be based only on whether they are old or new (FREIRE, 2020).

The so-called "Integrative and Complementary" Practices in health, including phytotherapy, struggle to coexist with the interests of the powerful medical-industrial complex, representing resistance to the ideological forces of capitalism and colonization. Countless traditional and popular health practices from the peoples of the most diverse origins have been subordinated, ridiculed, made invisible or even suppressed by the oppressors based on a eurocentric value attribution. Determining the existence of a single type of authoritarian, monocultural knowledge implies the automatic determination of the corresponding forms of ignorance. What does not fit the parameters of the current monoculture becomes non-existent or even represents an obstacle to the advancement of knowledge that is considered the only truthful one (NUNES; LOUVISON, 2020).

Thus, biomedicine, which determines the standards of evidence, is historically appropriated as a justification for oppressive projects that widely affect life in the context of society's medicalization process. Hence, rescuing traditional or integrative medicines is a decolonial act in itself. Bringing them into the academic space of knowledge production enables the possibility of de-silencing oppressed voices, fighting against the epistemicide of practices that are not in the oppressor's interest and promoting new dynamics of knowledge ecologies (NUNES; LOUVISON, 2020). Knowledge ecologies

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are based on recognizing the plurality of heterogeneous knowledge (one of them being modern science) and on sustainable and dynamic interactions among them without compromising their autonomy (SANTOS, 2007).

Holistic health and phytotherapy: below the iceberg

Prologue: the experience of acquiring and using an industrialized herbal medicine

I live in a metropolis, and my neighborhood has a drugstore on every corner.

A sore throat encourages me to get out of my apartment and take a short walk to the drugstore:

- Good afternoon! Do you have guaco syrup?

- Yes, ma'am. It's right here, in this aisle.

- This is just the one I'm taking. Thank you very much!

I go to the cashier, credit card on hand, and pay. He hands me the plastic bag with the medicine.

I get home, open the bottle, pour 5 mL into the measuring cup, as indicated, and drink it. I immediately feel relief from my discomfort.

Keeping the recommended dosage, I already feel much better the next day!

In the academic effort to build knowledge about the health practices of native Brazilian peoples or of the various immigrants - voluntary or forced - who settled here, it is usual that European thinking is adopted as a reference point. Adopting this external framework applies even to the very evaluation of thinking. Seeking security in European erudition, the criteria and perspectives adopted carry a colonizing, alienated judgment that prevents a legitimate engagement with the real native potentials, vocations and challenges. Brazil is considered a backward country (FREIRE, 2005b). It is not a matter of eliminating foreign contributions but of seeking to understand and integrate them from a local perspective (FREIRE, 2020).

Traditional and integrative practices propose interpenetration between communities and healthcare professionals, understanding that the knowledge of others is important and should be considered, as there is no single way to build health. The effort to silence what is popular and, therefore, proper to the oppressed, promotes the illness of the social context, with consequences beyond the individual result of therapeutic actions. Culturally debasing the actors of popular and traditional medicine leads to the constitution of acts of conquest and cultural domination.

The immersive experience in herbal medicine

I escaped the big city, and now I live in the countryside. After lunch, I take a short walk to my neighbor's house to deliver the seedling I prepared for her. Mrs. Silvia

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participated for years in the health education activities of the social organization where I coordinated our city's public phytotherapy program called Farmácia Viva (Living Pharmacy).

When I first met Mrs. Silvia, I didn't imagine we would be friends. I, in my late thirties. She, in her late sixties. I, raised in a big city. She, raised in the countryside. I, with a postgraduate degree. She, learning to read and write. I don't really know what my religion is. She is an evangelical devout. I, income of six minimum wages. She, income of a minimum wage. I am white. She is black. The common interest we have in plants brought us together.

From the gate, I smell the mixture of smells from the wood stove, the chicken coop and camphor, as a big camphor wormwood bush is planted by the fence. I see Mrs. Silvia feeding the poultry.

— Good afternoon, Mrs. Silvia! I call with a smile on my face and a wave of the hand.

— 'Afternoon, Anna! She replies, smiling widely, and waves back.

She comes walking in her colorful rain boots, black knit trousers and political propaganda T-shirt from previous years. Her hair is carefully pinned up. She opens up the gate, and we share a warm hug. Her plants are thriving. Begonias, caladiums and all sorts of foliage and flowers, daring the improvised materials she uses to make her vases and flowerbeds. I extend my hands, delivering the seedling to her.

— I finally managed to grow the stevia seedling you asked me for! Despite being a Brazilian species, this one was tricky to root! But better late than never, right?

She laughs as she takes it affectionately from my hands.

— I'm going to plant it in a large vase to take better care of it until it gets stronger — she says, softly caressing the leaves.

Critical consciousness represents things and facts as they occur in empirical existence, in their causal and circumstantial correlations. Such awareness promotes integration between reality and action, overcoming the fatalistic view and accommodation, in which there is no dialogue but only determinations that are authoritatively superimposed on people (FREIRE, 2005b). Accommodation requires a minimum dose of criticality, while integration requires maximum awareness (FREIRE, 2005b). Then, as critical awareness is acquired about popular and traditional health practices, such as phytotherapy, their real value is apprehended, leading to actions that integrate such practices intelligently and appropriately into the health-making of today's society.

In promoting critical awareness, knowledge and careful consideration of vocabulary are indispensable (FREIRE, 2005b). After all, language is always in dialogue with reality, and "changing language is part of the process of changing the world" (FREIRE, 2005a, p. 68). Thus, in line with Freire's tradition, reflecting on the concept of Phytotherapy adopted by the Brazilian Ministry of Health is important. In 2006, Phytotherapy was defined as the "therapeutic characterized by the use of medicinal plants in their different pharmaceutical

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preparations, without the use of isolated active substances, even if from plant origin" (BRASIL, 2016, p. 49). In 2008, this concept became "a treatment method characterized by the use of medicinal plants in their different preparations without the use of isolated active substances, even if from plant origin, *under the guidance of a qualified (recognized) professional*" (BRASIL, 2016, p. 148, emphasis added). Why restrict the use of the term to the guidance of a qualified professional? Recognized by whom? What does that mean? Suddenly, traditional or popular medicinal plant use is no longer considered phytotherapy?

She notices that I am staring at the back of the yard, watching a vigorous climbing plant that has completely covered the fence.

— Are you checking out my guaco plant, girl? I planted the seedling I got at the Farmácia Viva three years ago. Look how beautiful it is! I'm drying the leaves, just like you taught us in the workshop.

I look at the sturdy, dark green branches and foliage. Mikania glomerata, according to the botanical identification conducted by the Herbarium. I remember the day the botanist voluntarily came to collect the specimen for taxonomic analysis. I wonder if she comprehends how many people have benefited from her work.

— Mrs. Silvia, this plant you picked up at Farmácia Viva originated from a single seedling one day and turned into thousands of seedlings and medicine bottles for so many people!

— I have already distributed this plant to many people, including my daughter, and they also kept passing it on! — she reports staring proudly at the plant. — Take my neighbor's case: she is also harvesting and using the guaco and has even asked me to stop cutting the branches that go through the fence and end up in her backyard!

We laughed together, and she continued to explain.

— See: she makes a syrup for her grandson that solved his bronchitis better than the drugs he took since he was a baby!

— That is great news, Mrs. Silvia! I don't have guaco at home at the moment... Could you give me a branch? I ask enthusiastically.

— I'm going to get a pair of scissors right now!

We approached the guaco plant. Up close, I see in detail the beauty of its branches curling around the fence. I observe the environment it is in, shaded by a huge avocado tree. I notice some lighter green branches with smaller leaves on the edge of the fence under the merciless early afternoon sun.

— It seems to like the shade, doesn't it, Mrs. Silvia?

— That's right!

— When planting, I'll be careful to choose a suitable place! How often do you water it?

— The guaco makes its way. It doesn't ask me for much! You only need to water for the first few weeks — she says, and I nod in agreement.

As we speak, Mrs. Silvia swimmingly cuts several branches of the plant.

— Okay, here it is! – she says as she hands me the branches.

— Thank you very much! I'm going to plant them right now!

I open my arms, she comes to meet me, and we share another neat hug.

— Have a nice day, Mrs. Silvia!

— Have a nice day, girl! Then come back, huh?

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3.2 Divide and rule

The second component of antidialogical action is to **divide and rule**. One of its attributes, rarely noticed by naive professionals, even if serious ones, is the emphasis on the focalist perception of the problems and not on their perception as dimensions of a totality (FREIRE, 1987). This view aligns with that proposed by complexity theory, which states that the complex view is a starting point for a richer and less mutilating action (MORIN, 2005). Reductionism benefits the oppressive model. "To the extent that minorities, subjecting majorities to their rule, oppress them, dividing them and keeping them divided are indispensable conditions for the continuity of their power" (FREIRE, 1987, p. 138). The unification of popular masses or different process components into a whole thus represents a threat to the hegemony of dominant groups (FREIRE, 1987).

The health theme is usually perceived from a fragmented perspective, detached from its interactions with society, the environment and the economy. It is a key reality that disintegrates when it passes through the "cracks that separate disciplines" (MORIN, 2005, p. 12), a phenomenon outlined below.

> The man is obviously a biological being. He is at the same time an evidently cultural being, [...] who lives in a universe of language, ideas and consciousness. Now, [...] biological reality and cultural reality, the simplification paradigm forces us to separate them. [...] We will study biological man in the biology department as an anatomical, physiological being, etc., and cultured man in the human and social sciences departments. We are going to study the brain as a biological organ, and we are going to study the mind as a psychological function or reality. We forget that one does not exist without the other, even more so since one is the other simultaneously, although different terms and concepts name them (MORIN, 2005, p. 59).

The antidialogical mechanism of dividing and ruling can be easily perceived in the biomedical model, which often adopts reductionist and linear patterns, limiting illness and health to the individual biological contour and separating subjects from their integral life context (MINAYO, 1997). It perpetuates the ideology that the responsibility for failures "belongs to the losers as individuals and not to the structures or how these societies function" (FREIRE, 2005a, p. 157-158). Hence, the integral context of life is the first determinant of health status, considering food, housing, work and social cohesion (ILLICH, 1975). After all, according to WHO (1978), isn't health conceptualized as a state of complete physical, mental and social well-being and not merely the absence of illnesses or infirmities? Why do people keep thinking about health and organizing health agenda based on illnesses?

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From the reductionist point of view, using medicine – natural or conventional – to correct a problem without addressing what is really at stake is nothing more than a smoke screen. An example is the prescription of an anxiolytic for someone who works under adverse conditions without considering the root cause of the illness. This way of acting is at the service of the capitalist production machine, or, more than that, it is part of its gear. From this perspective, health promotion becomes a biopolitical control device at the service of the economic model (LOPES, 2019).

Legitimate health promotion practices appear marginally, not properly funded or executed by public management, which takes no responsibility. Even in Primary Health Care, the focus is on illness (LOPES, 2019). For example, nutritional education initiatives are not systematically offered, but on the other hand, there is funding for the development of nutritional education for groups of diabetic or hypertensive patients. To be included in the system, it is first necessary to become ill.

I arrive home, imbued with the mission to plant the guaco cuttings. I go to the compost pile I prepared last year and half-fill a bucket with this vegetable soil, feeling its soft and delicious texture. I mix much of this compost with some loam from the backyard, striving to create a balanced soil. Handling the earth is a meditative activity for me. I wonder: would the health that this guaco can bring me in phytotherapy be greater than the health promoted simply by planting and caring for it?

I put the fertilized soil in five recycled plastic bags, where I had already drilled holes for drainage. Since Mrs. Silvia has given me so many branches, I take advantage of this and make more seedlings to share! I prepare the cuttings carefully, remove the leaves to avoid dehydration and place them in the soil, pressing gently until the plants are firmly positioned. I leave the bags in the half shade. Then I discard the leftover plants in this year's compost pile to fertilize next year's plants. Nothing is lost, nothing is created, everything is transformed.

I reach the hose, turn on the tap and, as soon as water springs up, I water the five seedlings abundantly, smelling the comforting scent of wet earth. It occurs to me that this smell evokes our presence at the moment and must have the pharmacological potential to calm stress!

I decide to enjoy the momentum and water the other plants. My thoughts flow as freely as the water. As I water the lavender, myrrh and citron-scented geranium bushes, they repay me with their fragrances. Alongside the rustling of leaves in the wind and water drops on the plants, birdsong makes up the familiar, relaxing soundscape. I hear the yellow-rumped-cacique, the white-eyed parakeet, the great-kiskadee. This environment certainly minimizes the chance that I will fall ill.

I keep watering the spiny coriander, the garlic chives and the rosemary; their aromas evoke nourishment. It is an immense pleasure to feed myself from this biodiversity. A bead of sweat trickles down my warm face as I realize how gardening has transformed my physical and mental health. Such a powerful occupational therapy! Active time away from screens makes me feel so grounded and refreshed. Using herbal medicine and having a one-off improvement in health is just the tip of the iceberg compared to everything that plants can offer!

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The term *One Health* has been used to designate a transition proposal to a single health vision, seeking an integrated way to promote the health of ecosystems and people (CBD SECRETARIAT, 2020). This path makes it imperative that multiple approaches are compatible through thinking and doing health with a broader, ecological, holistic approach, in line with the sustainable development goals proposed by the United Nations (UN) and the 2030 Agenda in Brazil.

Encounters among different types of knowledge through participatory and integrative approaches pave the way for ecologies of knowledge supported by findings and practices that emerge from experiences and struggles for dignity and life against different forms of oppression. There is an undeniable interrelationship between the fight against pesticides and in defense of agroecology, the fight for the health of people from the countryside, the forest and the waters, the fight of quilombolas and peripheral urban communities, popular health education initiatives and Integrative and Complementary Practices (ICP)[4]. Dialogue enhances "collective action for liberation" (NUNES; LOUVISON, 2020, p. 11).

Concerning divide and rule, a reflection can also be made on the institutional organization presented for ICP in health in the different regulatory bodies or professional entities involved with the theme. Usually, such practices are thoroughly divided and categorized so that the defense of the Traditional Medicine of the Americas, homeopathy, or Traditional Chinese Medicine, for example, is perceived separately, and this division ends up promoting the reinforcement of a dominant medicine. The more the totality is pulverized, the more the alienation is intensified. And, the more alienation, the easier it is to divide and rule, intensifying the focalist mode of the ICP (re)existence and hindering their practitioners from a critical perception of reality, keeping them isolated and disconnected from diverse practices and struggles that are in dialectical relation with their own.

3.3 The manipulation

The third component of antidialogical action is **manipulation**. When the dominated emerge from complete crushing, manipulation practices become necessary and come into

[4] These practices are also referred to as Complementary and Alternative Medicine or Traditional and Complementary Medicine. In Brazil, the most accepted term is Integrative and Complementary Practices.

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play. This situation is a response that the oppressors have to give to the new concrete conditions of the historical process to avoid a threat to their dominion (FREIRE, 1987).

Since the end of the 20th century, the biomedical model has made efforts to accommodate emerging demands to maintain itself in the face of the legitimation crisis that affects it, thus triggering new attitudes on the part of healthcare professionals in their relationship with the patient (CONTATORE; MALFITANO; BARROS, 2018). In this context, practices such as patient-centered care, health literacy or shared decision-making with the patient have expanded. Such initiatives are welcome, but without being critical, they are not enough for the population to play a leading role in their health.

Without a deeper and more political reflection on these efforts, the desired objectives can be lost, manipulating the patient to consider the health prescriptions as the only valid options without displacing the power distribution between healthcare professionals and non-healthcare professionals. After all, how can the patient act significantly in his care process with the health team without being legitimized, without having received basic training in the health field and not even having the "appropriate" vocabulary universe for the clinical environment?

The concept of epistemic injustice is useful in reflecting on the difficulties of truly patient-centered care. This term refers to "a type of injustice that occurs when we exclude the contribution of one or more people to the knowledge production, dissemination and maintenance" (SANTOS, 2017, p. 143). Communication between healthcare professionals and patients is usually loaded with epistemic injustice.

When patients express themselves, they often have their suffering denied or minimized, even if unintentionally, by the health professional. Historical and structural forces determine the legitimacy level of the various forms of knowledge, making dialogue difficult in health environments. Formal knowledge is privileged and elevated to a gold standard in biomedical training, while patient stories are seen as illogical or unworthy. They are not perceived as "medically relevant", leading to the neglect of experiential, psychosocial aspects or contextual factors that are critical for the patient (THOMAS *et al*., 2020). Therefore, healthcare professionals must receive "literacy" about the reality of the patients and their way of experiencing illness, exploring their livelihood as "experiencers" and not "patients" about their illness situation (ANDRADE; MALUF, 2017).

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I soak the hibiscus, which was previously just an ornamental plant for me. I recently learned to eat its flowers and leaves in salads, which saved me a few trips to the grocery store and a few bucks. Watering the ginger, I observe that the purslane and dandelions are spontaneously sprouting again in the middle of it. At another time, I thought they were "weeds" and plucked them up mercilessly. But now I use these plants as food and herbal medicine. I remember the popular saying we have in Brazil: every plant is a weed when we don't know it. But when we know them, every weed is a plant. As a health professional, I see many people who feel powerless in the face of their health problems. Sometimes the resource for self-care may be sprouting nearby.

Immersed in my thoughts, I've watered everything! I turn off the tap, satisfied. I harvest some flowering lavender and honey-scented golden-rod sprigs and arrange them in a water-filled vase. I get inside the house and place it triumphantly on the coffee table in the living room while I think of the popular saying, "If you want things done right, do it yourself". Health is embedded in daily life. It is a continuous and active process. Health and everyday life are continually interwoven by the choices we make each day. Simple attitudes can make a big difference.

Through the window, I look at the freshly planted guaco seedlings and realize I will soon be able to make my own guaco syrup. I will no longer buy from the drugstore! But it occurs to me that I haven't had any more respiratory infections since I live here.

***

To illustrate this point of manipulation, one can also think of the ICP that finds some space, even if subjugated, alongside dominant medicine. Their practitioners may already consider themselves privileged by this inclusion and fail to perceive the greater and common objective of decolonizing medicine. In their naivety, these practitioners can occupy political spaces and lead commissions and associations, however remaining in paternalistic forms and their assistance-oriented extension. Thus, even if accidental disagreements occur between them and oligarchic groups injured in their interests, it is unlikely that great differences will surface (FREIRE, 1987).

Manipulation works like an anesthetic, distracting the popular masses from the true causes of their problems and their concrete solution. Thus, the population or even health workers working in different ICPs are divided into groups of individuals, often aiming to receive more for themselves (FREIRE, 1987).

Considering, for example, the practices listed in the 2006 Brazilian National Policy on ICP – which include phytotherapy, homeopathy, Traditional Chinese Medicine/acupuncture, crenotherapy and Anthroposophical Medicine – it can be noted that phytotherapy finds a privileged scenario of acceptance by conventionally trained healthcare professionals. Contrary to popular sayings, phytotherapy, as defined by the Ministry of Health (BRASIL, 2016), is an allopathic practice, not a homeopathic one. This statement favors their insertion in the same therapeutic rationale for which the

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professionals are already trained, being possible only to replace the therapeutic product at the end of a consultation (CIMBLERIS; SACRAMENTO, 2014).

Unlike the other practices in the National Policy on ICP, once the proper financial investments are made, phytotherapy can follow the same evidence trials used by conventional medicine for drug testing. However, this path can only be taken from the interest of those who hold the capital. Thus, market interests continue to immorally prevail over radically human interests (FREIRE, 2019).

While this logic is not disrupted, the false impression remains that the population already has access to phytotherapy in the official healthcare systems. Still, restricting phytotherapy only to its biomedical facet increases the chance that this ICP is perceived as already contemplated as long as it remains subjugated to the filter of scientific evidence as the only path of existence. Thus, the broader reasoning about the position that phytotherapy could occupy in favor of society from adopting a decolonial and integral health perspective is not covered.

Teaching phytotherapy to shamans

I slept far from home, in a light sleep, managing my expectations for the classes I will offer this week as a teacher of the Indigenous Degree Course. Early in the morning, I have breakfast at the tiny inn with Violet, the monitor responsible for escorting me. The driver of the scheduled taxi calls on the street, and we head toward the Maxakali village. A blend of enthusiasm and curiosity mix up with the butterflies in my stomach. The car is crowded. The trunk and seats are packed with the stuff we bought yesterday at the supermarket and our teaching materials. As she bends down to hold the folders that almost fall with the shaking of the precarious dirt road, Violet says:

— Did you know that among all the ethnic groups we attend in the course, only in the Maxakali villages do we bring this over-purchase? We can't bring the usually counted food and cleaning supplies. Because as soon as we arrive, they immediately divide the items among all the villagers, and we end up getting the course's operation hampered in the last few days...

— What an interesting way of life in solidarity! I answer. — I think getting to know this village will be an experience that will take me miles away from my comfort zone...

— For sure! The classes here flow very peculiarly — Violet points out. — The regular course students invite the whole community to the classes. Everything that happens in the village gains a collective status. For their medicinal plants classes, our students invited several shamans to participate!

— Wow, Violet, how could I teach about medicinal plants to shamans? This event intimidates me much more than giving lectures on medicinal plants to the most erudite audiences! — Violet demonstrates agreement by making the "yes" movement with her head. — I always think about the resistance of the Maxakali people, who are standing here more than 500 years after the arrival of the colonizers, proving that there are other very real ways of living and attending to healthcare. This cultural difference relativizes the science we were trained in at the university. It makes us feel small and naive!

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— Certainly, Anna. This story is millennial, and I respect it a lot! It is impressive how the Maxakali maintained their language, which preserved their way of life based on a rich oral tradition and sacred chants. But despite so much resilience, they also have immense vulnerability. In this village, there is a complicated social situation... Funai [Fundação Nacional do Índio / National Indigenous Foundation] allocated this indigenous community here a few years ago, on an emergency basis, due to conflicts in the region where they were previously located. It is not an ideal territory, as it used to be a cattle farm and is significantly environmentally impacted. In ancient times, when conflicts of a serious nature occurred within this ethnic group, the villages divided themselves by affinity and sought new places to settle. But nowadays, there's nowhere to go, as all land is someone's. Thus, people must wait years of bureaucracy to perform their political practice.

— I can imagine the consequences of forcing dissenting groups to coexist.... — I reflect. — And we don't even get to know about it! There's not a word on the news! I was born in Minas Gerais and never knew there were so many indigenous people here! I only found out about it when I started teaching in the Indigenous Degree Course. When I met the Maxakali people for the first time, I had no idea of their culture.

Another point one can reflect on concerning the composition of manipulation in the context of the antidialogical action applied to phytotherapy is the regulation of the performance of different professionals in the theme. Such debates tend to engender corporatist horizons more often than individual and collective health horizons. Freire reinforces the perspective that human interests must be considered superior to those of "pure groups or classes of people" (FREIRE, 2019, p. 98).

Physicians and veterinarians, prescribers par excellence, have been prescribing herbal medicines since these professions exist, despite the reduction of this type of prescription since the advent of the modern pharmaceutical industry. Other professions have had their performance greatly modified over time. Since 2008, with the global *boom* in interest in phytotherapy and the increases in public policies and national regulations, health professional councils have frequently issued new resolutions regarding the prescription of herbal medicines. This is the case of the Federal Councils of Pharmacy (CFF, 2008, 2013), Nutrition (CFN, 2007, 2021), Physiotherapy (COFFITO, 2000, 2010), Dentistry (CFO, 2008a, 2008b, 2012) and Biomedicine (CFBM, 2020). Holistic therapists can also recommend herbal medicines to their patients (BRASIL, 2002). Nurses (BRASIL, 1986, 2006a; COFEN, 1997), psychologists (SOBRAPA, 2007) and occupational therapists (COFFITO, 2001) can also act as prescribers of herbal medicines under some specific conditions. Moreover, professional practice in phytotherapy is not restricted to prescription and may extend to health education actions, occupational cultivation practices and other activities (BRASIL, 2012a).

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However, despite the encouragement of official bodies and professional councils, added to the great interest of the Brazilian population, the curricula of healthcare professionals still do not have the proportional inclusion of contents related to phytotherapy (BARRETO, 2015). Would this be the result of a lack of a project or a project in itself? Freire discusses at length in his work the question of educational programs elaboration, reinforcing that "the fundamental problem, from a political nature and touched by ideological inks, is to know who chooses the contents, in favor of whom and what their teaching will be, against whom, in favor of what, against what (FREIRE, 2005a, p. 110).

Until today, many health professionals – as well as non-professionals – still believe that using medicinal plants is a less scientific practice than using conventional medicines. Yet, the fact that passing through scientific scrutiny is linked to economic interest is hidden. Healthcare professionals know that most modern medicines originate from natural products and believing that medicinal plants are not effective or safe is a direct reflection of a manipulation mechanism. This situation is corroborated by the fact that 75% of medicines approved for marketing between 1981 and 2010 originate in natural products (NEWMAN; CRAGG, 2020).

3.4 The cultural invasion

Finally, the fourth component of the antidialogical action is the **cultural invasion**, which is the infiltration that invaders make into the cultural context of the invaded, disrespecting their potential and "imposing on them their vision of the world, while curbing their creativity, by inhibiting its expansion" (FREIRE, 1987, p. 149).

Several Brazilian native peoples and immigrants from different origins and traditions who settled in Brazil were convinced that biomedicine is the best option available and gave up their ways of doing health. "A basic condition for the success of the cultural invasion is convincing the invaded of their intrinsic inferiority" (FREIRE, 1987, p. 150).

Antidialogical action, as a mode of cultural action of a domineering character, is not always exercised deliberately. Often its perpetrators are also dominated beings, as exemplified by leaders who separately represent the ICP without an expanded awareness of the process in which they are inserted. Leaders who are unaware of their domination may act as pure metastases of the larger ruling elites. The same happens to professors in

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higher education health courses, the contents they pass on and even the format of their teaching practices (FREIRE, 1987). Universities, hospitals or primary healthcare centers exist in time and space and do not escape from the influences of the conditions of (im)posed reality. They end up working, to a large extent, as training agencies for future "invaders" who perpetuate the dominant structures (FREIRE, 1987). Healthcare students educated in this framework tend to follow the same rigid standards in which they (de)formed themselves when becoming professionals.

Technical-scientific training does not need to be antagonistic to humanistic training. With awareness, science and technology can be at the service of liberation, allowing healthcare professionals to overcome their dominated status and assume the role of historical subjects (FREIRE, 1987, 2019). This step also strengthens the assumption of historical subjects' condition to the population that healthcare professionals serve.

— How was your first contact with the Maxakali, Ana?

— It was such an adventure! When I arrived to teach the first class, I didn't even know they spoke another language! But right away, I understood that language would not be the only barrier to communication... I felt that the world these people inhabited was different from mine. The class was about food, and we hit a wall right on the first concept: nutrients. The Maxakali do not have a concept related to our notion of nutrients. In their culture, children's growth and health maintenance have much more to do with the spiritual life and the fulfillment of rituals recommended for each phase of life and in each situation.

Violet laughs and comments:

— What a story! We needed to write more about these experiences! So, how did you manage to work on curriculum content without disregarding people's culture?

— The course pedagogy proposed respect and dialogue among different cosmovisions, which allowed me to work on the "white man's" explanations for health, our theories, that have become possible in a given paradigm, in a given culture.

— Sounds like a great approach! — Violet remarks.

— The theory was excellent, but it was not always clear how to act. For example, when we approached parasitic diseases, a matter of great impact on indigenous villages in Minas Gerais. In the case of the Maxakali, we focused on schistosomiasis due to its high prevalence. But when I tried to teach about parasites and their cycles, I found that students didn't believe in microscopic life. They explained this was just a white man's belief, as they believed in their spirits. Their explanations for schistosomiasis differed. For example, children got big bellies to keep up with their mothers' pregnancies. But if they didn't believe in my theories, how could I help them learn our ways of preventing the disease?

— Their way of explaining life really takes our ground away! — Violet said, raising her eyebrows. — I attended an agroecology class right here in this village, and what caught my attention was that the Maxakali had no concept of nature. They simply don't distinguish themselves from nature!

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In the relationship between the health team and the population, whether in the clinical environment or health education, the knowledge gained from experience or the understanding of the world that each one has must be considered, never underestimating them. In its authoritarianism, biomedical practice, like banking education, tends to feel entitled to know what people need without even talking to them. They think that what "lay people" already know is irrelevant. Therefore, its task involves depositing knowledge or prescriptions to those supposedly empty consciences (FREIRE, 2005a). Still, "underestimating the wisdom that necessarily results from sociocultural experience is, simultaneously, a scientific error and the unequivocal expression of the presence of an elitist ideology" (FREIRE, 2005a, p. 85).

In the herbal medicine field, this is very clear. After all, to arrive at "discoveries" in ethnobotany, experts on medicinal plants from different origins are the pillar of information that leverages scientific progress. Research starts from the clues of traditional knowledge. In the case of Brazil, this baggage is part of descendants of indigenous peoples and immigrants from different countries, who orally perpetuate their survival and health practices using plants.

Scientific knowledge of medicinal plants from different Brazilian biomes is incipient, considering the entire therapeutic arsenal still underused. Popular wisdom carries unprecedented possibilities of treatments and cures for various health problems. Frequently, this knowledge is appropriated in an extractive way, with a predatory collection of both plants and knowledge, leaving the communities in worse conditions than they were before the researchers arrived. The fifth Global Biodiversity Outlook report (CBD SECRETARIAT, 2020), published by the United Nations Convention on Biological Diversity, describes that the current rate of biodiversity loss is unequaled in history, including Brazil.

Developmental pressure continues to occur not only upon the environment but also upon traditional peoples and their remnants, escalating the trend that the knowledge aggregated to native plants continues to shrink and end up disappearing alongside the very medicinal species, in irreparable losses. It is also noteworthy that the communities that use and care for these species must have the right to continue living and practicing their knowledge in their way, not just given the grant and value conferred by capital or biomedical research. The oppressors have not yet realized that the conservation of nature by traditional peoples does not only concern their interests but also the interests of all humankind.

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The driver interrupts the conversation, announcing:

— We're here!

I open the car door already with an ethnographic attitude. The smell of smoke beckons me to notice the remnants of a bonfire. I observe the residences made of rustic wood. The houses do not have walls but wooden slats. They look more like fences than walls, so the landscape brings together the intimate life of families and the collective world.

Davi, one of the students on the course, comes to greet us as soon as he sees the car arriving. He wears shorts and a Flamengo [soccer team] shirt. I smile, remembering that he explained the whole village roots for this team because its colors resemble the sacred coral snake. His wife, Liz, is at his side in her traditional design Maxakali dress. She always wears this dress in different colors and textures in all university classes. Initially, she came to the university to accompany her husband. Then she became a student on the course, too, even though Maxakali women don't usually speak Portuguese.

The children, all of them completely naked, quickly crowd around us in large numbers. I'm wearing a thick coat, but I'm still feeling a bit chilly, and I wonder if the kids aren't cold. Like most women, the children don't speak Portuguese, but we exchange smiles and greetings with body language. The Maxakali are easy-laughing people, and I completely relax when the fun begins. As we take the supplies out of the taxi, other villagers help. As Violet warned, they are already opening all the packages and distributing the items among them.

It is a fact that modern science has increasingly confirmed the "accuracy of popular knowledge findings" (FREIRE, 2005a, p. 135). Therefore, it is politically important that indigenous and country peoples, among others, become aware that scientific mechanisms are proving their knowledge. This finding acts on the mechanism of cultural invasion, triggering in people "confidence in themselves so indispensable to their fight for a better world" (FREIRE, 2005a, p. 135). The more the oppressed see the oppressors as possessing unsurpassed power, the less they believe in themselves. Popular and scientific knowledge does not need to be dichotomized and can act as partners in dialogic construction (FREIRE, 2005a, 2021). But establishing respect and partnership between them is not easy, as it is a continually provisional process (FREIRE, 2005a).

> Multiculturalism is not constituted in the juxtaposition of cultures, much less in the exacerbated power of one over the others, but in the *conquered* freedom, in the *assured* right of each culture to move while respecting each other, freely running the risk of being different, without fear of being different, of being each one "for oneself", only as it is possible to grow together and not in the experience of permanent tension, provoked by the all-powerfulness of one over the others, forbidden to be (FREIRE, 2005a, p. 156).

How could this collective and democratic construction take place in the phytotherapy field, in the health area? What teaching and what research is sought? What are the necessary regulatory actions? Adopting a multicultural model implies political will, mobilization and organization of each cultural group to achieve common ends, demanding a new ethics based on respect for differences (FREIRE, 2005a). It is a

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possibility that proposes the acceptance of contradictions coexisting harmoniously, as proposed by the complexity theory (MORIN, 2005).

— We're starting classes today — I declare excitedly, happy to be here.

— Let's get the people together! — Davi replies. — The shamans are thrilled!

Another student from the course arrived, Miguel, whom I greeted warmly. I asked for his help in translating what I said to the rest of the group.

— Baí[5]*! – I make a point of using the friendly greeting, which I learned from my students. — Some of you still don't know me. I am Ana.*

— Baí*! It is so good to be back! — Violet says.*

— Baí*! — the group answers, more or less in unison.*

I continue to explain:

— I'm here to exchange knowledge about medicinal plants. I acquired knowledge from books and scientific studies and have also been practicing it for myself and my family. I am very humbled by all the knowledge you have! In this matter, you are the greatest teachers, especially the elders and shamans.

Miguel does the translation. An older adult answers in Maxakali, and Miguel clarifies:

— We already know the use of the plants of the tikmû'ûm *– Maxakali. We want to know about the* ãyuhuk *– white people – understanding of the functioning of plants and medicines.*

I am glad we leveled the intention of intercultural exchange right from the start. Miguel gives a summary of some health issues in the village, in Portuguese:

— We have a Public Healthcare System team that visits us occasionally. We also had access to a primary healthcare center and a hospital on the land we lived on previously. Many doctors' recommendations do more harm than good to our people, and they have no interest in understanding our way of living. Nowadays, we have many more health issues than we had in the old times. Our deliveries took place in the village, and the women recovered their health and vigor under our care. Now, they sometimes spend long periods in the hospital and never fully recover. But there, they eat what they shouldn't eat, lie on high beds that impair their recovery... From the city also came alcohol, which has destroyed our people! There is no forest to get food from anymore, and we need basic food baskets. At school, we teach the children our culture, and we must understand more about how white people think too, so that we can communicate. I wish they would do the same and try to understand our ways!

Violet and I demonstrated our understanding of the problems with our body language. He then started to speak in Maxakali, but he was so quick that I concluded that he was summarizing the speech for the local community, which already knew these problems too well. And I replied:

— Indeed, not all healthcare professionals understand that you have your way of taking care of yourselves, and often you don't get the respect you should. We'll talk more about that later in the week. For this morning, if you agree, we thought we'd walk here on your land and talk about the plants we find.

After translating my invitation, they began organizing themselves for the activity. Mostly men remained, some of them shamans, and few women. We did a presentation round with simultaneous translation and then set off for our walk.

[5] Term from the Maxakali language used for greetings and farewells, which is also used as a positive expression of approval.

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Considering the mechanisms of cultural invasion and the actions of healthcare professionals who prescribe what the "lay" population should do, a parallel can be drawn with the repeated mentions of the **prescription** term in Freire's work. He points out that "one of the basic elements in oppressor-oppressed mediation is prescription", all prescriptions being the imposition of an option from one conscience to another (FREIRE, 1987, p. 34).

> This is why, subjected to the concrete conditions of oppression in which they alienate themselves, transformed into "beings for another" from the false "being for oneself" on whom they depend, men also no longer develop authentically. Because, thus deprived of their decision, which is found in the dominating being, they follow his prescriptions (FREIRE, 1987, p. 159).

In this sense, patients end up accepting and taking the practices of biomedicine as their own, disregarding other ways of knowing and doing health. Immersed in myths created by powerful social forces, they minimize themselves as objects instead of asserting themselves as subjects, even when they believe they are free (FREIRE, 2005b).

The ability to reject prescriptions involves inserting subjects into their problem-posing situation and their ability to choose, representing a great threat to oppressors (FREIRE, 2005b). According to Illich (1975), the sum of preventive acts, diagnoses and therapies within the biomedical conception reduces the health of society, as they reduce the population autonomy. People's belief that they cannot cope with diseases without modern medicine undermines their health, reaffirming the powerlessness of individuals and communities to provide care.

Referring to the process brought about by the industrial civilization on people's rupture with their own culture, Freire uses the term "uprooting", a very appropriate metaphor for phytotherapy. It is necessary to resist this logic, courageously discussing the problem-posing situation of which one is a part of, in an act of rebellion, which opposes the other option: that of "being taken and dragged to the destruction of one's own self, subjected to others' prescriptions" (FREIRE, 2005b, p. 98).

Violet and I, with our jeans, hats, sunscreen, boots, fanny packs, water bottles, cameras, and notebooks. Indigenous women, with their traditional dresses. The indigenous men wore shorts, some with and others without a shirt. They wear slippers or are plain barefoot. One of them brings a machete to collect parts of the plants.

During the walk, the Maxakali show their plants and talk about what they use them for. The uses of plants for health, handicrafts, construction, and religion are all treated with the same importance and seriousness level. With its hunter-gatherer culture, this community's life is closely linked to natural resources. I also share the knowledge I have about the found species. A Maxakali gentleman, after showing me how to remove the fiber from the imbaúba [a native tree that belongs to the Cecropia genera and is also

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considered a medicinal plant] to make bags and hammocks, begins to speak effusively in the Maxakali language. One of our students was doing the translation.

— We moved a few years ago to this new land and lost access to many important species for our needs and rituals. For some plants, we are already finding replacements. However, we do not know all the species here in the region. This area has suffered a lot from extensive grazing, and the few areas of available forest are young and not yet well developed, like this one where we are.

Listening to this reality, I am embarrassed, aware of my whiteness. My mixed family has a bit of everything... Colonizers, traditional peoples, refugees... A hard to trace origin of the typical Brazilian. But I feel that in their eyes, I was just white and represented a single story: colonization.

Another gentleman completes the speech in Maxakali, and our student promptly explains:

— Besides the loss of plants, for our people, when changing places, we lose protection and contact with our ancestors.

Unable to grasp the dimension of this loss, I keep thinking about the value of traditional oral knowledge, necessary for their way of life, now irrecoverable. The knowledge passed on by generations, for hundreds or thousands of years, can no longer be practiced, and is condemned to disappear. What would be the value of these practices to governments? How could public policies not prioritize this cultural heritage? Sadness and revolt settle in my body. I swallow those feelings for later, and we continue the walk. Each species found on this expedition is a stop, a bilingual exchange, a demonstration. Many species we know and use for the same purpose, while others we use to resolve or minimize different conditions.

We arrived at a watercourse. Hands and faces were washed, and water was drunk. An old shaman invites us to form a circle and sings a traditional Maxakali song. In the Maxakali language and practice, the same word designates song and spirit. I don't know what words are said in the loud chant, but I don't need to. The connection with that stream of water, nature and humanity not separated from nature is simply lived in this moment.

On the way back, I feel a strong kinship with that group: I finally understand that we are one people.

***

Freire (2005a, p. 185) reports a similar "autoethnographic" experience with native peoples in Fiji, describing their communion with the different expressions of life that "were not just that of men and women and gods and ancestors". In his words, the universe of such communion "encompassed the trees, the animals, the birds, the earth itself, the rivers, the seas. Life in its fullness" (FREIRE, 2005a, p. 185). With this last approximation between the experiences and reflections of the authors of this paper and those of Paulo Freire, this session of results and discussion ends.

4 Limitations

This research was an integral part of a doctoral thesis, which limited the time available for data collection, analysis and interpretation and the writing of the results to

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24 months. The possibility of continuing the study for a longer period would allow for greater depth in knowledge production.

5 Final considerations

This paper was based on real-life and work experiences to build a parallel between the phytotherapy situation in contemporary Brazil and the antidialogical action theory, pointing out sociocultural aspects that influence such practice and outlining a decolonial problem-posing that contributes to a critical analysis of the theme.

Some reasons for the low expressiveness of phytotherapy in the Brazilian official healthcare system were discussed and connected to broader social issues, considering that the current reality is socially constructed and should never be perceived as the only possibility. Thus, this article denounces a limit-situation, which contains the seed of the untested feasibility to be pursued.

As long as the issue of phytotherapy is perceived only from a technical point of view, further technological and regulatory advances will continue to be sought. However, from the discussion presented in this article, it is clear that technical increments, although relevant, will not be enough to overcome the current limit-situation. Establishing a critical practice that considers this theme's complexity is necessary to take advantage of the full potential of phytotherapy in Brazil.

This practice must be based on valuing Traditional Brazilian Medicine, including its systematic registration and adopting fair benefit-sharing models for the communities with such knowledge. As a priority point, such justice implies the possibility of people staying in territories where this knowledge can be practiced, preserving their access to biodiversity. After all, this is the foundation for including Brazilian Phytotherapy in the country's official healthcare system and will also allow its expansion in the future for the benefit of the international community.

It is essential to redesign curricula at different levels of education, especially for healthcare professionals, to add more and better content about traditional native peoples and their knowledge from a decolonial perspective. Disclosure about this topic in different media is equally relevant.

Due to their benefits, already recognized by the national government, the ICP can and should be strengthened. Bringing other types of knowledge into teaching, research and health institutions is urgent, always reinforcing that knowledge can be produced and

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validated in a logic different from the Eurocentric one but not ontologically inferior for that reason. Education about epistemic injustice and adequate welcoming of the patients' experience is also necessary, as well as the healthcare system's structural reorganization, so it is possible to transform imposed prescriptions into dialogic relationships between professionals and patients.

Scientific and popular knowledge can act as partners, and exchanges between them should be promoted, including the various ICPs, with a view to the greater interests of individual and collective health, not corporatist interests. To this end, health actions must be constructed and implemented from an integral perspective rather than organized from a disease-centered logic. Thinking about humanity's health without considering ecosystems' health is not plausible. In this redesign, more studies are needed in history, sociology and politics applied to health, specifically phytotherapy.

In the acute sense of hope affirmed by Freire throughout his work, it is hoped that this paper is another step toward engendering possibilities for breaking with the current situation of oppression and building a broad, ecological and socially fairer health project.

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