Esc Anna Nery 2023;27:e20220164

Health conditions and relationship with health services from *Quilombola* people's perspective

Condições de saúde e relação com os serviços de saúde na perspectiva de pessoas de quilombo

Condiciones de salud y relación con los servicios de salud desde la perspectiva de las personas de quilombo

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Submitted on 05/10/2022.
Accepted on 10/28/2022.

DOI:https://doi.org/10.1590/2177-9465-EAN-2022-0164en

Abstract

Objectives: to analyze the perceptions of the *Quilombola* population of Caldeirão about their health conditions and to identify the possibilities and difficulties in the relationship with the health services in their territory. **Method:** a qualitative, descriptive and exploratory study, carried out in the *Quilombola* Community from Caldeirão, Marajó Island, Pará, Brazil. Data production took place from March to April 2021, through individual semi-structured interviews with 30 residents, and thematic content analysis was applied. **Results:** two empirical categories originated, revealing the *Quilombola* population's perceptions about their health conditions and the health-disease process, the relationship that the community had with the local health services and the strengths and weaknesses inherent to this relationship. **Conclusions and implications for practice:** *Quilombola* people's perceptions showed a predominance of biomedical knowledge and a hospital-centric view, in addition to their weakened relationship with local health services. It is expected that the research results will encourage dialogue about these populations, considering that they represent a traditional group in a vulnerable situation. It is necessary to carry out further research to investigate/strengthen the Family Health Strategy role and unveil/problematize traditional knowledge in the face of biomedical knowledge hegemony in the scenario of *Quilombola* populations.

Keywords: Health Services Accessibility; Primary Health Care; African Continental Ancestry Group; Vulnerable Populations; Health of Ethnic Minorities.

Resumo

Objetivos: analisar as percepções da população quilombola de Caldeirão sobre suas condições de saúde e identificar as possibilidades e dificuldades na relação com os serviços de saúde em seu território. **Método:** estudo qualitativo, descritivo e exploratório, realizado na Comunidade Quilombola de Caldeirão, Ilha de Marajó, Pará, Brasil. A produção dos dados ocorreu no período de março a abril de 2021, por meio de entrevistas semiestruturadas individuais com 30 moradores, e aplicou-se a análise de conteúdo temática. **Resultados:** originaram-se duas categorias empíricas, revelando as percepções da população quilombola sobre suas condições de saúde e o processo saúde-doença, a relação que a comunidade mantinha com os serviços de saúde locais e as potencialidades e fragilidades inerentes a essa relação. **Conclusões e implicações para a prática:** as percepções dos quilombolas evidenciaram predomínio do saber biomédico e da visão hospitalocêntrica, além de sua relação fragilizada com os serviços de saúde locais. Espera-se que os resultados da pesquisa suscitem o diálogo acerca dessas populações, considerando que representam um grupo tradicional em situação de vulnerabilidade. É necessário realizar outras pesquisas para investigar/fortalecer o papel da Estratégia Saúde da Família e desvelar/problematizar os saberes tradicionais, frente à hegemonia do saber biomédico, no cenário das populações quilombolas.

Palavras-chave: Acesso aos Serviços de Saúde; Atenção Primária à Saúde; Grupo com Ancestrais do Continente Africano; Populações Vulneráveis; Saúde das Minorias Étnicas.

Resumen

Objetivos: analizar las percepciones de la población *quilombola* de Caldeirão sobre sus condiciones de salud e identificar las posibilidades y dificultades en la relación con los servicios de salud en su territorio. **Método:** estudio cualitativo, descriptivo y exploratorio, realizado en la Comunidad *Quilombola* de Caldeirão, Isla de Marajó, Pará, Brasil. La producción de datos se llevó a cabo de marzo a abril de 2021, a través de entrevistas semiestructuradas individuales con 30 residentes, y se aplicó análisis de contenido temático. **Resultados:** se originaron dos categorías empíricas, que revelaron las percepciones de la población *quilombola* sobre sus condiciones de salud y el proceso salud-enfermedad, la relación que tenía la comunidad con los servicios locales de salud y las fortalezas y debilidades inherentes a esa relación. **Conclusiones e implicaciones para la práctica:** las percepciones de los *quilombolas* mostraron un predominio del conocimiento biomédico y una visión hospitalocéntrica, además de su debilitada relación con los servicios locales de salud. Se espera que los resultados de la investigación estimulen el diálogo sobre estas poblaciones, considerando que representan un grupo tradicional en situación de vulnerabilidad. Es necesario realizar más investigaciones para investigar/fortalecer el papel de la Estrategia de Salud de la Familia y develar/problematizar los saberes tradicionales frente a la hegemonía del saber biomédico, en el escenario de las poblaciones *quilombolas*.

Palabras clave: Accesibilidad a los Servicios de Salud; Atención Primaria de Salud; Grupo de Ascendencia Continental Africana; Poblaciones Vulnerables; Salud de las Minorías Étnicas.

INTRODUCTION

Quilombola peoples (people living in Brazilian hinterland settlement founded by people of African origin) are groups formed by people of black descent, due to their African origin, trafficked to Brazil between the 16th and 19th centuries to work as slaves on sugarcane plantations in precarious conditions. After slavery abolition, there was a significant increase in the number of *Quilombola* communities that were constituted in Brazil, and an estimated number of 2,958 across the country, with the states of Bahia, Maranhão, Pará, Minas Gerais and Pernambuco bringing together the largest number of communities in their territories.[1] They present a historical process of marginalization and segregation, from which they experience a socioeconomic reality of exclusion in relation to the Brazilian population in general.[2]

After centuries of struggle and resistance and, currently, militating as an organized group through popular participation, *Quilombola* people conquered the right to definitive possession of their lands, which was legitimized in the Federal Constitution of 1988, reaffirming the historical importance of these territories and moving away from the understanding that considered *Quilombola* people as groups of fugitive slaves that posed risks to the colonial order.[3] However, the grouping of these communities was marked by social inequities, suffering the effects of historical segregation and racial expropriation.[4] They remain residing in communities with greater social and health vulnerabilities, precarious water supply and sanitation, irregular garbage collection, low education and low family income.[5]

Considering the vulnerabilities in black Brazilian population's daily life, which culminated in the social struggles undertaken by it, the Federal Government created, through Law 10.678/2003, the Special Secretariat for Policies for Racial Equality Promotion (SEPPIR – *Secretaria Especial de Políticas de Promoção da Igualdade Racial*), currently recognized as the Brazilian National Secretariat for Racial Equality Promotion Policies (SNPIR – *Secretaria Nacional de Políticas de Promoção da Igualdade Racial*),[6] establishing, in 2004, the Brazil *Quilombola* Program and, in 2009, the Brazilian National Policy for the Comprehensive Health of the Black Population (PNSIPN – *Política Nacional de Saúde Integral da População Negra*), aiming to combat inequalities in the Unified Health System (SUS – *Sistema Único de Saúde*) and promote comprehensive health care for the black population.[7]

In this scenario, Primary Health Care (PHC) is fundamental for the continuous process of comprehensive care for individuals, especially in the context of the family and the community, being the basis and strategy for the reorientation of professional practices, reorganization of the services provided and effective qualification of levels of care in the health system.[8-9] In order to extend coverage, access and services throughout the national territory, the Family Health Strategy (FHS) has established itself as a model for the reorganization of care within the scope of PHC.[8] However, *Quilombola* communities, due to their condition as vulnerable populations, have not yet been effectively contemplated with these services.[10]

This reflection is supported by the fact that the vulnerabilities inherent to *Quilombola* communities are produced daily by the absence of public policies that effectively address social inequalities, given that, even in a post-slavery abolition historical moment, the Brazilian State produces, maintains, strengthens and perpetuates unequal conditions between the black population and other social groups.[11-12] The challenges imposed by this scenario are often reflected in the fragmented and insufficient care of *Quilombola* people's health needs in the context of FHS.[13]

In recent decades, although there have been significant advances in public health policies for ethnic minorities and for the black population, there are still barriers that hinder their access to health services.[14] For this reason, it is essential to reflect on strategies that make it possible to expand accessibility and promote changes in the current scenario for this population,[15] subsidizing comprehensive care and the association of *Quilombola* communities' sociocultural identity with new health care practices.[11]

Therefore, understanding *Quilombola* people's health conditions, from their perspectives, can favor new possibilities of action for professionals and managers involved in the care of these people, which strengthen health promotion and illness prevention actions, fostering evidence that reflects the need for better health conditions for them.[16] Thus, this study aimed to analyze the perceptions of the *Quilombola* population of Caldeirão about their health conditions and to identify the possibilities and difficulties in the relationship with the health services in their territory.

METHOD

This is a qualitative, descriptive and exploratory study, whose writing was guided by the COnsolidated criteria for REporting Qualitative research (COREQ),[17] which allowed the main researcher to seek meanings of the phenomenon, listening to participants and considering their contexts and subjectivities.[18]

It was carried out in a health unit of the *Quilombola* Community of Caldeirão, in the municipality of Salvaterra, Marajó Island, state of Pará, Brazil. In this area, since 2004, fifteen rural black communities, with a long history of agrarian conflicts with landowners and loggers, began to identify themselves as *Quilombola*, waging struggles for their ethnic recognition and their territories, among them that of Caldeirão.[19]

Participants were 30 residents registered at the health unit, of both sexes, over 18 years old and who defined themselves as *Quilombola*, selected by convenience. This amount considered 10% of the existing families in the community and data saturation, which was reached when no new element was found among the data and the addition of new information was not necessary, as it did not change the understanding of the object of study.[20]

Data production took place from March to April 2021, through individual interviews, carried out by the main author, using a semi-structured script, prepared by the authors, containing questions about participant sociodemographic characteristics and perceptions about health conditions and access to services offered in the community. The questions were not previously tested, however, aiming at a better understanding of the target

audience and achieving the objectives, the script was prepared with accessible language and in order to contemplate the relevant aspects to apprehend the studied phenomenon.

Initially, the project was presented to the vice-president of the *Quilombola* association, the director of the health unit and other professionals, in order to explain the research operationalization and facilitate the approach to possible participants. The invitation to participate occurred during the presence of residents at the unit, and, upon acceptance, each participant was led to a reserved room, maintaining their privacy. For those who decided to grant the interviews at another time, prior scheduling was carried out, according to their availability. It is important to note that the data were produced during the COVID-19 pandemic, reason why the researchers obeyed the health protocols and adopted all the relevant measures for individual and collective protection during contact with the community.

The interviews were transcribed to compose the *corpus*, submitted to thematic content analysis.[21] To this end, the testimonies were organized by questions, on their horizontal axis, and by respondents, on their vertical axis, classified based on the registration units corresponding to each question. From them, words and theme-phrases were extracted, grouped into clusters of meaning, identifying, predominantly, ten themes (registration units), through the regularity with which they appeared in the testimonies, in occurrence and co-occurrence.

The analysis provided two lines of organization, the basis for the analytical categories, with the 1st being called "Health-work-community dimension", and the 2nd, "The relationship between the population and health services". Thus, the topics related to the 1st line made up the first category, entitled "Health conditions of the *Quilombola* population: perceptions about health".

The themes that pointed to the 2nd line formed the second category: "The relationship of the *Quilombola* population with health services: strengths and weaknesses". Theme representativeness was highlighted in the research results, with absolute and relative frequencies that indicate their expression in the set of perceptions.

The study complied with Resolution 466/12 of the Brazilian National Health Council,[22] and was approved by the Research Ethics Committee of a Graduate Nursing Course at the *Universidade do Estado do Pará*, under Opinion 4,547,344, in February 2021. Participants signed the Informed Consent Form, and had their identities preserved using alphanumeric codes, composed of letter Q, followed by the sequential number of the interviews, which were recorded with consent.

RESULTS

Participant characterization

Among the participants, 21 (70%) were female; 12 (40%) were aged between 20 and 31 years old; 21 (70%) were single; 14 (46.7%) had completed high school; 18 (60%) had a family income of up to one minimum wage; 11 (36.7%) were housewives; 10 (33.3%) were farmers and/or fishermen; and 17 (56.7%) were unemployed.

In this context, it is worth informing that, in the community of Caldeirão, the main sources of subsistence are related to self-employment, in small family businesses, such as grocery stores and açaí processing places. Family farming, with the cultivation of vegetables to supply the trade in Salvaterra, and the raising of animals, such as pigs and poultry, are productive activities normally carried out by women, leaving the men with activities in the cassava swiddens, for flour production, and fishing, main source of income for families, as the community is located on the banks of the Paracauari River. The only source of formal employment is a fish processing meatpacking company, which employs a small portion of the local population.

As for housing, 29 (96.7%) lived in masonry houses, with water supply from an artesian well (untreated water) and disposal of solid and liquid waste in aseptic tanks, with 28 (93.3%) incinerate household waste. With regard to health care, 19 (63.3%) used the services offered at the Caldeirão health unit and, of these, four (21.1%) used them in the last 12 months. The main reasons for seeking care were related to pain, for five (26.3%), and hypertension, for four (21.1%).

The categories organized from analysis of results are presented below.

Health conditions of the *Quilombola* population: perceptions about health

In this category, participants' perceptions about their health conditions and in relation to the health-disease process are evident, as well as their understanding of what it means to be healthy, based on knowledge acquired through their daily experiences.

Regarding what they understand by being healthy, 12 (40%) associated being healthy with the absence of disease and being a person with a healthy appearance, without imperfections:

> *In my opinion, a healthy person is a perfect person!* (Q3).
>
> *Health is a person who is well, does not show symptoms of illness, is always alert, does not feel any pain and is always active* (Q24).

It is noteworthy that five (16.7%) related health with good physical conditioning, strength and dexterity to work or perform household chores, an understanding strongly rooted in the sociocultural characteristics of *Quilombola* populations:

> *It is a person who is healthy, strong and dexterous to do things, is in vigor, is young and resistant, i.e., in good health to work* (Q3).
>
> *Being healthy is a very good thing, people who are healthy have everything, they can work and do their homework* (Q20).

For five (16.7%) participants, an unhealthy person becomes a problem for the community, as it demands care and efforts from others, meaning the disease as a negative event, not only for

the individual context, but that brings harm to the community's life and daily activities:

> *A healthy person is the most beautiful thing, a sick person depends on others, and not everyone treats a sick person well, besides the mother* (Q1).
>
> *Illness is a bad thing, because a sick person is useless to do anything* (Q20).

In this understanding, 11 (36.7%) also associated being healthy with practicing good eating habits, performing regular physical activity, having adequate housing and being mentally well, interpreting good health as an association between these elements:

> *To be healthy is to eat well, not to show any change in health, to have good body resistance* [...]*, exercise regularly, occupy your mind with good things, because health comes from the mind. If we have a peaceful and good mind, our body is fine* (Q29).
>
> *It means being healthy, having good housing, having considerable basic sanitation, not living in degrading conditions, being physically and mentally healthy. All this contributes to good health* (Q26).

As for self-rated health, 18 (60%) considered it as good or very good, justified by the fact that they rarely seek physicians and/or hospital care, knowledge linked to biophysician knowledge and the hospital-centric view of health:

> *Very good, because it is difficult for me to go to the physician!* (Q4).
>
> *I consider my health to be good, because I am living life without going to the hospital too much* (Q16).

The relationship of the *Quilombola* population with health services: strengths and weaknesses

This category highlights the relationship between *Quilombola* people and local health services, based on difficulties faced by the community in accessing health goods and services, often insufficient or nonexistent, as well as coping strategies for these difficulties and expectations for improving services.

Regarding their actions in the event of illness, 13 (43.3%) reported taking care of themselves, practicing self-medication. Only in case of medication ineffectiveness, the alternative would be to seek a health service:

> *When I'm sick, I try to take some medication* [...]. *If I have a headache, I have good headache medication at home; if I have a fever, a little tea solves it, I don't think it's necessary to go to a physician* (Q15).
>
> *I take medication from the pharmacy, such as paracetamol. I prefer to take the medication, if it doesn't get better, I look for the physician* (Q22).

This behavior seems to be related to negative view of the care provided at the health unit, as 11 (36.7%) mentioned that it did not fully meet their needs, while six (20%) said they attended, but then reported some degree of dissatisfaction with the services offered:

> *They don't meet all my needs, because the* [health] *center doesn't have the support people need, they don't have medication* [...]. *The health center has a physician, but she doesn't come every day of the week, and when she does, the person has to go at dawn to get a form to be seen* (Q11).
>
> *The health center meets my needs because it has a physician, but not a dentist. The difficulty is that, sometimes, we go to the health center and we don't have money to buy the medication that the physician prescribes* (Q9).

Still in this context, 11 (36.7%) did not attend the unit, even when they were sick, presuming poor quality of care, making them resort directly to the municipal hospitals of Salvaterra or Soure, located close to the territory, since, according to participants, they had more resources:

> *I never looked for health services at the health center, I prefer the hospital in Salvaterra, because there are more resources there. At the health center, there is a lack of medication and a physician. Due to difficulties at the health center, we first look for the main hospital* (Q7).
>
> *I never needed to go to the health center, but I know that there is never any medication, they don't apply dressings,* [...] *and many people want to be seen, they want to take an exam for the physician to look at, but they have difficulty getting a form* (Q14).

Thus, considering the imposed difficulties, the most frequent practices adopted by the community were pointed out. In this regard, six (20%) participants mentioned the use of home medications or some type of medicinal herbs, whether for the preparation of teas or for use during bath (herbal bath), many of them preferring to use exclusively these practices, culturally perpetuated:

> *Here, we take care of health first using medicinal herbs, making boldo tea if it's a stomach ache, or lemon balm tea if it's nervousness, there's always a home remedy. Then, if it doesn't get better, we go to the hospital to resort to the medical part, make an appointment and tests, but usually we start with home medications, finding a way around the situation at home. In general, when we look*

> *for a physician, it's because we did something at home that didn't work* (Q2).
>
> *Generally, here in the community, people treat themselves with medicinal plants. In almost every house there are these plants, people use them to cure minor illnesses* [...]. *We resort to these plants because it was a custom that our grandparents left to our parents and they left it to us* (Q29).

Magical-religious thinking was also present in the testimonies, with faith being an alternative, often overlapping with health care, since eight (26.7%) mentioned faith in God as fundamental for disease healing:

> *I was very sick in the past, but God is merciful and I got better from asthma, he healed me and freed me from this disease* (Q3).
>
> *When it is not possible to treat it at home, then we look for a physician, but our physician is God* (Q12).

It is noteworthy that, even with the negative views and difficulties faced in accessing health services, six (20%) recognized improvements in services in recent months, due to change in unit management:

> […] *today, I think the service is acceptable, because there was a change in management and there was an improvement in the service, there is a physician and a nurse, and it is working morning and afternoon* (Q2).
>
> *Under this new management, the health center has improved, now it has vaccines for children, prenatal care and some consultations* [...] (Q6).

These changes generated expectations in the population and brought new perspectives to users, reported by four (13.3%) participants, who already noticed positive changes in care and wanted them to continue to occur:

> *We are at the beginning of a new administration, so something changes here and there, and, after six or seven months, the situation starts to improve. The people expect it to improve the health part* (Q16).
>
> *Today, the health center has physician and nursing care, but before that we had to go to Salvaterra at dawn to get a consultation form. Now, it made it a little easier and I hope it makes it even easier* (Q10).

DISCUSSION

Participants' perceptions of health are still linked to biophysician knowledge and the hospital-centric view, understanding it as the absence of disease, good physical conditioning, strength and dexterity to work or perform household chores, and little need to seek medical appointments and hospital care. This conception seems linked, mainly, to the weakened relationship of *Quilombola* people with the local health services, faced with the difficulties identified in accessing health goods and services, mobilizing the search for alternatives to face these difficulties and generating expectations regarding the improvement of services.

The predominance of females and the fact that a significant portion of participants declared themselves to be housewives and had a family income of up to one minimum wage are characteristics also found in other studies with *Quilombola* populations.[16,23-24] However, education as complete high school, declared by almost half of participants, is a result that differs from those found in different surveys.[12,16,24] In any case, the preponderant role of women in domestic activities in these communities is evident, as the male chauvinist view is still present in *Quilombola* reality, which associates the woman with taking care of her home, children and being responsible for strictly domestic tasks, while the man is responsible for supporting the family through work outside the domestic environment.

A study carried through in agricultural area, with *Quilombola* characteristics of the countryside of Bahia,[25] reaffirmed that *Quilombola* people are traditional Brazilian populations of black descent who keep their cultural and religious traditions, their kinship and their identity alive, marked by resistance to oppression, the denial of their rights and racial segregation, residing in communities with greater social vulnerabilities, such as precarious water supply and sewage, irregular garbage collection, low level of education and inadequate family income. Such data corroborate the findings of this research.

The occurrences of muscle, joint and back pain and hypertension, highlighted as the main reasons for seeking health services, allow inferring that the expressive performance of subsistence occupational activities, such as those linked to agriculture and fishing, and the particular way of life of this rural community significantly influence their health conditions. Similar to this result, a study conducted in a *Quilombola* community in Santa Catarina[26] showed that reports of muscle, joint, and bone pain were associated with physical exertion undertaken in household chores by women and manual work performed by men, as well as work in agriculture and charcoal, activities commonly performed in these communities.

As in this study, the occurrence of diseases such as hypertension in *Quilombola* populations was evidenced in other studies, which pointed out the influence of diet, sedentary lifestyle and the insertion of other eating habits, usually urban, in a negative way on the health and quality of life of these human groups.[12,27] Additionally, in this study, it was found that people with hypertension resorted to health services only in case of hypertensive emergencies or to receive medication, but rarely for follow-up consultation and assessment of blood pressure levels or looking for guidance on healthy habits.

It is denoted, therefore, that the precariousness of housing conditions, the lack of basic sanitation, the discreet or non-existent

access to treated water for human consumption, the inadequate disposal of waste and unsatisfactory access to health services support the vulnerability of these groups, contributing to the high incidence and prevalence of parasitic infections and chronic pathologies, such as hypertension.[28]

It is worth noting that the concept of health, from participants' perspective, is strongly linked to the state of not becoming ill. In this sense, the figure of someone with a healthy appearance emerged in their imagination, a conception that disregards other factors intertwined with the expanded concept of health. The health-disease process was reduced to the mere view of the absence of disease, a thought closely linked to biophysician and curative knowledge, showing that it is necessary to encourage debate about the concept of health, from a comprehensive and holistic perspective, encompassing social, political, psychic, cultural and historical issues, strengthening this broad concept and disseminating it to society.[15]

It was also noted, in the definition expressed by the participants, the combination of factors seen as essential to have a healthy life, such as adequate housing, basic sanitation, water quality, good eating habits, physical activity and mental health care. Thus, the concept requires an assessment of living and health conditions in *Quilombola* communities, noting the various social determinants, such as work, income, housing, education and food, essential for strengthening care and the health-disease process dynamics.[15]

Still in this aspect, *Quilombola* people consider the strength and physical conditioning to work as inherent to the state of health, relating them to the importance of work for communities like theirs, especially work in the fields and/or fishing, essential subsistence practices for them. Thus, a sick individual is a cause for concern for the community, requiring additional costs, constant attention and an overload of care from their family members, becoming a burden on the entire community, as health care requires everyone's efforts. Health, therefore, was closely linked to the driving force and social activities related to the maintenance of family support, while illness is seen as an obstacle to this, with self-care being a fundamental element in the health-disease process.[29]

These conceptions are linked to the ways of life, production and social reproduction related to land, work and the struggle for the conquest of constitutional rights. In interactions with the earth, the *Quilombola* population expresses at work their autonomy for life maintenance.[30]

In this context, when assessing their health status, the idea that it was good or very good prevailed, as they rarely used health services and physicians. A study conducted in a *Quilombola* community in Bahia[12] also identified that most participants self-rated their health as good, however, it should be noted that the sociocultural peculiarities and the meaning that the subject gives to their process of living are what define living with or without health and not simply an organic, natural and objective indication, much less a state of equilibrium, thus overcoming biomedical knowledge.[31]

Regarding health services, participants expressed that the offer and quantity of actions are insufficient to meet the community's demands and expectations, as they do not have more complex resources and, even when assistance with a certain professional category is available, operational and managerial challenges limit users' ability to schedule an appointment. It is understood that this contributes to strengthening sociocultural conceptions that guide individuals to seek health services only when faced with a morbid condition, often with complications, and not to prevent illness or seek professional guidance.

The practice of self-medication reflects the lack of services to meet participants' health demands, inducing them to choose first to take care of themselves independently at home, using over-the-counter medications and, if they do not have the expected effect or the condition worsens, seek local health services as a last resort. Research in the *Quilombola* Community of Abacatal, Pará,[32] pointed out that self-medication, with pharmaceutical product consumption, was also used by residents, due to the wide access and ease of purchase.

Dialoguing with this data, another investigation on the satisfaction of users of health units in Coari, Amazonas,[33] revealed that the lack of medications was the predominant factor of dissatisfaction, because it caused losses to actions of prevention and control of chronic diseases, leading users to resort to other units, sometimes more distant, in search of medications.

This dissatisfaction, also found in this study, makes *Quilombola* people not seek community health services, presuming poor quality of care, a conception arising from previous negative experiences. Therefore, it is expected that a satisfactory service responds to users' expectations, being a determinant of satisfaction with the services, and should be based, among other aspects, on the resolution of health actions so that users do not have to look for alternatives in institutions far from their locality.[34]

In Brazil, there is a strong correlation between race, racism, racial discrimination, including its intersectionalities, and income, causing racially discriminated groups to occupy lower levels in the social pyramid. This scenario is the result of political and socio-historical processes that generate and perpetuate situations of inequality, resulting in greater vulnerability for these groups, subject to the offer of precarious public or private health actions.[13,29]

Starting from this theoretical reflection, and considering its relevance and strong applicability in the national territory, it is appropriate to infer that, in the *Quilombola* reality, the population's difficulty of access and fragile relationship with health services can be, in part, explained by the concept of institutional racism, configured as the difficulty or impossibility of public institutions, especially those aimed at promoting social rights, effectively responding to racial inequalities.[35]

Institutional racism has relationships with the concept of programmatic vulnerability, moving from the individual dimension and establishing the structural dimension, which corresponds to organizational, political, practice and norms that result in unequal treatments and results.[13] It is also called systemic racism which, acting as an important lever for the differentiated exclusion

of various subjects in this population, promotes the selective exclusion of racially subordinated groups,[13] problem fed both by the belief in the absence of racism in Brazilian society and by the lack of knowledge of its negative influences on people's health.[36]

Strengthening this reflection, research with remnants of *quilombos* from northern Tocantins[28] pointed out that the scarcity of financial resources, the location of the communities, the lack of health professionals and the difficulties in scheduling exams constituted barriers to the population's access to health services. Moreover, the negative perception of the care received and the low commitment of managers may reflect negatively on health indicators and, above all, affect *Quilombola* people's quality of life and well-being.

In view of this scenario, it is essential to ensure that health services prioritize the quality of their actions and contemplate the doctrinal principles of equity, comprehensiveness and universality advocated by the SUS so that the *Quilombola* population has access to health care levels and their biopsychosocial needs are valued and effectively resolved. In this context, PHC is an element that promotes comprehensiveness, because, due to its scope and territorial organization, its function is to bring users closer to spaces where health actions take place in their locality, whether in the health unit itself or in community environments, facilitating these individuals to build a good relationship with the social environment where they live.[37]

Therefore, ensuring continuity of care is a relevant attribution of PHC, whose professionals must consider each population's needs to establish and/or strengthen bonding relationships through user embracement promotion. In this sense, embracement is an opportune tool to expand access and appreciation of *Quilombola* people in health care, as well as overcome weaknesses inherent in this context, as it has the potential to improve, through dialogue and qualified listening, individuals' self-esteem and the relationships established between users and health teams, overcoming old strategies for organizing work in health.[38]

The use of medicinal plants and herbs as a means of treatment, traditional practices shared by older adults with the young, is perpetuated over generations. Thus, deep knowledge about plants and herbs, as well as the different methods of medicinal preparation, demonstrate the traditional wealth spread by the ancestors of these communities over the years, through oral tradition and healing practices.[39]

In addition to tradition, it is understood that the maintenance of these practices considers the reliability of the beneficial effects of plants and herbs, as it is understood that they do not pose health risks and are often used as the first therapeutic strategy. This strengthens and perpetuates popular belief in these natural resources, thus constituting the main option for treating diseases for residents.[39]

Thus, Integrative and Complementary Practices (ICP) constitute a strategy that promotes changes in the predominant health care model, as they propose to produce and legitimize alternative knowledge and practices, prioritizing health over illness, emphasizing care/self-care, autonomy and promotion of health for people and collectivities. Such practices provide a singular view about individuals and the health-disease process, not being perceived solely as care practices, detaching themselves from the process determined and regulated by the biophysician model and medicalization by pharmaceutical industries, as they propose a comprehensive interpretation of individuals in their entirety.[40] Therefore, this reflection dialogues with the traditional knowledge and practices unveiled in this study, which appear as fundamental elements of participants' daily life, as they constitute their imaginary and their tangible world, contributing to give meaning to their material and sociocultural reality.

There was an expressive manifestation of magical thinking and religiosity evidenced by the mention of God, associating him with good health and the cure of some illness. In this perspective, for participants, faith in God works as a foundation, because, when they do not find the necessary solutions in health services, begin to place their hopes and trust in faith healing. This understanding is in line with the results of research carried out with *Quilombola* women in Rio Grande do Sul,[41] which highlighted the dimension of religiosity expressed in the meanings they attributed to faith and to God, with faith being a motivational resource, and God, the deity to whom they entrusted their lives.

Therefore, assessing health care in the context of *Quilombola* communities requires understanding the inequalities faced and greater exposure to challenges inherent to social determinants. This, consequently, makes them more susceptible to iniquities,[28] because they are factors historically present in these communities and that directly influence their living and health conditions.

It is important to emphasize that, in a subtle way or disguised as operational and/or structural difficulties, potentially the marks of institutional racism are disseminated in health services. They prevent or limit individuals to effectively overcome the barriers imposed by the privileges between different social subjects and to have full rights to the health actions instituted by the services, which meet their biopsychosocial needs and contribute to mitigating inequities and their repercussions among ethnic-racial groups.[42]

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The study allowed us to understand the perceptions about the health conditions of a *Quilombola* community in the Brazilian Amazon, evidencing the predominance of biomedical knowledge, the hospital-centered view and the fragile relationship of this population with local health services. Bearing this in mind, the aforementioned health conditions and access to services proved to be deficient, as the assistance offered does not fully meet the population's needs.

In order to contemplate the SUS equity and comprehensiveness principles and PHC attributions, it is essential to prioritize *Quilombola* people's demands and expand the coverage of family health teams to serve in the territory of these communities, inserting them in actions aimed at promoting/recovering health and preventing illness. Moreover, managers must seek to reduce historically

existing inequalities, implementing more effective and resolute public policies that meet the population's demands and provide them with better conditions, observing the social determinants, but also their popular knowledge and their sociocultural identity.

It is hoped that the research results will encourage dialogue about these populations, seeking to identify and problematize their particular realities, considering that they represent a group with ancestors from the African continent in situations of vulnerability. These go beyond health, also passing through education, basic sanitation, racism and generation of jobs and income, constituting obstacles to achieving a better quality of life and health in its fullness.

The results showed that it is necessary to carry out further research to investigate and strengthen the FHS role and the decisions inherent to this model of care in dealing with inequities and their repercussions, especially in the scenario of *Quilombola* populations. Faced with the hegemony of biomedical knowledge, it is also necessary to unveil and problematize traditional knowledge, in order to value it and help to deconstruct thoughts and practices based on prejudices that still occur in social relationships, including within the scope of health services.

As a limitation of this study, it is understood that part of results may not be generalizable, since it was carried out in a health unit of a *Quilombola* community which has peculiar characteristics, endowed with imagination and practices influenced by social, cultural, economic, political and regional conditions. However, the results can encourage reflections and the development of new research on the subject, to strengthen it, disseminate it and provide its timely application in interventions in the reality of these communities.

AUTHORS' CONTRIBUTIONS

Study design. Rosimere de Freitas de Sousa. Ivaneide Leal Ataíde Rodrigues. Alexandre Aguiar Pereira.

Data collection. Rosimere de Freitas de Sousa.

Data analysis. Rosimere de Freitas de Sousa. Ivaneide Leal Ataíde Rodrigues. Alexandre Aguiar Pereira.

Interpretation of results. Rosimere de Freitas de Sousa. Ivaneide Leal Ataíde Rodrigues. Alexandre Aguiar Pereira. Laura Maria Vidal Nogueira. Erlon Gabriel Rego de Andrade. Ana Kedma Correa Pinheiro.

Article writing and critical review. Rosimere de Freitas de Sousa. Ivaneide Leal Ataíde Rodrigues. Alexandre Aguiar Pereira. Laura Maria Vidal Nogueira. Erlon Gabriel Rego de Andrade. Ana Kedma Correa Pinheiro.

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Responsibility for all aspects of the content and integrity of the published article. Rosimere de Freitas de Sousa. Ivaneide Leal Ataíde Rodrigues. Alexandre Aguiar Pereira. Laura Maria Vidal Nogueira. Erlon Gabriel Rego de Andrade. Ana Kedma Correa Pinheiro.

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