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Essay
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Challenges to comprehensive health care and emancipation of enslaved workers

O desafio da atenção integral à saúde e da emancipação de trabalhadores escravizados

Abstract

Introduction: contemporary forms of slave labour have different impacts on occupational health, requiring new and emancipatory care practices. **Objective:** to analyze the theoretical and practical dimensions of the health-disease-care process and workers' emancipation in a context of enslavement. **Methods:** this essay problematizes theoretical and conceptual aspects of the health-work-slavery relationship, emphasizing the importance of broadening the concept of worker beyond wage-earning relations. **Results:** the article presents a critical review of Brazilian experiences in supporting the emancipation of enslaved workers and a critical reading of the 'National Flow of Assistance to Victims of Slave Labor,' highlighting the pressing challenge of developing new health care routes and the role of the Brazilian Unified Health System (SUS) and of the workers' health, especially for post-rescue moments, to overcome the risk of re-enslavement and reduce social vulnerabilities. **Conclusion:** the continuous struggle to expand and strengthen emancipatory strategies requires the leadership and organisation of workers, connecting unions, social, gender and racial struggles as struggles for freedom and dignity. Fights for health that promote the construction of territories free from slave labor, containing a set of actions to ensure basic conditions for a dignified life and the exercise of freedom.

Keywords: enslavement; occupational health; healthcare.

Resumo

Introdução: as formas contemporâneas de trabalho escravo trazem impactos diferenciados à saúde desses trabalhadores, necessitando haver desenvolvimento de práticas de cuidado emancipatório. **Objetivo**: analisar as dimensões teórico-práticas do processo saúde-doença-cuidado e da emancipação dos(as) trabalhadores(as) em cenário de escravização. **Métodos**: trata-se de ensaio que problematiza aspectos teórico-conceituais das relações saúde-trabalho-escravidão, destacando a relevância da ampliação da noção de trabalhador para além das relações de assalariamento. **Resultados**: o artigo apresenta revisão crítica das experiências brasileiras de apoio à emancipação de trabalhador(a)s em situação de escravidão e leitura crítica do "Fluxo nacional de atendimento às vítimas do trabalho escravo", ressaltando o desafio premente de desenvolver novos caminhos de cuidado em saúde e o papel do Sistema Único de Saúde (SUS) e da saúde do trabalhador, especialmente para os momentos pós-resgate de trabalhadores, de modo a superar o risco de reescravização e reduzir vulnerabilidades sociais. **Conclusão**: o processo social de luta contínua para ampliar e fortalecer as estratégias emancipatórias requer o protagonismo e organização de trabalhadores, conectando as lutas sindicais, sociais, de gênero e raça como lutas por liberdade e dignidade. Lutas por saúde que promovam a construção de territórios livres de trabalho escravo, contendo conjunto de ações para assegurar condições básicas de vida digna e exercício da liberdade.

Palavras-chave: escravização; saúde do trabalhador; atenção à saúde.

Introduction

The development of comprehensive health care strategies for workers subjected to contemporary slave labor (CSL) is one of the major challenges facing the field of Worker`s Health (WH) today. Transformations in the world of work, the withdrawal of rights, and the increase in poverty and social inequality have amplified exploitation and the imposition of exhausting working hours, degrading conditions, and mechanisms of servitude and coercion as different forms of slavery[1,2].

In this context, theoretical and practical production related to the dimensions of the health-disease-care process and the emancipation of vulnerable workers rescued from slavery—the latter understood as a process of transforming domination and the conditions of possibility of violence and subjection in order to provide a greater degree of autonomy, political participation, social integration, and recognition of rights for this working population[2,3]—still falls short of the specific demands of this reality[4,5]. It is necessary to strengthen, deepen, and disseminate analysis-intervention experiences that aim to overcome the historical neglect of these social groups and strengthen the fight to eradicate contemporary slave labor[4,5].

Therefore, this article analyzes the theoretical and practical dimensions of the health-disease-care process and the emancipation of these workers on the national scene, in order to support the expansion of Brazilian strategies. This is a theoretical essay that addresses theoretical-conceptual aspects of the health-labour-slavery relationship, drawing attention to the importance of broadening the notion of "worker," as well as presenting a brief review of experiences of support for their emancipation and a critical reading of the recently launched "National Flow of Assistance to Victims of Slave Labor"[6], highlighting the pressing challenge of developing new care paths, especially for the moments after workers are rescued, in order to overcome the risk of re-enslavement and reduce social vulnerabilities.

Slave labor history and diversity

From the colonization of Brazil to the present day, social relations and the wealth generated in all sectors and economic cycles of the country's history have been marked by some form of enslavement, resulting from the levels of exploitation in the international division of labor in the different phases of capitalism, in various global production chains[7,8].

These exploitations cover both the period of legal slavery and post-abolitionism, and include the exploitation of indigenous people, the expropriation of Africans, and debt bondage in the rubber cycles—during the period of neo-colonialist expansion in Midwestern Brazil on the agricultural and mining fronts. They also refer to the use of impoverished immigrants and women in domestic and/or sexual services[4,7,8] and the subordination/exclusion of poor, Black, and *quilombola* populations, among others.

Furthermore, the process of abolishing slavery in Brazil had as its backdrop the absence of legal, economic, and social reparations that would contribute to the real emancipation of the formerly enslaved populations[9]. This historical reality, based on patriarchalism, the manorial-colonial ideology originating from mercantilism and the European monarchy, and the consequent association between economic liberalism and slavery[10], has profoundly marked the social relations of production in Brazil, which are still visibly based on social inequalities, elitist political-economic hierarchies, latifundia, and structural racism[4,7].

It would be wrong to say that colonial slave labor had been overcome by a linear transition to free labor, as even in post-abolitionist Brazil, different labor relations resembled slave practices[1,11]. For example, 28 years after the abolition of slavery, sanitarian Belisário Pena, on his missions to the interior of the country, identified work situations that were "practically slavery."[1] He was one of the pioneers in describing these peculiar conditions, which would come to be called contemporary slave labor (CSL) and/or labor analogous to slavery, since, at that time, legally free men and women experienced very violent work situations, whose proximity to legalized slavery was undeniable. This explains why, after the word "slave" was removed from the post-1888 Brazilian Penal Code, the word returned under the expression "labor analogous to slavery" in Article 149 of the 1940 Criminal Code[1,12].

Many similar labor relations continued to manifest themselves in Brazil in the mining, charcoal, and agricultural sectors over the following decades. Some were denounced by activists and social movements in the countryside, such as bishop Pedro Casaldáliga in 1971 and the Pastoral Land Commission. Different social movements began to systematically fight these practices, leading Brazil to officially recognize the existence of CSL in the early 1990[13].

During this decade, the struggle of social movements, the executive branch, and the judiciary led to the expansion of the concept of slave labor in the Brazilian Penal Code. The empirical observations and the descriptions of the conditions of food, housing, pace, intensity and extent of work activities, violence, restrictions, lack of protection, and neglect of workers' health showed that their lives were openly threatened and put at risk in these work situations. New elements then became defining of CSL, so that a new wording was given to Article 149 of the 1940 Penal Code by Law 10,803 of December 11, 2003[14].

This socio-political category—"labor analogous to slavery"—was built from a memorable social struggle and is a Brazilian achievement, as it broadened the characterization of the phenomenon based on the work realities observed empirically in the country. It shows that CSL is not a remnant of pre-capitalist relations or ownership over others, nor is it synonymous with precarious, informal work, or a situation on the margins of the economic system, but is characterized by specific labor relations, typified by one of the following markers: forced labor, debt bondage, exhausting working hours, and/or degrading conditions[14].

The socio-political category is also innovative in the international scientific debate because, by broadening the range of recognition of the conditions of slavery beyond the curtailment of freedom and compulsory labour, it expands the possibilities of social emancipation[2]. The international literature on the subject explicitly uses the category "modern slavery," which, apart from being very problematic, offers no consensus on its definition[2]. This expression is an umbrella term to cover various phenomena that were the subject of standardization during the 20th century by international organizations, such as the conventions on forced labor of the International Labour Organization (ILO), abolition of forms of slavery in the United Nations, prohibition of human trafficking, among others. The issue is part of the global political and institutional agenda and of the Sustainable Development Goals, which, in Target 8.7, defines the need to "take immediate and effective measures to eradicate forced labor, end modern slavery and human trafficking"[15] (p. 11). It is even estimated that 50 million people are in slavery worldwide[16]. In Brazil, in 2023, 1,443 workers lived in conditions analogous to slavery and, since 1995, 61,711 workers have been rescued[17].

It is important to emphasize that the Brazilian category "labor analogous to slavery" covers the concept of enslavement as the subtraction of human dignity and not just the deprivation of freedom, thus providing a more critical perspective in relation to the markedly liberal interpretations of these terms: "modern slavery," "new slavery," "forced labor," "unfree labor," "human trafficking," and "debt bondage." It also opens up new possibilities for recognizing the variety of gradations in the spectrum of labor relations that are not usually classified as forced labor, modern slavery, or human trafficking, but which take place in absolutely exhausting and degrading conditions, as they consume the workers' mental and bodily energies, accelerating wear and tear and increasing the degree of indignity, social humiliation, and immobility[2,4,18].

All these forms of subsumption, coercion, control, and subordination of the human workforce challenge the field of Workers Health to incorporate approaches capable of expanding the modalities of analysis and strengthening the practices of care and socio-political action towards social emancipation. This requires broadening the very notions of "worker" that circulate in this field, since they have been hegemonically marked by the seduction of the modern industrial concept of free wage labour[19]. This concept is too narrow to capture the diversity of work situations that develop outside the wage-earning nexus that has prevailed in human history and is still in force. A broader approach to the category "worker" therefore helps to overcome the invisibility of countless workers subjected to contemporary slavery in the current capitalist system.

Scholars of critical theory and economists[20,21] argue that the category of labor/worker in modern times has tended to exclude a multitude of services and activities, such as women's work and various branches of service. Moreover, Linden[20] states that we lack a historical perspective capable of integrating slavery and so many other forms of work that exist outside the wage nexus, understanding them not as stages overcome in the distant past by

"free" forms of wage-earning relations, but as a present element that affects a huge group of "subalternized workers"[20]. Historically, the rule has been the existence of an immense number of subordinate workers occupying different scales between slavery and free labor. After all, slave labor is not the exception in history, but wage labor is.

In this sense, Fraser[22], from a different perspective, also highlights the need to recognize the figure of both the free and exploitable working citizen and the dependent expropriated subject. The central point to be stressed is that these forms of expropriation of the body, exploitation of the free workforce, and types of enslavement coexist in a complex way and intensify in contemporary times, ultimately being determined by the characteristics of the unequal and combined development of capitalism.

Recognizing this reality favors overcoming the social invisibility of entire portions of this wide range of workers, whose health needs have been neglected. The construction of worker's health in Brazil has not always considered a set of socially useful, unpaid activities responsible for maintaining the sphere of production. This is because the typical working social group most often considered was the proletariat, mostly consisting of "free" men (to sell their labor power to the owners of the means of production), generally the urban, industrial, and unionized class, leaving the broader and more complex reality of workers in different services and contexts of enslavement in the background.

The theoretical-practical field of worker's health and the Brazilian Unified Health System (SUS) have the challenge of paying attention to this broad and diverse working population in different situations, such as unpaid work in agriculture in exchange for favors; the work of children and adolescents under the control of gangs and drug trafficking; girls from poorer regions "given" to wealthier families to work in unpaid domestic activities, without a fixed schedule and with multiple functions; older women expropriated in domestic service; women sexually exploited in brothels and trafficked out of Brazil with false promises; possible forced labor in custodial institutions; the intersections between the work of children and adolescents exposed to environmental-occupational risks; the forms of expropriation of *quilombola*, indigenous, and encamped communities; and the quantity of daily services performed in strenuous and degrading conditions for human dignity[2,4].

Health-work as a social condition of freedom and dignity

This inattention needs to be overcome, since the forms of CSL represent the denial of the right to health as a social condition of freedom and dignity. Health as a right is linked to the notion of human dignity, as this is a condition that is proper, inalienable, and inherent to every human being, and must be recognized, respected, and protected against any threats to personal and collective integrity[23]. In the same way, it is linked to the notion of freedom, not just in the sense of safeguarding the possibility of coming and going, but of expanding the ability to self-determine, associate, and cooperate with others and with society, along the lines of a "social freedom"[24] that goes beyond the neoliberal sense of atomized individualistic freedom. These health fundamentals, besides overcoming the reductionism of hegemonic biomedical models, show that enslavement is its antithesis, as it operates exactly in opposition to freedom and human dignity. After all, enslavement involves power relations, modes of domination, exploitation, and subjection that generate occupational risks, exhausting working hours, physical, psychological, and/or sexual violence (control and abuse), as well as the degradation of human living conditions (housing, food, clothing, access to water, income, etc.)[6,25,26].

The social process of enslavement poses a high risk to collective well-being and has repercussions on the physical and psychological health of the victims, the effects of which are devastating in varying degrees of severity and types of manifestation[26]. It is a process with a high degree of wear and tear, given the intensity of exposure to degrading conditions combined with the absence of mitigating factors for dangers, violence, risks of accidents, and deaths, as well as opportunities to replenish energies, undermining the body by sapping its strength[4,5,27].

In CSL, workers are denied the basic conditions of food, housing, income, land, decent treatment, transport, water, access to medical and hospital services, etc. If health is also working in decent conditions, having adequate housing to restore strength and leisure options, being able to eat, moving around freely, etc., cases of enslavement represent the denial of these possibilities. The health conditions of these workers express a deterioration of life,

which triggers a serious public health problem. How can the health of these workers be guaranteed in contexts where they are denied the basic conditions for a life of dignity and freedom?

Considering that the ways in which social groups get sick and die are circumscribed by their insertion in certain living/working conditions[28], it is necessary to recognize that workers in situations of slavery constitute a collective with specific processes of determination, needs, and health conditions and, consequently, demand attention from health professionals and services in a unique way.

Defending the right to health of these workers implies strengthening and expanding care for the vulnerable and those rescued from slavery; protecting and expanding freedom and dignity as fundamental elements of the right to health; and mobilizing the means to dialectically overcome CSL using emancipatory practices, based on the concrete reality of the victims' experiences and their experiences as social subjects interested in and committed to changing this social reality.

SUS and the National Flow of Assistance to Victims of Slave Labor

The process of slavery-emancipation and health-disease-care has several stages: vulnerability, enticement, transport, exploitation, escape/complaints, inspection of work environments, rescue of workers, access to rights, programs and benefits, attention to health needs, recovery, and social reintegration, among others.

The Brazilian experience of combating CSL includes different preventive, repressive, and recovery strategies, aimed at breaking the cycle of enslavement at different points in the process. However, although there are experiences, initiatives, and projects to support workers in contexts of CSL, mobilized by civil society organizations, social movements, and sectors of the State, more specific practices for the post-rescue period still need to be expanded in terms of public policy.

The complexity of the challenge of developing comprehensive and emancipatory care that reduces the risk of re-enslavement and helps overcome the vulnerabilities of enslaved people implies strengthening and expanding these socio-institutional anti-slavery practices that already exist in the Brazilian social fabric.

The 2003 and 2008 national plans to combat CSL, for example, were important achievements in this direction, as they outlined and boosted prevention and repression actions and met the needs of the victims of slave labor[29,30].

In this sense, the work of the Pastoral Land Commission on various fronts stands out, including the reception of enslaved people, with the *De Olho Aberto Para Não Virar Escravo* (Keep your eyes open so you don't become a slave) campaign, and the production and dissemination of information on violence in the countryside as a popular slavery surveillance[31].

Other experiences of supporting workers and vulnerable communities offer citizenship, technical and professional training, and educational upgrading to rescued workers who are vulnerable to slavery, as part of policies to prevent (re)enslavement. This is the case with the Integrated Action projects of the Integrated Action Movement (MAI), active in the states of Mato Grosso, Bahia, and Rio de Janeiro; and the Integrated Action Network to Combat Slavery (RAICE). With different types of activities, these projects bring together Regional Superintendencies of Labor and universities (among other state sectors), the third sector, the Public Prosecutor's Office, social movements, and vulnerable communities[32].

From the point of view of education for prevention, non-governmental organizations (NGOs) such as Repórter Brasil—especially with the *Escravo, nem pensar!* (Slavery, no way) program—have played an important role with the education sector in states and municipalities with a high incidence of CSL. The presence of NGOs, popular forums to combat CSL and Human Rights Centers, such as the Carmen Bascarán Center of Defence of Life and Human Rights in Maranhão, are also important references in promoting meetings between rescued workers so that they can share their experiences with each other, promoting greater autonomy, valuing their knowledge, preventing re-enslavement, and providing mutual support[33].

Considering the importance of land in the process of emancipation, other initiatives focus on regularizing and giving rescued workers access to land in order to develop local production chains with decent work and agroecological practices, such as the Nova Conquista settlement in Monsenhor Gil, Piauí[34]. Agroecology experiences in the face of the predatory agricultural model are promising alternatives for generating other labor relations that promote health, care for nature, and the production of healthy food[35]. The issue of land in the context of confronting the determinations of CSL is fundamental not only for those rescued, but for other groups of landless workers, campers, and/or settlers, as well as traditional and native peoples threatened with expropriation and migrants, precisely because they experience the injustice of this social condition that drives the reproduction of slavery.

From a legal point of view, one of the main measures created to protect victims of slave labor in Brazil in the post-rescue moment is Law 10,608 of December 20, 2002, which guarantees Special Unemployment Insurance to workers rescued from slavery[36]. It was responsible for supporting more than 45,000 rescued workers in the country and also helped record data on the occurrence and characteristics of slavery, available in the Observatory for the Eradication of Slave Labor and Human Trafficking[37], an important Brazilian collection for measuring the problem and providing a basis for policymakers.

Ordinance No. 3,484 of October 6, 2021, was also recently published; it addresses the National Flow of Assistance for Victims of Slave Labor in Brazil[6], the result of joint work by the National Commission for the Eradication of Slave Labor (CONATRAE), the São Paulo State and Municipal Commissions (COETRAES and COMTRAE-SP), ILO-Brazil, and other public entities and civil society.

The aim is to "promote specialized and systematized care for victims of slave labor through integrated and organized action by its protection network"[6] (p. 62; our translation), defining the necessary practices, measures and responsibilities based on three lines of action: "From reporting to planning," "Rescue," and "Post-rescue."

The axis "From reporting to planning" covers the reception and screening of reports of enslavement and the organization of inspections to rescue workers. Those immediately responsible would be the Ipê System for receiving reports of slave labour, Dial 100, 190, 191, the Public Ministry of Labour, the Federal Public Ministry, the Federal Highway Police, the Federal Police, the CPT, the COETRAES, the Special Mobile Inspection Group (GEFM) and/or the Regional Superintendence of Labour (SRT) "in coordination with other public bodies […]"[6] (p. 62; our translation).

The second axis concerns the rescue of workers and the inspection of workplaces to remove workers from conditions of enslavement. The central role highlighted is that of the Ministry of Labor's "labor inspectorate," in conjunction with COETRAE, and social assistance, to issue Unemployment Insurance forms and Work Accident Reports (the latter when applicable), obtain contact details for workers and refer them for emergency health care, as well as providing emergency shelter and transport back to their place of origin[6] (p. 63).

The Unified Social Assistance System (SUAS) is emphasized as having an important role in articulating social protection, welcoming the rescued, as well as seeking their inclusion in benefits and services, such as health, income generation, vocational training, either locally or in the person's region of origin. This would involve other bodies responsible for providing civil documentation, legal advice, referrals to the Institutional Defense and Immigration Police Stations and the Public Prosecutor's Office of Labor (MPT) and Federal Public Prosecutor's Office (MPF) to "gather information for possible legal action"[6] (p. 63; our translation).

The third axis, the post-rescue of workers, refers to the "phase of assistance and monitoring of the assistance provided in the previous phase"[6] (p. 62; our translation), a stage that would involve social assistance bodies—such as CONATRAE, the Federal Police, among others—and civil society, in order to identify the needs of those rescued, refer them to institutional care, include them in benefits and social assistance policies and services, look after families, issue civil documentation, provide care at the place of origin, accompany victims, judicialize claims, monitor those rescued and "refer them to other public policies, such as health, employment, and education"[6] (p. 63; our translation).

This ordinance represents a step forward in the sense that the state is seeking to provide more answers to the complex social demand for care for vulnerable populations and returnees, establishing organizational parameters, minimum actions required, and making government actors and sectors responsible for their implementation via multi-sectoral, inter-institutional practices and in collaboration with civil society.

Despite this progress, it is necessary to draw attention to the role of the SUS in this process and to the assets of public health in terms of surveillance, care, education, prevention, and promotion of workers' health.

The forms of CSL are not only the responsibility of the police, the judiciary, SUAS, and the labor inspection sector but they are also the responsibility of the SUS, since they are a public health issue. The fact is that public health is usually left out of plans and decision-making on tackling CSL[18] or, at best, the health system is understood from a hospital-centered perspective, limited to treating illnesses and emergency conditions in the medical and psychosocial care of victims.

In the ordinance, for example, health is mentioned in the sense of a policy, service, or sector to receive "referrals." The word health appears four times, three of them referring to rescue and one to post-rescue, in the following expression "Refer to other public policies, such as health, employment and education"[6] (p. 63), with social assistance being responsible for referring workers for emergency health care[6] (p. 63). If, on the one hand, as we have said, it is necessary to expand the concept of worker, on the other, it is equally important to expand the notion of health since conceptions restricted to the logic of medical and psychological care greatly limit the understanding of the complexity of the process and the incorporation of the breadth of the SUS in the production of care based on equity, integrality, and participation.

It seems appropriate to point out the need for greater public recognition over the importance of the health sector in all stages of this flow, as well as a broader vision of workers' health as intersectoral and participatory actions, in order to expand the possibilities for emancipation. This is because the SUS has responsibilities in all the phases mentioned in the flow, in identifying, notifying, and forwarding complaints, as well as in planning inspection actions and labor inspection practices, in psychosocial care actions, damage assessment and medical clinics for recovery from violence, adding joint efforts with the other entities involved.

The SUS has also acted to identify new cases of CSL, via urgent and emergency health units and primary care, and has also organized surveillance actions[4,5]. In many parts of Brazil, agents from basic health units, health inspectors, and professionals from the medical and hospital care networks identify people in situations of exploitation and enslavement, take action, and collaborate in anti-slavery practices[4,5]. At the same time, the SUS has already developed different mechanisms to help tackle CSL, such as Violence Surveillance, in the sense of producing information based on the notification forms for CSL cases, but also in the provisions of the National Workers' Health Policy[38] and the National Comprehensive Health Policy for Rural, Forest and Water Populations[39]. Many Reference Centers for Workers' Health take part in intra- and intersectoral actions and training to prevent recruitment and intervene at certain points in the enslavement process[40]. At national level, RENAST can strengthen these strategies and expand its surveillance practices in networks of popular participation and health promotion, especially in communities vulnerable to CSL, in order to mobilize family farming experiences and the production of an emancipatory agroecology.

Undeniably, more investment is needed, particularly to expand comprehensive care practices for workers who are vulnerable and/or subjected to enslavement in the day-to-day services of the SUS, creating paths toward qualifying care at all points in the network to better understand and act on the needs of victims of this form of violence.

These experiences need greater visibility and public recognition. Mapping and gaining a better understanding of their scope and limits, in order to systematize them and connect them to each other and to the wider struggles, would represent a fundamental step towards expanding the opportunities for health professionals and services to act even more as fundamental agents of neoabolitionism.

To do this, there is also a need to decolonize the health system itself, reflecting on its role in the socio-cultural process of maintaining social inequalities and institutional racism. On the other hand, despite the limitations of the SUS, the entire health movement and the worker's health field have undeniable potential to combine the struggle to guarantee health rights with the struggle to expand utopias of emancipation[41].

The expansion of social dialogue and participation in an inter-network perspective would be fundamental, combining the health, popular, and social movements to promote economic, political, and social measures to counteract the disruptive and amplifying forces of social inequality.

It is also important to avoid the risk of mystifying the State itself, because many of its economic policies are exactly what underpin the conditions that make it possible for the socio-economic causes of enslavement to worsen. After all, the current economic cycle and the policies of unbridled expansion of agriculture, mining, and the clothing industry, among others, based on the imposition of a mode of development for the elites and for capital income, in the form of a squeeze on labor and social discouragement, tend to create more conditions for the reproduction of slave labor. Notably, the State has historically been responsible for the reproduction of the CSL, not least because of its omission of this class of workers and the fragmentation of its actions and policies. It is no coincidence that in 2016 the Brazilian government was condemned by the Inter-American Court of Human Rights for the crime of contemporary slavery[23].

Conclusion

The challenge of comprehensive health care for vulnerable workers rescued from slavery implies recognizing the existence of this diverse and specific group of workers, as well as unveiling the processes of social determination of their health and the particularities of their life needs, in order to overcome negligence in care practices. Expanding and strengthening these emancipatory strategies in this direction is a social process of continuous struggle that fundamentally requires the protagonism and organization of workers, whether formally free or subjected to enslavement, connecting trade union, social, gender, and racial struggles as struggles for freedom and dignity, and therefore struggles for health. The composition of networks and collective subjects of emancipation, to conduct processes, networks, and knowledge of care for enslaved workers would contribute not only to improving care but to building territories free of slave labor. After all, guaranteeing the health of workers in these contexts of enslavement requires a wide range of actions to improve the basic conditions of a dignified life and the real exercise of freedom.

The development of these emancipatory care practices is, in fact, an urgent challenge, to which any silence and/or distancing on the part of the Workers" Health field in the coming years would represent a regrettable negligence.

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