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Family Health, quilombola territories and the defense of life

Saúde da Família, territórios quilombolas e a defesa da vida

Salud de la Familia, territorios quilombolas y la defensa de la vida

Hayda Josiane Alves[1] Maria Raimunda Penha Soares[2]
Rute Ramos da Silva Costa[3] Letícia de Assis Santos[4]

[1]Universidade Federal Fluminense, Curso de Graduação em Enfermagem, Departamento Interdisciplinar do Instituto de Humanidades e Saúde, Rio das Ostras, Brasil.
haydaalves@id.uff.br

[2]Universidade Federal Fluminense, Curso de Graduação em Serviço Social, Departamento Interdisciplinar do Instituto de Humanidades e Saúde, Rio das Ostras, Brasil.
mrpsoares@id.uff.br

[3]Universidade Federal do Rio de Janeiro, Centro Multidisciplinar, Instituto de Alimentação e Nutrição, Macaé, Brasil.
rutecosta@macae.ufrj.br

[4]Universidade Federal Fluminense, Curso de Graduação em Enfermagem, Instituto de Humanidades e Saúde, Rio das Ostras, Brasil.
leticiaassis@id.uff.br

Abstract

This article presents and debates historical elements of *quilombola* struggle and resistance as significant aspects for the production of health and defense of life in these territories. We articulate and reflect upon the importance and limits of the Family Health Strategy in the recognition, appreciation and integration of knowledge and practices of *quilombola* communities to professional health care focusing on their work processes. This study results from a participatory health research developed with workers of a Family Health Strategy in a *quilombola* community from north of Rio de Janeiro (Brazil) during the COVID-19 pandemic. We concluded that, despite the potential of the Family Health Strategy, the challenges for comprehensive health care in the territory studied tend to compromise the community's protagonism – especially that of women – and the effectiveness of care. *Quilombola* knowledge, experiences and ancestral memories of care are not valued within the scope of the Family Health Strategy. These aspects have little impact on territorialized health care and, therefore, far from a public policy of rights.

Keywords Family Health Strategy; *quilombola* communities; community-based participatory research.

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Resumo

Este artigo apresenta e discute elementos históricos de luta e resistência quilombolas, aspectos significativos para a produção de saúde e defesa da vida nesses territórios. Articula e tece reflexões sobre a importância e os limites da Estratégia Saúde da Família no reconhecimento, na valorização e na integração de saberes e práticas de comunidades quilombolas ao cuidado profissional em saúde com foco em seus processos de trabalho. Trata-se dos resultados de uma pesquisa-ação participativa em saúde desenvolvida com trabalhadores de uma unidade de Saúde da Família em uma comunidade quilombola no norte do Rio de Janeiro no período da pandemia da Covid-19. Concluiu-se com a pesquisa que, apesar das potencialidades da Estratégia Saúde da Família, os desafios para a integralidade da atenção à saúde no território estudado tendem a comprometer o protagonismo da comunidade – especialmente das mulheres – e a efetividade do cuidado. Não são valorizados, no âmbito da Estratégia, saberes, experiências e memórias ancestrais de cuidado do quilombo – aspectos com pouco rebatimento na atenção territorializada da saúde e, por conseguinte, distantes de uma política pública de direitos.

Palavras-chave Estratégia Saúde da Família; quilombolas; pesquisa participativa baseada na comunidade

Resumen

Este artículo presenta y discute elementos históricos de lucha y resistencia de quilombolas, aspectos significativos para la producción de salud y defensa de la vida en estos territorios. Articula y digiere reflexiones sobre la importancia y los límites de la Estrategia de Salud de la Familia en el reconocimiento, la valoración y la integración de conocimientos y prácticas de comunidades quilombolas a la atención profesional de la salud, centrándose en sus procesos de trabajo. Se trata de los resultados de una investigación y acción participativa en salud desarrollada con los trabajadores de una unidad de salud familiar en una comunidad quilombola en el norte de Río de Janeiro durante el período de la pandemia de Covid-19. Se concluyó con la investigación que, a pesar del potencial de la Estrategia de Salud de la Familia, los desafíos para la atención integral de la salud en el territorio estudiado tienden a comprometer el protagonismo de la comunidad – especialmente de las mujeres – y la efectividad del cuidado. En el marco de la Estrategia no se valoran los conocimientos, experiencias y recuerdos ancestrales de la atención del quilombo, aspectos con escaso refutación en la atención territorializada de la salud y, por lo tanto, alejados de una política pública de derechos.

Palabras clave Estrategia Salud de la Familia; quilombola; investigación participativa basada en la comunidade.

Introduction

Quilombola's struggle for life is a historical one and it needs our solidarity (Soares et al., 2021). The approximately four hundred years of slavery the peoples forcedly brought to Brazil were subjected to, to be used in the production of wealth for Europe, produced misery, slaughter and annihilation of the Native American and Afrodiasporic peoples. The legacy of the colonial model of production, built on the dehumanization of those peoples, sustains, until today, an enslaving *ethos* (Moura, 1993), which naturalizes inequities and violences, apart from justifying the perpetuation of vulnerabilities and of structural racism (Almeida, 2019), affecting the life and health conditions of generations. This struggle calls for alliances with the healthcare sector, where its legitimacy and acknowledgment may weigh in the defense of life.

Despite the reach of the death policies from the times of captivity, the *quilombola* struggle and resistance performed from their territories overcame the direct conflict against slavery until becoming a way of life that still needs guarantee of rights. Among them, the right to the land – at the center of the *quilombola* struggles about land regularization of traditional territories –, access to, and use of fundamental public policies, such as health, education and sanitation (Silva and Souza, 2021).

On that trail, strengthening the National Health Policy, especially the National Primary Health Care Policy (PNAB in Portuguese) (Brazil, 2017) in *quilombola* territories, implies the need to strengthen solidarity with those peoples, as well as improving healthcare assistance qualification on an antiracist and decolonial perspective. It is important highlighting that National Healthcare System (SUS), especially the Family Healthcare Strategy (FHS), with their multiprofessional teams and community and territorial approach, has a decisive role in the quality of continuous health assistance, especially in times of social and sanitary crisis, as was the case during the pandemic of COVID-19 (Giovanella et al., 2020). The death of *quilombolas* from rural areas due to COVID-19 was four times greater than among White people in urban areas, as highlighted by the Racism and Health Theme Group from the Brazilian Association of Public Health (Abrasco) (Escola Politécnica de Saúde Joaquim Venâncio, 2021).

Illness and death in those communities compromise, not only people's lives, but the memory of their African ancestry, including knowledge and practices of care already victimized by the *epistemicide* and environmental degradation that devastates Afro-rural populations (Soares, 2021). Therefore, especially in *quilombola* areas, territory and, subsequently, community appear as fields of action par excellence of the FHS, regarding the acknowledgment of knowledge and practices related to the ways of living and taking care of health in a historic, political, cultural, and environmental context. In other words, elements organic to the FHS' work capable of enabling reading the territory and acting on it, regardless the risk and vulnerability factors that stigmatize those communities.

Broadening the scope of healthcare, and the usufruct of that right in *quilombola* communities, implies the need the FHS territories have to embrace the dynamics of life those communities have, which express a particular way of thinking and living the territory, producing knowledge and care practices of their own community life. Granting equality in health, as the National Healthcare Policy for Black Population (Brazil, 2009) highlights, means 'listening to the voices' of the Black people, based on their references and civilizatory landmarks as part of their life and health conditions, despite the inequities to which that population is systematically subjected.

In face of the potentiality of territorialized care in *quilombola* communities, this work brings reflections regarding those territories as spaces for producing care and (re)existance. For his purpose, it introduces and brings for debate part of the results of a participatory action-research in healthcare aimed at understanding how the workers in a FHS in a *quilombola* community acknowledge and value healthcare collective knowledge and practices and integrate them into the team's professional practice in COVID-19 pandemic times.

Methodologic pathway

This article is part of a participatory action-research in healthcare that approaches popular knowledge in times of the COVID-19 pandemic (Alves et al., 2022), developed since June 2020 in different rural territories of the State of Rio de Janeiro – among them, a *quilombo* located in the city of Quissamã: the Machadinha *Quilombola* Community.

The Community or Quilombo Machadinha is located in a region with a visible history of sugar cane production during the colonial period, with a heavy history of slavery, which, even after the end of slavery, still reproduced, in its social relationships, the *ethos* from that time (Soares et al., 2017). The Quilombo is a territory built from five communities: Fazenda Machadinha, Sítio Santa Luzia, Bacurau, Sítio Boa Vista and Mutum, consisting of approximately three hundred families. What connects the communities and constitutes the local territoriality goes beyond the degree of relatedness; it converges in a particular mode of production of life, resistance, and struggle to remain in the location where their ancestors were enslaved and struggled for their survival and their liberty. Today, the Machadinha *Quilombola* Community lives out of a small family production and of formal and informal jobs in Quissamã. It maintains several cultural practices alive, like the jongo dance, the food, the fado from

Quissamã and the *boi-malhadinho* tradition, practices of resistance, which allied to the use of plants and medicinal herbs for health care, give concreteness to the Afrodiasporic ancestry.

Despite the fact of having been recognized as *quilombo* in 2006, the community doesn't have the ownership title over their lands yet, a reality shared by thousands of quilombos all over the country, since, out of the over six thousand existing quilombos in Brazil, less than 5% have the land tenure title (Silva and Souza, 2021; Soares, 2021). This situation creates uncertainty, conflicts, and above all, it prevents their inhabitants from accessing, in a safe and permanent way, the productive use of the land and all the cultural, ancestral, and memory potential, passed over to them through their relationship with the territory.

It is important to highlight that some of the authors of this manuscript already have a life experience and work bond of more than ten years in Machadinha. This favored the research process, the shared construction of educational activities (teaching-service-community) and the dialog with the territory, even during the pandemic (Alves et al., 2022). The partnership with the local Health Department also allowed gathering epidemiologic information about COVID-19 (2020 and 2021) in the city's epidemiologic surveillance. This work subsidized a permanent education activity as part of the research, which was possible thanks to talks (Pinheiro, 2020) with Family Health (FH) workers from Machadinha. The activity lasted a little over an hour and was guided by a script with the following issues for discussion: information about the community, the work process in the unit during the pandemic, and community health care and prevention practices. In that occasion, cards and the activities carried out as part of the major research were presented (Alves et al., 2022). A recorder was used as a device to register the information obtained through dialogues.

The information recorded was later transcribed for analysis. To preserve the anonymity of the participants, the conversations were identified with a letter 'T' and a corresponding number to identify each healthcare worker that participated in the conversation. For qualitative data, we use a subject-based analysis, following Minayo (2014). In the theoretical debate about *quilombo*, memory and care, we resort to Gonzalez (2020) with her writings about the dialectics between consciousness and memory as a heuristic resource to delve into the *quilombo's* collective memory and their social practices, among them, the community health practices performed by women.

Results and discussion

Community identity, *quilombola* territory and the protagonism of women: founding elements of health care

Building the *quilombola* identity goes through the hands of the women, for they are main protagonists in the creation of affection, care, exchange, knowledge, and doings networks, and everyday resistances and insurgencies that give meaning and concreteness to the collective (Soares, 2021; Soares, Costa and Alves, 2022).

During the colonial period, quilombos arise in all the regions where there was slavery, as a social and historic phenomenon of objection and resistance to slavery (Moura, 1988). It was in those territories of liberty, many with ephemeral existence, other with centennial survival, where enslaved Black people could recover practices of their original territories, often articulated with other Native American cultures. In the *quilombos*, as well as in other spaces of resistance, an Afrodiasporic memory was consolidated, articulated to survival, material, cultural and spiritual strategies, that originated a singular, social and historic identity – Afro-Brazilian, *quilombola* and 'Amefrican', in terms of Gonzalez (2020).

After a long period of fights, decimation and 'illegality' that threatened slavery, quilombos became, during the post-abolition, territories of resistance. Even with different origins and diverse structures, they resisted, survived, were reconfigured, and made sure that particular modes of production of existence, of

relationship with the territory, of health care, of production of food, would not disappear. Within this fight for survival, organized Black and *quilombola* movements conquered the right to their existence as subjects in the Federal Constitution of 1988, and the possibility of the legal recognition of their territories. However, despite that legal framework, there was little progress in *quilombola* land titling.

There are over six thousand *quilombola* communities in Brazil nowadays. Less than 5% have collective land titling, and many live under threats, violence, and rights violations, which turns the struggle for territory the main *quilombola* claim (Conaq and Terra de Direitos, 2018). About 3,470 communities were recognized and certified by the Fundação Cultural Palmares, with 80% of those recognition processes having occurred after 2003. This is an important legal framework for the *quilombola* claims, in face of the publication of decree n. 4.887/2003 (Brazil, 2003) which introduces the procedures for identification, recognition, delimitation, demarcation and titling of land occupied by *quilombolas*. In 2003, the Extraordinary Secretariat for Promotion and Protection of Racial Equality (Seppir) was created and, on the following year, the *Programa Brasil Quilombola* (PBQ), with the purpose of consolidating an agenda of social protection for *quilombola* areas.

It is important to highlight that, with the coup against President Dilma in 2016, not only those programs were extinct or rid of their State policy status, but there was also a stop in the recognition and titling of *quilombola* lands. Until March 2022, the National Institute of Colonization and Agrarian Reform (Incra) had 1,816 opened processes of *quilombola* territories regularization, with 144 referring to lands in the Northern region, but during the Bolsonaro government only 12 territories were titled: four by the Incra and the rest by State agencies (Lobato, 2022). Hence,

> Considering the pace since then, it would take 1,170 years for all the 1,716 processes for the *quilombola* lands titling processes opened in the Institute to be completed. Which means that, while the period of legal enslavement of people lasted for 350 years, it will take at least five times that much time to repair at least that historical debt (Schramm, 2019).

Being land central to the production of *quilombola* livelihood, through family production, agriculture, sustainable extractivism and artisan fishing (Brazil, 2013), we can verify the impact and the setbacks in terms of guarantee of rights that *quilombola* populations had to face with the Bolsonaro Government, which, clearly built a social disprotection policy regarding those communities. There are also other direct threats the *quilombolas* experience in their territories: the advance of agrobusiness, large public and private businesses, predatory extractivism, which has launched conflicts with deaths or other impacts in the life of *quilombolas*, especially women and children. This is how the dispute for territory has left a trail of blood and violence in those communities. But, for the *quilombolas*, territory is more than just land; territory means an organic relationship with nature, with the rivers, the woods, the forests, the magical beings, which exceeds the notion of productive use and implies dimensions that don't fit into the privatistic conception that prevails in capitalist society (Soares, 2020).

It is important showing how much those challenges cause violence and death. Both during the colonial period and today, the bodies of women still are the most targeted in processes of violence, rape, and control. If men are who die the most in different conflicts, including rural ones, women are target of multiple violences, especially gender-based – as sexual violence. As the Director of the Brazilian Association of Agrarian Reform (Abra) highlights in relation to rural conflicts, in general, Northern and Northeastern regions account for most of the cases in terms of families affected, with 47% and 31%, respectively (Diretoria da Associação Brasileira de Reforma Agrária, 2022). Regarding who suffered the action, we have Indigenous people (with 26%), *quilombolas* (17%), landholders (17%) and landless workers (14%) as the largest populations affected (Comissão Pastoral da Terra, 2022). The report *Conflitos no campo* (Rural Conflicts), by the Comissão Pastoral da Terra (2022), shows the numbers of that violence, highlighting the Indigenous, *quilombola*, and riverside territories, among

others, as the most affected, stating that violence against women holds particular risks for the existence of a Black female body in a patriarchal society. When referring to violence against *quilombola* women, it is stressed that:

> While, talking about *quilombolas*, the most recurring form of humiliation are racist references! If among *quilombola* men it represents 25% of the violences suffered, for *quilombola* women, it represents 40%, being the violence most frequently experienced by them. There is a clear indication that humiliation points out the aggravating factor of being Black and being a woman in the rural conflicts. The aggravating condition of being a *quilombola* woman proves to be even more evident when we look at the various violences they suffered between 2011 and 2021: 21,13% of the violent attacks were rapes! (Ribeiro & Da Silva, 2022, p. 190).

Apart from being the most targeted, they are also the ones who resist the most (Soares, 2020; 2021; Soares, Costa and Alves, 2022), in different and, sometimes, silent ways, to the ones who still cannot or don't accept hearing their voices of resistance echoing. With their knowledge, mastery of ancient healing and health care technologies, it is women who, through their knowledge and practices, give corporeality to the fight for territory, turning itself into a fighting body-territory.

It is them who ensure the survival of orality in the transmission of *quilombola* and indigenous knowledge and practices. It is also them who give life to backyards as seeding spaces for edible, ornamental and ritual plants, used by their communities for health care, protection and praying. Therefore, without those women and their care and resistance practices, their daily doings, there would not be a community and there would not be a sense of collective struggle. The power they wield is also expressed in the fear they produce, and, subsequently, in the attempts to delegitimize and demonize their practices. In this sense, it is important noting that calling traditional practices 'creative novelties' within the therapeutic scenario, without naming them, without localizing them historically, and without recognizing the effort of those women to keep them alive means forging the very *epistemicide* – functional to the deletion of Afrodiasporic culture and the weakening of communal identity (Soares, Costa and Alves, 2022).

Gonzalez (2020) coined the term 'Amefricanity' to refer to the existence forged from the encounter of African diaspora and Native American life experience, which enabled the survival for collectives and individuals, but also the survival of knowledge and practices that transit through those territories, in the *quilombos* and *terreiros*, such as blessings, *jongo* and *capoeira* rounds, songs and worshiping the enchanted beings. These and other manifestations of Amefrican existence are more than just cultural traits, they consist in powerful forms of resistance to their deletion, to the destruction of humanities and the objectification of life; violences that were historically carried out against Indigenous and African peoples, and that today gain sophisticated contours, according to the myth of racial democracy and necropolitics. Care and cure practices are concrete examples of Amefrican (re)existence nurtured especially by the *quilombola*, Black and Indigenous women, immerse in a dimension of powerful collective and ancestral knowledge, to help interpret the signs of the body and of the spirit in the care of health in those territories, where caring is a part of the collective memory.

It is in this encounter that care becomes a daily practice of resistance, as a transgression and not as a service or a commercial activity. However, it is apparent that the necessity to survive in a society in which the production and reproduction of life are mediated by the buying and selling of goods and services that take *quilombola* women to work in paid jobs, usually as housemaids or other activities that imply a practice of care in exchange for a salary. Young *quilombolas* have also entered universities and reshaped spaces determined by gender in their communities. It is important to highlight that developing practices of care mediated by a salary, it is, through a job/profession, is not enough to rid those practices of their transforming potential. Those contradictions are present in most of the

quilombola communities, but it is especially through the action of women that communities have kept daily life as a space of exchange and sharing, without the mediation of money and without the demand for a counterpart (Soares, Costa and Alves, 2022).

In those terms, family and communal care practices developed in the quilombo defy the idea of Judeo-Christian universality (Carvalho et al., 2022), that subjugates them as primitive superstitious, exotic, or folkloric practices. Also, they defy the process of ethnocide disqualification perpetrated by the obliterating force of Eurocentric superiority (Carneiro, 2005). Instead of invisibilized and annihilated, care practiced in the *quilombo* is a powerful mediator of communal identity, for it is recognized as part of the wisdom and technologies present in the collective spaces. It becomes, hence, part of the resistances of Afro-rural communities and of the other traditional territories at the center of the struggles for the enjoyment of social rights, among them the right to healthcare. It is fundamental that all public equipment and their officials are solidary to the *quilombola* struggle. In this sense, FHS in *quilombola* areas must recognize and promote identity movements in their territories and legitimize the importance of the elder as references of ancestral wisdom, apart from considering the primordial role of women in the history and (re)existence of the community, safeguarding knowledges and care practices.

Facing COVID-19 in Machadinha: notes on health surveillance

Epidemiologic surveillance aggregates epidemiologic information from Machadinha as if it was one of the city's neighborhoods, including micro areas linked to the FHS of Machadinha, which go beyond the *quilombola* territory, such as Beira de Lagoa – an area situated near Lagoa Feia, on the border between the cities of Quissamã and Campos dos Goytacazes. With this, epidemiologic data is not restricted to the Quilombo Machadinha, but they effectively refer to territories of circulation and common use, turning it into a relevant factor in the case of a highly transmissible community disease. Even with that caveat, COVID-19 cases increased by four in the territory from 2020 (eight cases) to 2021 (32 cases) with higher incidence in the population above 20 years old, especially between 30 and 39 years old (13 cases in 2021), and similar for both male and female. There was one death registered from COVID-19, a *quilombola* elder woman.

The morbidity surveillance during the pandemic was considered the greatest challenge to public health. Before the uncertainties about the real magnitude of the COVID-19 contagion and death data – whose lethality is increased due to the lack of assistance –, the measurement of exceeding deaths has become more frequently used as a parameter to estimate both the direct and indirect effect of the epidemic on mortality (Orellana et al., 2021). However, this demands a systematic and sharp look at the morbidity data in the territory, during a specific period, information we did not have, apart from not being specific object of this study.

Despite the access granted by the Municipal Health Department to the information produced by local epidemiologic surveillance, the lack of separate treatment of that epidemiologic information from the Machadinha *quilombola* territory becomes a frailty in healthcare assistance, which also happened in other *quilombola* territories. Since the beginning of the pandemic, the National Coordination of Black Rural *Quilombola* Communities Articulation (Conaq) has been reporting the statistical void relating *quilombola* communities, which generates lack of information about contagion and death from COVID-19. Those communities did not receive the appropriate attention from public authorities, suffering from the worsening of socioeconomic and sanitary conditions, due to the pandemic (Valente et al., 2021; Arruti et al., 2021). All throughout the pandemic, *quilombola* communities and their partners had to build their own strategies, such as the COVID Observatory in the Quilombos[1], because of the underreporting and the lack of an official information system, as well as the production of leaflets in partnership with universities and social movements to tackle the lack of appropriate guidance (Conaq, 2020; Cavalcante, 2020; Universidade do Estado do Rio Grande do Norte, 2020).

It is also important to stress that the loss of a *quilombola* life means the loss of knowledge, history, memory, and a number of struggles and resistances that are kept in the people and are transmitted, mainly through orality and bodily experience (Bâ, 1982). As losses due to the pandemic of COVID-19 affect more directly the elder, that loss entails a break in intergeneration transmission of knowledge, which is performed through orality, from the elder to the younger. Apart from that, dealing with a scenario of death and changes implies in daily transformations in the ways of communal living and sharing, which is identitary to those territories. Qualifying basic attention in those territories demands sensibilizing FHS epidemiologic surveillance teams towards the singularity contagion and death acquire in those scenarios, signaling the relevance of appropriate tools and strategies for monitoring (and intervention on) the population.

Knowledge and practices in Family Health

As a part of the research activities, we did a round table with officials from the FHS of Machadinha in June 2021. The proposal was to talk about the activities for tackling COVID-19 we developed in the territory, identifying lessons learned and signaling those experiences with regards to the practices developed by the Family Health Unit (FHU) team. The results were organized according to the emerging theme category, defined through interest clusters concerning the research objectives in three large categories, subdivided into small classes for data interpretation.

Category 1 – Healthcare in the pandemic by the FHS in the quilombo

In this category, we included the strategies for tackling COVID-19 related to how the FHU in the Quilombo Machadinha works. Some elements linked to the changes in everyday life of the FHU were identified:

– Changes in the unit's workflow (team rotation, telephone contact, home visits):

> [...] at the peak of the pandemic, when a rotation of the team was established, the unit remained open, except for the dentist and preventive exams, that were suspended [...] We also did monitoring via telephone [...], but we were already doing that stuff like reception, family care, and over-the-phone monitoring, which we were already doing due to the difficulties with transportation [...] And we didn't stop doing visitations, home visitations. At first, what we did first was what we were told by the coordination, we had to do external visitations (T1 not *quilombola*).

– Referring for support services in the city, due to the centralization of COVID testing services in the urban area:

> And we started controlling people's entrance, instructing them that in case of symptoms, instead of coming here to the unit, they should seek testing – that was where we were redirecting symptomatic people, *right?* (T1 not *quilombola*).

– Limits and changes linked to access to the unit: "We only allowed the entrance to the unit to people using face masks"; "Yes, because, if not, we wouldn't be able to offer the service" (T1 not *quilombola*).

– About the use of personal protective equipment (PPE), a novelty for many members of the FHS team: "The news was that, at that time, we were all working wearing a mask" (T4 not *quilombola*).

In this category, it is possible to identify the effects of the pandemic on the unit. While in some urban centers we see closed Family Health basic units, in many cities, specially at the beginning of the pandemic, with workers transferred to the COVID-19 testing centers, the FHU Machadinha remained open. This highlights the important role played by this equipment in the territory. The FHU and the basic health units function as privileged access points to the SUS, hence, a valuable mechanism

for tackling COVID-19, regarding the strengthening of bonding as a tool for health promotion and prevention, to stimulate an integrated care. But centralization of healthcare in testing centers in urban areas, and favoring the hospital-centric logic, in detriment of FHS, onset the segmentation of care and the waste of SUS potential in community approach (Silva et al., 2021).

Maintenance of resources already used in basic attention, now with new adequations, proved to be fundamental in that sanitary context. The findings of the research demonstrated that in the FHU of Machadinha strategies like external household visitation, maintenance of bonds and support via WhatsApp were put in place. Mandatory use of protective face masks in the unit also became fundamental to encourage adherence to COVID-19 prevention guidelines.

Category 2 – Limits and challenges for care from institutional spaces in a *quilombola* rural community

The FHS in Machadinha team faced some difficulties, as well as limits and important challenges for a territorialized care:

– Slowness/lack of information that would guide the conduct of FHS professionals: "At the beginning, we were in the dark, right? Because information came through bit by bit" (T1 not *quilombola*).

– Social distancing and community culture:

> It was complicated, especially with children, because all of them are affectionate and they are used to run and hug you when they see you. And we have to go: "Slow down, sweetie, are you aware of the virus, the little bug that's out and about? You can't do that" [...] Because there are many houses that connect to the next one, right? (T1 not *quilombola*).

– The importance of listening to the people considered wiser, that in the formal sector of care (FHS institutional space) are physicians and nurses: "Carefully, thank God, life continues here, we shall prevail. Thank God, with instructions from the unit and the guidance of the wiser people" (T4 not *quilombola*).

– Wisdom legitimized in the services is identified with specialized and scientific knowledge, with foundations in schools of knowledge like universities:

> It's that old story, they know almost everything and nothing at all... Because they know something, but not everything. They didn't study, it is unfounded. But when the story is good, it has to count, it is founded (T4 not *quilombola*).

– There is no space for traditional knowledge in the FHU:

> But then it is easier for the patient to take care of us than for the doctors, even with the herbs (T2 *quilombola*).

> And we, in the end, with the demands we have, the objectives we have to achieve in the unit, we end up not addressing those issues (T1 not *quilombola*).

– Legitimacy of local knowledge (by outsiders) *versus* struggles for the (re)cognition of *quilombolas* and their knowledge:

> There was a period when [...] with the professionals from UFRJ [Universidade Federal do Rio de Janeiro], we did a work here, several activities with the population, with the community, to show the herbs and explain what each one of them could be used for (T1 not *quilombola*).

> Up until then, for things to happen here, they needed to have a limit, right? You understood what the education, what it was… it took the Public Prosecutor's Office [intervention], our economic resources that had already been assigned to building our unit were redirected downtown (T2 *quilombola*).

– Resistance to medical attention: fear of a disease with no possibility of cure following the local and ancestral practices of care:

> One was sick with COVID symptoms for a little over a week, but refused to go to the doctor (T2 *quilombola*).

> Fear, fear (T1 not *quilombola*).

In the second category, it was noticeable that technical recommendations were not in dialog with the way of caring and understanding health of the traditional communities, creating a gap between those two knowledges. The discrepancy in that process of recognition and appreciation of health care based on the knowledge of traditional communities points out the frailties in the communication between techno-scientific knowledge and popular/traditional knowledge, apart from the urgent necessity for strategies to overcome that situation (Alves et al., 2022).

It is important questioning how hard it was to conciliate local culture with social distancing decrees in an environment where community is seen as an extension of their homes, and daily practices of work and care are guided by group actions. Another factor to stress was the frailties in the information strategies passed on to the FHU professionals, who felt disoriented and under supported, especially at the beginning of the pandemic, which made them feel "in the dark" (T1).

Historically, traditional communities show practices of construction and transmission of knowledge based on the wiser ones, through orality, from one generation to the next, so that knowledge is learned and not lost with the passing of time (Durães and Ramos, 2021). One of the participants, mentioned the importance of listening "to the wiser ones" (T4), which in the institutional environment of the health sector can be understood as the professional physicians and nurses, but it is necessary to reflect on who those people are for the community. On that perspective, the timeless struggle for the recognition of that knowledge, often delegitimized, has doubted that knowledge.

Carneiro (2005) denounced the processes of destitution of rationality of the culture and civilization of the 'other', and the role of the institutions in the consolidation of racial hierarchies as a part of the epistemicide that attacks knowledge and practices of African background. (Also) Sustained by a matrix of racial oppression, that epistemicide probably has repercussions on the health services, as hierarchization of institutionalized cure practices (biomedical) subjugates popular practices as care practices, distant from effective cure practices.

Likewise, public policies still reproduce knowledge colonialities derived from conceptualizations and sociability that belittle the cosmoperception (Oyewumi, 2021) of *quilombola* peoples and other traditional peoples. As a reflex of that, public equipment, such as healthcare services for those peoples and communities, reinforce institutional racism instead of combating against it. Even though the National Policy on Integrated Health of Black Population (PNSIPN) points out essential elements in the combat against racial inequities and structural racism, healthcare services still lack effective mechanisms for sensibilization, apart from the qualification of technical-operational devices capable of recognizing the forms and 'subtleties' of racism, as well as including the combat against it in the work and basic attention quality assessment processes.

It is important to emphasize that that reality becomes true in a historical context of defunding of SUS, precarization of the structure and organization of services and denial of social movements – elements enhanced during the pandemic, when this work was carried out (Servo et al., 2020). As signs of neoliberal policies, those aspects undermine the structure and capability for public health

services to respond to the society's demands, especially in times of sanitary crisis, while also eroding the possibilities of social and community organization to tackle vulnerabilities and enforce the principles of a comprehensive primary health care (Starfield, 2002).

Healthcare professionals need to acknowledge traditional communities as knowledge producing spaces, built collectively and through a good relationship with nature, having a lot to teach us about the production of care and cure, in an antiracist perspective. The FHU still shows some resistance in allowing those forms of taking care of the health, legacy of African communities, be discussed within its environment. Traditional communities constantly face a struggle to 'validate' their knowledge, which, at times, are resorted to by people that do not belong to the territory, but that show them as therapeutic novelties, without acknowledging that this knowledge pre-exists as communal practices.

The experience of the pandemic of COVID-19 also opened space for questioning about the limits of the biomedical knowledge before the fear of an unknown disease, and the place the communal knowledge could have in that gap. Research pointed out how valuable it would be to direct technical guidelines towards the care practices from the communities, strengthening dialogues and sharing, based on a relationship of trust, knowledge and experience exchange between the community and healthcare professionals.

Category 3 – Being *quilombola*: an issue for public health

Quilombola identity is an important aspect of the quilombos' historical struggle for recognition, also strongly tied to territory as the place of a particular way of (re)existing. In this regard, it is necessary that the *quilombola* identity is not only acknowledged in the communal environment, but also legitimized in the process of implementation of public policies, as it occurred with the vaccination against COVID-19:

– Vaccination – an action of public acknowledgement of the *quilombola* identity and strengthening of communal belonging:

> I know that it was really good that the vaccine reached the *quilombolas*. It was great that it served, comprehended everyone, everybody thanked God, everybody was vaccinated, they got rid of the risk, because we know that only God knows what could have happened if it didn't get there on time, and we moved on. I've already taken the third shot, I took the first one, I took the second one and I took the third one. And everyone, thank God, most of us here was vaccinated (T4 not *quilombola*).

> Researcher: "At the beginning, when the government released the vaccine for the *quilombola* populations, did they show up?" "They did, dear child! It became hell in here [...] And it didn't slow down, second dose was the same thing" (T2 *quilombola*).

> And the questioning was: why the *quilombolas*? I simply answered: because I was born Black, with spiked hair, because I am, because I live there, in a thing there. Oh, but did it have to open for everyone? Well, each one at their time. So, if we are a priority, we have the right to take the vaccine, whether you want it or not. I always said, I always answered: "Whether you want it or not, we are a priority, we are taking it" (T2 *quilombola*).

Other aspects also arose in the research, such as sensitive issues in the Quilombo Machadinha when exposing a particular way of caring-curing, as well as when pointing out challenges based on the *quilombola* identity, which demand attention from the health sector:

– The use of herbs as a part of the local culture and traditional care:

> I have patients that don't agree on using medicine from the pharmacy, who only use herbs (T1 not *quilombola*).
>
> They looked for more! But now everyone is blessed (T4 not *quilombola*).

– Suicide cases: a recurring fact among youths in the community:

> Yes, there is even a new one, three months ago, I think, and another one is with… (T2 *quilombola*).
>
> It's been almost eight to nine months now (T4 not *quilombola*).
>
> Both of them young [...] They were in their early thirties (T3 *quilombola*).

The category "Being *quilombola*: an issue for public health" denotes the importance of the health sector acknowledging and legitimizing the struggles and resistances for the recognition of the rights of the *quilombola* people. Conaq was able to judicially grant vaccination for the *quilombolas*, residents or non-residents in the quilombos, considered as one of the priority groups in the immunization campaign against COVID-19 (Coordenação Nacional de Articulação das Comunidades...; Terra de Direitos, 2020). FHU officials said there was adherence to vaccination by the *quilombolas*, although with the questioning of this right by the not *quilombolas*.

During the research process, it was verified that the demand for and the use of herbs for taking care of health were important, especially during the pandemic. In the literature, those practices are usually carried out in traditional territories preparing homemade medicines with medicinal plants precisely because, historically, those communities associate the process health-illness-cure to nature. That care is cultivated in their own territory and oriented by the ones who know more (the elderly) about their use (Ruckert, Cunha and Moderna, 2018), which denotes the material and symbolic breadth of the healthcare in traditional territories.

Mental health in the communities in rural areas also needs to be put under discussion, with a *quilombola* identity approach. Suicide cases of young people in the community can be an indication of the mental health assistance vulnerability in the territory. Studies show the importance of rural population's mental health care and prevention strategies (Montheit et al., 2021). The debate on racism and psychological distress is fundamental. Despite of often being neglected, Black intellectuals from different historical moments and nationalities have always pointed out to the relevance of that issue as part of their trajectories – we can cite Fanon (2020), González (2020) and Kilomba (2019), among others. Faustino (2019), when discussing racism as part of a colonial discontent, stresses that recognizing it as social determinant of psychological distress is urgent, which implies in the construction of political, clinical, and pedagogical devices capable of promoting mental health in an antiracist perspective.

Final considerations

Even when the research on the territory informs about ancestral knowledge tied to nature and to the land, produced, memorized and transmitted mainly by women, apart from the *quilombo's* communal identity practices, FHS officials recognize there is a distance of the team's work from those practices, largely reflecting historical strains in the National Health Policy, parallel to the weakening of basic care in recent years. During the pandemic, the team favored disseminating information about personal protection against coronavirus, without establishing a dialogue with daily life dynamics and local care practices, to attain communal dimension (and its meanings) for the care of health in the territory.

There was a high adherence of the community to vaccination against COVID-19 as a legitimate right of the *quilombola* Being.

Regardless the potentialities of FHS to overcome the traditional care model, there are important challenges for an integrated health care in *quilombola* territories, in which recognizing, engaging, and integrating professional care to knowledge and practices present in the territory may have weight. This compromises the leading role of the community and the effectiveness of care. Knowledge and care experiences are wasted, as also are identitary memories of Being *quilombola,* an aspect that needs to be valued as part of de alliance of the health sector with those communities in the defense of life.

From this perspective, it would be really productive investing on processes of acknowledgement and training of professionals or community members appointed by the association, as the community's representing entity, to collaborate as mediators in the community-service relationship (as *quilombola* popular agents or *quilombola* territory agents), in order to produce 'racial literacy' of the health team, based on the *quilombola* cosmoperception. This would strengthen reflexive work processes, articulated with the singularities of the quilombo and the demands on the FHS.

It is also highlighted that it is important making the work of the FHS in *quilombola* territories meet the SUS guidelines and the National Policy on Basic Healthcare dispositions, especially regarding ensuring care based on the person, their necessities and demands, as well as enabling and strengthening the active participation of the community in building the National Health Policy.

Finally, we found that the care practices articulated with traditional and communal knowledge must not be treated in a compensatory perspective of the difficulties of access and use of the health system, but understood as legitimate, inherent to the ways of life and to the production of care in the quilombo.

Note

[1] Available at: https://quilombosemcovid19.org/

Article information

Authors' contribution

Concept of the study: HJA, MRPS, RRSC and LAS.
Data curating: HJA, MRPS, RRSC and LAS.
Data collection: HJA and LAS.
Data analysis: HJA, MRPS, RRSC and LAS.
Writing - original manuscript: HJA, MRPS, RRSC and LAS.
Writing - revision and edition: HJA, MRPS, RRSC and LAS.

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Conflict of interests

Non existent.

Ethical aspects

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Introductory presentation

This article results from the research study *Technical recommendations, popular knowledge and practices in the combat against COVID-19 in rural areas*, project developed in a partnership between UFF-Rio das Ostras, UFRJ-Macaé and Fanzinoteca do IFF-Macaé; and of the pre-graduation project *Health care of rural population in times of COVID-19 pandemic: knowings and doings alongside Family Health* (UFF-Rio das Ostras).

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