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INTEGRATIVE REVIEW OF THE LITERATURE
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HEALTH OF QUILOMBOLAS WOMEN: DIALOG WITH THE LITERATURE

Saúde das mulheres quilombolas: diálogo com a literatura

Salud de las mujeres quilombolas: diálogo con la literatura

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ABSTRACT

Objective: to carry out a mapping in the literature on studies addressing the health of quilombolas women. **Method:** integrative review of literature of qualitative approach, held in three databases, using the combination of the descriptors: african continental ancestry group, women, health, in a time interval of 10 years. **Results:** 66 articles emerged, being included 58 for analysis and discussion. It formed themes, and from these 25 were related diseases of the quilombo women and limited discussion of health promotion and social determinants. The other 33 articles were related to the historical and social context of the quilombos, Primary Health Care, social inequity and violence, racism and discrimination and access of quilombos women to health services. **Conclusion:** we identified limitations front the social determination with focus on research of biological nature and an emphasis on disease, highlighting the necessity of studies regarding at promoting the health of this population.

Descriptors: Community; Social determinants of health; Woman.

RESUMO

Objetivo: realizar um mapeamento na literatura sobre os estudos que abordam a saúde das mulheres quilombolas. **Método:** revisão integrativa de literatura de abordagem qualitativa, realizada em três bases de dados, com a utilização da combinação dos descritores: Grupo com Ancestrais do Continente Africano, Mulheres, Saúde, num intervalo temporal de 10 anos. **Resultados:** emergiram 66 artigos, sendo incluídos 58 para análise e discussão. Formou-se eixos temáticos, onde 25 estavam relacionadas as doenças das mulheres quilombolas e com limitada discussão da promoção da saúde e dos determinantes sociais. Os outros 33 artigos relacionavam-se a contextualização histórica e social dos quilombos, Atenção Primária à Saúde, iniquidade social e violência, racismo e discriminação e acesso das mulheres quilombolas aos serviços de saúde. **Conclusão:** Identificou-se limitações frente a determinação social com foco em pesquisas de cunho biológico e com ênfase na doença, destacando a necessidade imperiosa de estudos voltados a promoção da saúde desta população.

Descritores: Comunidades; Determinantes sociais de saúde; Mulheres.

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RESUMÉN

Objetivo: realizar un levantamiento en la literatura sobre los estudios que abordan la salud de las mujeres quilombolas. **Método:** revisión integrativa de literatura de abordaje cualitativo, realizada en tres bases de datos, con la utilización de combinación de las siguientes palabras clave: Grupo con Ancestrales del Continente Africano, Mujeres, Salud, en un intervalo temporal de 10 años. **Resultados:** han surgido 66 artículos, de los cuales 58 se ha analizado y discutido. A partir de esto, se ha formado ejes temáticos, de los cuales 25 artículos presentan relación con enfermedades de las mujeres quilombolas y con limitada discusión de la Promoción de la Salud y de los Determinantes Sociales. Los otros 33 artículos presentan relación con la contextualización histórica y social de los quilombos, Atención Primaria a la Salud, iniquidad social y violencia, racismo y discriminación y acceso de las mujeres quilombolas a los servicios de salud. **Conclusión:** se identificó limitaciones frente a la determinación social con foco en investigaciones de carácter biológico y con énfasis en la enfermedad, destacando la necesidad imperiosa de estudios volcados a la Promoción de la Salud de esta población.

Descriptores: Comunidades; Determinantes sociales de la salud; Mujeres.

INTRODUCTION

The National Policy for Integral Health of the Black Population[1] defined the set of principles, brands, guidelines, and objectives aimed at improving the health conditions of this population. It comprised actions of care and attention to health, as well as participatory management, social control, knowledge production, training, and permanent education, aiming to promote equity in the health of the black population.

In the Brazilian black population as a whole, it is possible to identify that the group of quilombola communities seems even more neglected. Almost always located in rural areas, these communities, originally constituted by descendants of slaves, survived the fringe of social benefits, preserving the dependence of the earth for its physical, social, economic and cultural reproduction.[2]

The scarce literature, at least in the health area, on the quilombola communities also highlights the invisibility of these communities in the eyes of the academy. There are few studies that address the health issue of black communities or, more specifically, quilombolas. Some studies are confined to isolated communities and do not allow generalization of data. It should be noted that this group is still marked by processes of discrimination and exclusion, and that many of the health indicators are still far from ethically acceptable values.[2]

Quilombola communities are characterized by ethnic particularities that differentiate them from the rest of society. Historically, this group has been on the fringe of government social benefits for several years. Its official recognition, with the granting of full rights of citizenship, only occurred after the Federal Constitution of 1988, and special policies of social assistance and health for this group were only implemented later.[3]

In brief, there is still a set of deficiencies and weaknesses that point to a history of abandonment of the quilombola communities. The National Policy on Integral Health of the Black Population,[3] which proposes transversal actions in the *Sistema Único de Saúde (SUS)* [Unified Health System], aiming to guarantee the realization of the right to health of the black population in relation to the promotion, prevention, and treatment of health problems, does not yet appear to have materialized. As a result, access barriers, lack of ties and accountability on the part of health professionals are perpetuated. The issues raised are serious and lead to the insertion of ethical aspects in the discussion of specific policies for quilombola communities, seeking to even give voice to the individuals involved.[4]

Therefore, it seems necessary to reconsider health care for quilombola communities, bearing in mind their particularities, the context of predominantly rural location, cultural peculiarities, access to durable consumer goods and public services, social opportunities, and epidemiological characteristics. Inclusive processes and more effective strategies to promote equity are imperative to reduce the recurring damages that institutional racism has thrown to quilombola communities.[2]

The role of socioeconomic position in these racial inequalities has also received almost no attention. Given that black women in many countries are disproportionately disadvantaged in the social hierarchy, it is plausible to attribute these disparities, at least in part, to socio-economic inequalities throughout life.[5]

Hence, when we reflect on the mentioned aspects and think about the relevance of this topic, we have the following guiding question:

What is the knowledge production in the health database regarding the quilombola women's health issue over the period from 2006 to 2015?

Targeting to answer the guiding question, it is proposed as a general objective:

To carry out a literature mapping of studies that address the quilombola women's health issue.

METHODS

The methodological strategy adopted to reach the objective of this study was the integrative literature review, whose purpose is to gather and summarize results of studies about a specific issue or topic, in a systematic and orderly manner, with a view to contributing to the deepening of the knowledge of the subject investigated.[7] The analysis of the works followed the following steps: formulation of the research question and objectives of the integrative review; establishment of criteria for inclusion and exclusion of articles (sample selection); definition of the information to be extracted from the selected articles; analysis of results; interpretation and discussion of results.[6]

For the development of this study on the health of quilombola women, scientific literature searches were conducted in the following online databases/research portals: Scientific Electronic Library Online (SciELO),

Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS) [Latin American and Caribbean Literature in Health Sciences] and Medical Literature Analysis and Retrieval System Online (Medline). The descriptors and expressions used during searches in the databases were: *"African Continental Ancestry Group" OR "Group with African Ancestors" OR "African Descent Group" OR "Continental African Descent Group" OR Quilombola* *Women OR woman OR female* *Health.

The articles published between the years 2006 and 2015, in the Portuguese, English and Spanish languages, which were relevant to the subject studied, were searched. Also included were governmental documents and publications, important for definitions and concepts.

A total of 66 articles were found, excluding articles published before 2006 that did not address the objective of this study and/or whose complete text was not available, resulting in 58 articles for analysis.

The articles were studied in their entirety and compiled from the central core of the research, being grouped based on the Minayo Thematic Analysis (2010). This is the form that best meets the qualitative investigation of the material, since the notion of theme refers to an affirmation related to a certain subject. It allows innumerable relationships and can be presented through a word, a phrase, a summary, in which the presence or frequency represents some meaning for the object under analysis. The analysis is divided into three stages: a) pre-analysis; b) exploitation of the material and c) handling the results obtained and interpretation.[7]

The keywords of the articles found led to the construction of five thematic cores of analysis: Historical and social contextualization of quilombos and quilombolas; Primary Health Care; Diseases related to quilombos/women; Social inequity/Violence, Racism, and Discrimination; Access of quilombola women to health services.

RESULTS AND DISCUSSION

Among the journals that most published articles referring to the health of quilombola women, the "*Caderno de Saúde Pública*" with nine publications stands out. Another period with a significant number was "*Ciência e Saúde Coletiva*" with six publications on the subject. Health and Society in third place with five publications. "*Revista de Saúde Pública*" and "*Revista Brasileira de Epidemiologia*", both with three publications. He also had two publications in international journals (both in the "West Indian Medical Journal"). The others were in periodicals of nutrition, medicine, psychology, nursing, dentistry, and public health, emphasizing the multidisciplinary approach given to the theme.

As for the publication year, the articles were published in the period from 2006 to 2015. Of these, three in the year 2006, six in the year 2007, four in the year 2008. The years 2009, 2011 and 2013 were the years with the greatest number of publications related to the subject, in the total of twenty-four (eight in each year). In 2010 and 2014 there were a total of twelve publications (six in each year), in 2012 four and only one in the year 2015.

Concerning the States with the largest publication, *Bahia* had 17 publications during this time, ratifying information from the *Comissão Pró-Índio de São Paulo (CPISP)* that informs that *Bahia* with the State of *Minas Gerais*, are the Brazilian States with the largest number of quilombos. The other States with publications were, as follows: *Rio de Janeiro* (three), *São Paulo* (three), *Mato Grosso do Sul* (four), *Goiás* (two), *Rio Grande do Sul* (one), *Paraná* (two), *Alagoas*, *Espírito Santo* (two), *Minas Gerais* (four), *Maranhão* (two), and *Pernambuco* (two). Among the articles selected in the second stage were also eleven Brazilian States and another carried out through the Mortality Information System. Regarding the type of research, 87% are original research. The others are documentary research, review article, reflection article and experience report.

Observing the "methodological paradigm of the study", 74% are quantitative research; 22% of both qualitative and quantitative researches and only 4% are qualitative research.

Regarding the theme, the studies on the health of quilombola women presents a directed look at the prevalent diseases. Out of the 58 resulting articles, five thematic axes were formed, of which 24 represent the "diseases correlated to quilombola women". A limited discussion regarding Health Promotion, focused on the biomedical model and distant from the Social Determinants, is perceived. The other speakers are: "historical and social contextualization of quilombos" (11 articles), "Primary Health Care" (04 articles), "Social Inequity/Violence, Racism and Discrimination" (17 articles) and "health services"(02 articles).

Historical and social context

Within the general black population, there is a peculiar segment, consisting of descendants of African negroes who, as slaves, fled from the slave quarters where they lived and formed organized communities to resist the persecution imposed by the ranchers and police authorities. These communities were called quilombos. After the abolition of slavery in Brazil, many of these communities were conserved and exist until today, being denominated remnants of either the quilombos or communities quilombolas.[8]

These communities are described as a vulnerable and socially marginalized group. In this context, the relationship of living conditions and their social determination in the subjects' health is highlighted. It is necessary to reflect how much the ethnic-racial and economic differences still as sources of social inequities in the researched populations. The struggle for better living conditions among quilombolas and overcoming discrimination is historical and needs significant changes to overcome the exclusion and differences that are exposed in relation to society.[9]

A neglected aspect of the national literature in relation to the iniquities of women's and children's health care that

is influenced by skin color is highlighted for many years. For a long time, it was believed that studies focused on socioeconomic determinants could highlight the influence of racism on health indicators, a fact that is no longer acceptable.[10]

Primary Health Care

The National Household Sample Survey (PNAD) conducted in 2009 (1) in Brazil estimated the Brazilian population at 189,953 million inhabitants, of which 96 million people are black or brown (according to the *Instituto Brasileiro de Geografia e Estatística (IBGE)* [Brazilian Institute of Geography and Statistics]), with 50.7% of the population being composed of black people, self-declared as black or brown.[11] (*IBGE*, 2010). Although numerous, the Brazilian black population still finds itself in the poorest strata and in a chronic situation of inequity in relation to health.[3]

Evaluative studies that seek to confer the effectiveness and reach of health policies with vulnerable groups, including black communities and quilombolas, represent a social commitment and support in the construction of equity.[12]

Therefore, when evaluating health services for the quilombola population, it is revealed that almost all attributes of primary care are not adequately present in the care process. It reports that there is no adhesion of the services to the new care model and perpetuates the proposal of biomedical and curativist assistance with a centrality in the biological aspects of the health-disease process, revealing a situation of non-conformity to the proposal of reformulation of the care model and portraying, in greater dimension, the perverse iniquity to which the quilombolas of the evaluated community are subjected.[12]

In fact, the *SUS* has advanced in the fulfillment of its principles and in the production of services, but still there are geographical and social inequalities in access, especially when the analyzes are stratified according to race/color and ethnicity.[14] (GOMES *et al.*, 2013). People who identify their skin color as brown, black or indigenous most often belong to lower income groups with lower schooling, and tend to face greater inequalities in health conditions. Studies confirm that blacks, brown and indigenous people have the worst indicators of mortality, lower life expectancy at birth and unequal access to health services.[14]

The experience of the quilombolas in Brazil is marked by a history of mobilization and struggle for the recognition of their rights, especially the right to own their lands, but also for the silent struggle for the equity of health conditions.

Some authors emphasize underutilization and refer to greater difficulty in accessing health services by the quilombola population.[13] One possible explanation for this reality is that the iniquities faced by this population go far beyond the difficulties in accessing and using health services, mainly due to the worse social and economic conditions.

The growing racial inequities in health expressed by the differentials in the risks of becoming ill and dying, generated by heterogeneous conditions of existence and access to goods and services. Differences are considered iniquitous if they derive from limited choices, restricted access to health care, and are more exposed to harmful factors.[14]

The inequalities in health indicators between the race variable, referring to social determinants as the only influential factor in the worst health condition for blacks compared to whites. The results point to the influence of social determinants as part of the explanation for poor access to health services, but they can not explain all the difference that can be attributed to the consequences of discrimination.[14]

Correlated diseases

Quilombola communities, recognized only recently by the Brazilian Constitution, are self-defined based on relationships with the land, kinship, cultural practices and presumption of black ancestry. They represent the rescue of a historic debt with the Afro-descendant population, which constituted the Quilombos in their struggle against oppression suffered and for the freedom of the slave regime that lived in the country in the colonial period.[15]

This situation can express the longitudinality of primary care, which has relevance for allowing the user to link with the unit and/or the professional and because it is strongly related to good communication among those involved, which tends to favor the monitoring of the person, allowing the continuity and effectiveness of treatments and also contributing to the implementation of actions of promotion and prevention for diseases of high prevalence.[16]

It is worth noting the difficulty of quilombola women's access to preventive exams linked to the women's care program. Thus, a significant association between failure to perform the preventive examination for cervical cancer and failure to perform a clinical examination of the breasts in three or more years or never has been performed. Also significant is the association between not having seen a doctor in the last twelve months, never having had blood glucose or having had it performed two or more years ago with the Pap smear in three years or more. It also emphasizes the link between the low level of schooling of quilombola women as an important factor of vulnerability.[16]

Furthermore, it was revealed that quilombola women use public services more than men and are more tested for Human Immunodeficiency Virus (HIV) in these services. This difference may arise from the test offer in the prenatal routine. The greater frequency of reporting of signs and symptoms that could match Sexually Transmitted Diseases (STDs) among women may be due to increased funding for the service.[17]

A high prevalence of nutritional risk for Chronic Non-communicable Diseases (CNCDs), especially

among women living in quilombola communities. When considering the precarious conditions of life and health that characterize these communities, it is recommended that intersectoral actions be drawn and implemented with a view to promoting healthy lifestyles that cooperate to reduce body weight and nutritional improvement in quilombola communities, thus reducing inequalities in the country.[15]

Overweight and abdominal obesity are significant health problems in quilombola communities and, more specifically, among women. They are in line with the growth of body and central obesity in the poorest areas of Brazil, especially among certain vulnerable groups.[15]

When we reflect on female health, studies conducted in the United States report that uterine leiomyoma occurs 2-9 times more in blacks than in white women of all ages and are associated with more severe symptoms in blacks who are diagnosed at younger ages young and have higher rates than whites of hysterectomy.[5]

With regards to the CNCDs, hypertension represents one of the main public health problems in black populations worldwide, and in Brazil, because it is more frequent in Afro-descendant populations, it stands out in the context of the most important diseases for ethnic reasons.[18]

Brazil is the second largest black nation in the world, behind only Nigeria. According to data from the *IBGE* in 2010, the population of blacks and mulattoes in Brazil corresponds to 50.7% of the population. Given the persistence of racial disparities, evidence indicates that blacks have a higher incidence of disease and die earlier in life, at all ages. Among the diseases that affect this population, arterial hypertension appears prominent, being about twice as prevalent in non-white individuals and strongly associated with lower social strata.[18]

Women of African descent are more susceptible to central obesity, a condition that is strongly associated with chronic non-communicable diseases, such as hypertension.[19] These characteristics classify them as a group particularly vulnerable to morbidity and mortality from cardiovascular diseases, which justifies the implementation of specific preventive measures and affirmative policies that guarantee the rights and quality of life of this population.[19]

Still, diabetes is highlighted as a serious public health problem and one of the important risk factors for cardiovascular diseases. It shows an increase in its occurrence in several regions of the world, specifically in black ethnic populations, which recent studies show that the occurrence of diabetes are higher than in other population groups.[20]

Among the diseases correlated with this population, there is also a high prevalence of Hepatitis B Virus (HBV) infection markers in some communities of quilombos in Central Brazil (reaching 42.4% and 7.4% for anti-HBc and HBsAg, respectively, in the community named *Furnas dos Dionísio*) and a low rate of hepatitis B vaccination (9.1%). Moreover, the family history of hepatitis and sexual activity in addition to increasing age were statistically associated with HBV infection in this population.[21]

In Brazil, despite complaints and complaints from black movement organizations, the discussion about racial differences in health is still incipient. Through the "race" category, expressed through the variable "race/skin color", it is possible to identify at least part of the inequality and social injustice caused by racism.[22]

Social inequality/violence, racism and discrimination

It is perceived the importance of deeper approaches to violence against women and, especially, black, considering that the inequality between men and women constitutes a factor of great vulnerability for this group. This scenario of inequality, where violence is exercised, favors the emergence of innumerable diseases such as STD/AIDS, psychological diseases, worsening of other pathogenic situations, and contributing to high mortality rates.[22]

Historically the black woman occupies in the Brazilian society the last social position, because it has the color component that makes it even more discriminated. Adding to the fact that she is a woman, a black woman, and yet, by its historically occupied social class, makes her threefold discriminated and in great social vulnerability.[22]

Violence is perceived as a cruel and perverse form that contributes to the disrepute of the dignity of being a woman, making it a reality. In this experience of violence present in the daily life of women, she is humiliated, mistreated, disqualified, and unauthorized.[22]

It is also worth noting the historical struggle of the black movement in the face of the rescue of citizenship. The black women's organizations dialogue with the feminist movement and with the public and private managers, aiming that all social actors can re-signify their eyes and perceive the racist attitudes imposed by a discriminatory praxis that Brazilian society produces and reproduces in reality everyday life.[22] The struggle of black women has been aimed at denouncing forms of racism, social exclusion, the myth of racial democracy, the situation of poverty, extreme poverty, illiteracy and precariousness of care in health care, education and services, treating a majority without access to existing goods and services in our society and still often exposed to gender and racial violence.[23]

Considering the victimization by homicides in Brazil, one of the studies reveals that the black population suffers more and still affirms that the relative risk of homicides grows in this population, suggesting the increase of the inequalities, emphasizing that the race/color factor can predict the occurrence of homicide.[24]

The blacks most at risk of being victims of violence are men, young people, singles, from lower-income families and residents of urban areas; life expectancy is lower among black men and women, and the majority of the poor are in the most precarious positions of the labor market and

have the lowest levels of formal education. But not all the inequalities observed are the result of discriminatory processes.[24]

Bearing this in mind, race acquires predictive value in the characterization of homicide victims, and the increase of these inequalities points to the partial efficiency of Brazilian public policies of violence control when they do not adapt universal policies to the specificities that characterize the population diversity.[24]

Against this, ethnicity is cited as an important marker of social inequality. Compared with white people, the black population was almost four times more likely to die. It reports that non-white youth are the most vulnerable to violence, reflecting the state of social inequality of people living in areas with low quality urban life and violence facing in their daily lives.[25]

Given the aforementioned context, it is important to emphasize that a large part of health research favors socioeconomic analyzes at the expense of racial issues. Emphasizes the importance of including racial analysis mainly in studies that evaluate the health-disease process. Race, health-disease process, socioeconomic level and education, are deeply intertwined themes.[26]

The author also ratifies that the violence that affects adolescents is not indiscriminate. It is rather a selective violence that affects black adolescents who live in the middle strata and worse condition of life.[26]

The Ministry of Health recognizes the existence of pathogenic potential arising from discrimination. In the case of black women subjected to racial, gender and social class discrimination, the risk of compromising their identity, body image, self-concept and self-esteem is even bigger.[27]

Hence, the presence of discriminatory practices in health care results in the reduction of access, in the exclusion of adequate care, influencing the way of birth, living and dying of black women.[27] Discrimination takes many forms and can be clearly expressed by establishing distinctions and preferences that allow the explicit exclusion of individuals from the social segments.

The unequivocal discrepancy of socio-racial inequalities in Brazil is also reported and, consequently, reveals the influence of socioeconomic and political-cultural determinants and the non-recognition of the exclusionary and vulnerable racial singularity of a large part of the population.[28] Some authors prefer the concept "ethnicity", the term "race" has been adopted by the Black Social Movement in Brazil. The "black" category includes "blacks" and "browns" because it is understood that, historically, individuals who have declared themselves to be black and brown are those who have been treated in a discriminatory manner, being in large proportions, outside the political decision-making process.[29]

The interrelationship between race, violence, and space is part of a long process of inequality. Therefore, their understanding requires the joining of interdisciplinary efforts that contribute to increase the knowledge on the subject and consequently to guide more specific Public Health Interventions.[30]

Conclusively, the discourses reveal inequities in the health care of black women, who inherit the inequalities resulting from social and political relations based on sexist and racial discrimination, with violations of rights that hinder access to social ascension and dignified health conditions.[27]

Access to health services

The studies reaffirm the situation of vulnerability of the black population in the issue of access and use of health services. The study reaffirms the need for specific public policies targeted at the most vulnerable segments, taking into account the trend of the epidemic. It is important to emphasize the need for training and encouragement to the Family Health teams, given their relevance in the care of these communities.[17]

Women attribute the triggering of discriminatory attitudes both by social status and by color, but also by the fact that they are women, have sickle cell anemia and arrive at the health service usually alone. Racial discrimination experienced can have a major impact on their lives, generating stress and illness. Experiencing situations of discrimination can in itself be an element that triggers health problems, especially when it happens in the context of a health service.[27]

Discrimination varies with gender cut and provides clues about the different experiences each woman experiences when confronted with services and professionals unprepared to promote equality. Racial discrimination is often associated with gender discrimination: Black women have less access to education and are included in the less skilled positions of the labor market.[27]

Accordingly, when evaluating the categories gender, class and race, the authors understood better how the practices of discrimination are consubstantiated in difficulties of access to the health services of black women. In this same study, racial discrimination was defined as differential treatment based on race, which puts specific racial groups at a disadvantage.[27]

The presence of discriminatory practices in health care results in the reduction of access, in the exclusion of adequate care, influencing the way of birth, living and dying of black women.[27]

CONCLUSIONS

By performing a literature mapping, this study was able to identify themes related to social inequities/violence, racism, and discrimination as well as the access of this vulnerable community to health services as expressive tools of political and philosophical reflection, pointing out the imminent importance of the implementation of relevant public policies.

It also accentuates the limitation of social determination focused on biological research, with emphasis on disease and focused on the biomedical model, far from socio-political contexts. Another limitation observed was the restricted number of publications compared to this population in health journals within the study period. Therefore, it is important to emphasize the need for studies aimed at promoting the health of this population.

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