Esc Anna Nery 2023;27:e20220166

RESEARCH | PESQUISA

www.scielo.br/EAN

Health care practices with *Quilombola* children: caregivers' perception

Práticas de cuidado em saúde com crianças quilombolas: percepção dos cuidadores

Prácticas de cuidado de salud con niños quilombolas: percepción de los cuidadores

Lauro Nascimento de Souza[1]
Laura Maria Vidal Nogueira[2]
Ivaneide Leal Ataíde Rodrigues[2]
Ana Kedma Correa Pinheiro[3]
Erlon Gabriel Rego de Andrade[2]

1. Universidade do Estado do Pará, Programa de Residência Multiprofissional em Saúde da Mulher e da Criança. Belém, PA, Brasil.

2. Universidade do Estado do Pará, Escola de Enfermagem Magalhães Barata, Programa de Pós-Graduação em Enfermagem. Belém, PA, Brasil.

3. Universidade Federal do Rio de Janeiro, Escola de Enfermagem Anna Nery, Programa de Pós-Graduação em Enfermagem. Rio de Janeiro, RJ, Brasil.

Corresponding author:
Erlon Gabriel Rego de Andrade.
E-mail: erlon.rego@hotmail.com

Submitted on 05/10/2022.
Accepted on 08/20/2022.

DOI:https://doi.org/10.1590/2177-9465-EAN-2022-0166en

Abstract

Objective: to analyze, in caregivers' perception, the health care practices provided to *Quilombola* children. **Method:** an exploratory-descriptive, qualitative study carried out in the *Quilombola* community Santa Rita de Barreira, São Miguel do Guamá, Pará, Brazil. Data were produced between July and September 2021, with caregivers of children aged zero to five years, through individual interviews guided with a semi-structured instrument. For analysis, Microsoft Office Excel 2019 and the *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* 0.7, alpha 2 were used, through Descending Hierarchical Classification. **Results:** eighteen female caregivers participated, aged between 20 and 67 years. They related care to disease prevention and treatment, life habits, health services access and popular practices that value traditional medicine. **Conclusions and implications for practice:** women's knowledge and actions expressed influences from their culture, their beliefs and their ways of interpreting and symbolizing reality. Recognizing and questioning *Quilombola* practices in child care is a challenge that goes beyond the biomedical, reductionist and stigmatizing discourse, a context in which it is necessary to expand the interdisciplinary debate on the subject.

Keywords: Child; African Continental Ancestry Group; Vulnerable Populations; Child Health; Health of Ethnic Minorities.

Resumo

Objetivo: analisar, na percepção dos cuidadores, as práticas de cuidado em saúde prestadas às crianças quilombolas. **Método:** estudo exploratório-descritivo, qualitativo, realizado na comunidade quilombola Santa Rita de Barreira, São Miguel do Guamá, Pará, Brasil. Os dados foram produzidos entre julho e setembro de 2021, com cuidadores de crianças de zero a cinco anos, por meio de entrevistas individuais guiadas com instrumento semiestruturado. Para análise, utilizou-se o *Microsoft Office Excel* 2019 e o *software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* 0.7, *alpha* 2, por meio da Classificação Hierárquica Descendente. **Resultados:** participaram 18 cuidadores do sexo feminino, com idade entre 20 e 67 anos. Relacionaram o cuidado à prevenção e ao tratamento de doenças, aos hábitos de vida, ao acesso aos serviços de saúde e às práticas populares que valorizam a medicina tradicional. **Conclusões e implicações para a prática:** os saberes e as ações das mulheres expressaram influências de sua cultura, suas crenças e seus modos de interpretar e simbolizar a realidade. Reconhecer e problematizar as práticas quilombolas no cuidado às crianças é um desafio que ultrapassa o discurso biomédico, reducionista e estigmatizante, contexto no qual é preciso ampliar o debate interdisciplinar sobre o tema.

Palavras-chave: Criança; Grupo com Ancestrais do Continente Africano; Populações Vulneráveis; Saúde da Criança; Saúde das Minorias Étnicas.

Resumen

Objetivo: analizar, en la percepción de los cuidadores, las prácticas de atención a la salud que se brindan a niños *quilombolas*. **Método:** estudio exploratorio-descriptivo, cualitativo, realizado en la comunidad *quilombola* Santa Rita de Barreira, São Miguel do Guamá, Pará, Brasil. Los datos fueron recolectados entre julio y septiembre de 2021, con cuidadores de niños de cero a cinco años, a través de entrevistas individuales guiadas con instrumento semiestructurado. Para el análisis, se utilizó el programa *Microsoft Office Excel* 2019 y el *software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* 0.7, *alpha* 2, a través de la Clasificación Jerárquica Descendente. **Resultados:** participaron 18 cuidadoras, con edades entre 20 y 67 años. Relacionaron el cuidado con la prevención y tratamiento de enfermedades, hábitos de vida, acceso a los servicios de salud y prácticas populares que valoran la medicina tradicional. **Conclusiones e implicaciones para la práctica:** los saberes y acciones de las mujeres expresaron la influencia de su cultura, sus creencias y sus formas de interpretar y simbolizar la realidad. Reconocer y cuestionar las prácticas *quilombolas* en el cuidado de los niños es un desafío que va más allá del discurso biomédico, reduccionista y estigmatizador, contexto en el que es necesario ampliar el debate interdisciplinario sobre el tema.

Palabras clave: Niño; Grupo de Ascendencia Continental Africana; Poblaciones Vulnerables; Salud del Niño; Salud de las Minorías Étnicas.

INTRODUCTION

Care has always been ontologically part of everyday life, based on human experiences and their understanding of the needs to perform it. In this sense, care becomes authentic and allows giving meaning to the different forms of care, actively manifesting itself in daily life.[1] It can be said that care is inherent and inseparable from man and his nature and culture, being built from the understanding of health and disease, which is closely related to the social, cultural, political and geographical representations elaborated in the living process.[2]

Therefore, caring is determined by the connotations of those who practice it, and it differs depending on the particularities of different human groups, as in the case of *Quilombola* communities, which conceive health in a particular and singular way, considering the way they organize themselves socially, their culture and their identity experiences.[3]

These communities are ethnic-racial groups linked to black ancestry, which gradually conquered their visibility and their rights of access to services and public policies. Assistance to these people involves the valorization of their historically traced specificities, which are reflected in the way they care and in the health determinants, especially in the context of child care, which involves politics, culture, society and economy.[4]

In the midst of the rights conquered, the guarantee to health stands out, through the *Programa Brasil Quilombola* (*Quilombola* Brazil Program), implemented in 2004.[5] As a result, the Ministry of Health published Ordinance 1,434 of July 14, 2004, which finances health actions,[6] and the Brazilian National Policy for Comprehensive Health for the Black Population (*Política Nacional de Saúde Integral da População Negra*), established by Ordinance 992 of May 13, 2009, which establishes guidelines for equity promotion for the black population's health.[7]

Although these achievements have been achieved in the Brazilian context, the invisibility of *Quilombolas*' health is still predominant due to racism, power relations and professional disqualification, characterizing them as vulnerable populations.[8] In this scenario, culturally disqualified assistance is offered to *Quilombola* children, while their invisibility in the field of child care policies is recognized, without ensuring comprehensive, universal and equitable care that articulates the biological, psychosocial and cultural dimensions. Thus, cultural appreciation is neglected in the Brazilian National Policy for Comprehensive Caren for Children's Health (*Política Nacional de Atenção Integral à Saúde da Criança*)[9] and in assistance to growth and development.[10]

Therefore, in the context of studies on ethnic minorities' health, it is essential to know and interpret care practices, which are constructed, signified/symbolized and shared in the context of *Quilombola* children's health, considering the peculiar demands of the age group and the sociocultural particularities that affect the interventions undertaken by their caregivers. It is understood that these interventions occur in everyday life in society, based on the relationships established with the social group and the environment, a scenario where people attribute meanings to their actions.

Considering the relevance of the theme, the research question emerged: what is the perception of caregivers about the health care practices provided to *Quilombola* children? To answer this question, this study aims to analyze, in caregivers' perception, the health care practices provided to *Quilombola* children.

METHOD

This is an exploratory-descriptive, qualitative study carried out according to the COnsolidated criteria for REporting Qualitative research (COREQ), which guides qualitative research according to the domains: characterization and qualification of the research team; study design; and analysis of results.[11]

It was developed in the *Quilombola* community Santa Rita de Barreira, in the municipality of São Miguel do Guamá, northeast of Pará, Brazil. It has a territorial dimension of 371.3032 ha and title deed issued by the *Instituto de Terras do Pará* (ITERPA), on September 22, 2002, in addition to a certificate of land recognition by the *Fundação Cultural Palmares*, published in the *Diário Oficial da União* on December 22, 2011.[12] The community does not have health services, having to move to the urban perimeter of the municipality to receive basic and hospital care.

Data production took place between July and September 2021. We included caregivers of children aged from zero to five years, aged 18 years and over, residents and natives of the *Quilombola* community, regardless of sex/gender, who cared for children native to the community. We excluded caregivers who had cognitive disabilities or any other that made clear communication with the researcher difficult, with no exclusion.

The approach to the community took place at a meeting of the Residents' Association, which was attended by leaders and other residents. On that occasion, the research was presented, and individual interviews were scheduled with those who agreed to participate, with the collaboration of the association's president to facilitate the approximation and establishment of a bond between researcher and participants.

Prior to the interviews, participants received the Informed Consent Form (ICF) for reading, clarification of doubts and subsequent signature. To guide the interviews, we used a semi-structured instrument containing questions regarding participants' sociodemographic conditions and their perceptions about caring for children.

The interviews took place in places previously defined by the participants, ensuring comfort and privacy, and were mostly carried out in their homes. They were recorded with consent and transcribed in full, composing the textual *corpus* for analysis. Participants were identified the letters Q, for "*Quilombola*", and C, for "caregiver", followed by the sequential Arabic number of the interviews.

For the analysis, sociodemographic data were processed in Microsoft Office Excel 2019, and those from subjective questions, which addressed perceptions about care, were processed in the *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRaMuTeQ), version 0.7, alpha 2. IRaMuTeQ allows managing and processing texts from open

questionnaires, enabling lexicometric understanding and providing greater reliability in qualitative research results.[13] We opted for the treatment of subjective data according to the Descending Hierarchical Classification (DHC).

The study was approved by the Research Ethics Committee of the *Universidade do Estado do Pará*, under Opinion 4,748,604, in June 2021, respecting all the ethical principles established by Resolution 466/2012 of the Brazilian National Health Council.[14]

RESULTS

Eighteen caregivers participated, all female, with a mean age of 30.8 years, ranging from 20 to 67 years. All reported being Catholic, 83.3% (15) live in a stable union and 77.8% (14) have agriculture as their main income-generating activity. As for family income, 77.8% (14) reported a monthly income lower than the current minimum wage, and 72.2% (13) live with more than three people in the household, with a mean of 4.38 residents per household. Of the total, 83.3% (15) are assisted by a government income transfer program.

Through DHC, 307 text segments (TS) were identified, with use of 245 (79.8% of the *corpus*), resulting in three branches, which gave rise to four classes: Class 3 – Meanings of care (with 60 TS, 24.5% of the material); Class 2 – Identification of care needs (63 TS, 25.7%); Class 1 – Access to formal care services (62 TS, 25.3%); and Class 4 – Use of popular practices (60 TS, 24.5%), as shown in Figure 1. It was decided to demonstrate them in that order, focusing on data organization and clarity. These classes, with the excerpts that best represent them, are presented below.

Class 3 – Meanings of care

This class gathers information regarding the meanings of care, demonstrating how such perceptions are related to health. Thus, for *Quilombola* caregivers, care takes on the expression of caring for the living space and for those who inhabit or occupy this space, according to the following statements:

> [...] *for me, that's what care is, it's having zeal, taking care of our things in our family, for our children* (QC1).
>
> *For me, care is taking care of the things we have, being zealous, things as such* (QC2).
>
> *For me, care is taking care of others, of our things, of our home* (QC7).

Participants also related care to the organized home environment:

> *For me, care is seeing things tidy up* (QC4).
>
> *For me, care is wanting to see things tidy, everything right* (QC11).

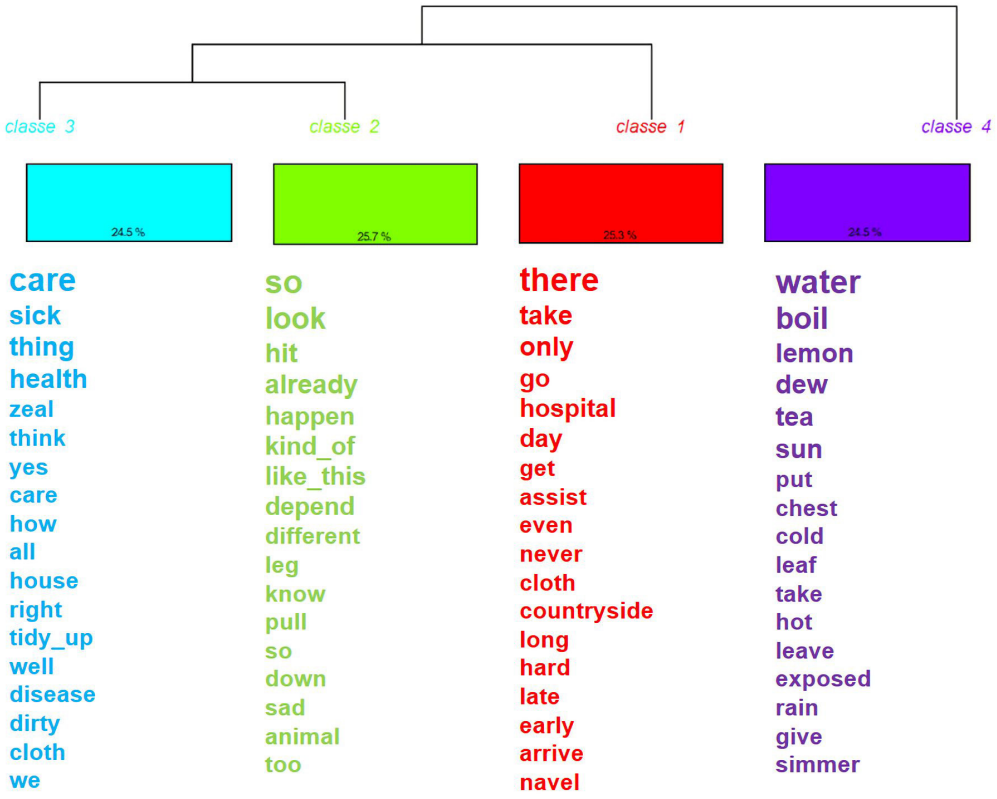

Figure 1. Dendrogram of analyzed text segments. Belém, Pará, Brazil, 2021. Source: prepared by the authors.

Other perceptions, revealed in the study, refer to the understanding of care as a feeling of the other being well or as a commitment to offer attention:

> *Care, I think it's seeing the other person well and happy* (QC10).
>
> [...] *care is for us to do things to get well or help to get well* (QC16).
>
> *For me, care is to pay attention* (QC17).

When related to health care, these understandings are parallel to disease prevention and treatment actions, as observed in the statements:

> *Care for health, for me, it's like that, if I'm sick, you give that affection and that attention to treat the disease, then it's to take it to treat that disease somewhere, to see if it gets better, to teach the medicines* (QC13).
>
> [...] *if I'm careful, I always have to look at things well, then I'll be healthy. And I think, therefore, that care has to do with this, because, when we take care, the person avoids having a disease and is healthier* (QC14).

Class 2 – Identification of care needs

In this class, caregivers' perceptions of care needs are portrayed, with a strong association with primary care. Caregivers understand that the first acts of care are related to the need to prevent diseases, which are expressed in the concern with life habits, including feeding children, personal hygiene and general care:

> *I have to take care of them* [referring to children] *on a daily basis, with bath, food, and watch them not pick up something they don't have to pick up* (QC1).
>
> *First, care is with food, with the fruits that we will give to the child. I think I'm careful not to give things to them, for fear of getting sick* (QC2).
>
> [...] *I teach them to brush their teeth properly* [...] *then, bath too: there are three baths a day, because, if not, it gets all filthy with dirt, then it gets roundworms. And the food, I'm very careful not to make it greasy. I remove all that oil that comes out and I don't let them keep eating this candy, skilho* [industrialized snack] *and popcorn thing all the time* (QC12).

Caregivers' watchful eye for possible signs expressed in the children's behavior changes or even in their mood stands out, awakening them to investigate morbid conditions:

> *I know they are sick when they are quiet, because they are very dangerous* [i.e., anxious, restless]. *Then, when they just stay at home, I already know they have something* [...] *then, I'll see what they have* (QC4).
>
> *When I look at him, I see that he changes, he becomes different: if he is happy, he becomes sadder, he feels down* [...]. *These days, I didn't know that he had kicked his leg, I saw that he was sad, and then I kept seeing that he wasn't joking, and he also likes to dance* [...], *I saw that he kicked his leg. He totally changed; I already knew he was sick* (QC5).

Class 1 – Access to formal care services

This class concerns the provision of services in the municipal health unit. It was identified that the search, on the part of caregivers, includes actions restricted to checking weight and height and updating the children's immunization schedule:

> *At the* [health] *center, I take him to check his weight and vaccinations* (QC4).
>
> *I take him over to the center. At the hospital, I don't think I ever took it, but at the health center, I take it to be weighed and see how much it's measuring* (QC9).
>
> *I take him more to see the vaccine issues and also weight and height* (QC12).

When questioned about the quality of services provided, most caregivers defined it as being good. However, they reported obstacles to accessing the health unit, determined by two main factors: mobility difficulties, due to the unit's location in relation to the community; and flow and opening hour organization:

> *We get there* [at the unit] *and it is a sacrifice, sometimes. We are in a hurry, because there is a farm* [work activities in the countryside], *so we arrive early and wait there, and they only take care of the countryside* [i.e., people who live in rural areas of the municipality] *one day a week, then they take a long time to assist* (QC3).
>
> *I think it takes a long time to start assisting, because we are from the countryside, we get there very early, even because of the bus that takes us, then they will start working around nine o'clock, and not to mention the difficulty to schedule this appointment* (QC8).
>
> *I like it and I think it's good, because the nurse is very attentive, but it's hard to make an appointment, because here our* [Community Health] *Workers is the president of the community, then he travels and it gets complicated* (QC11).

Class 4 – Use of popular practices

In this class, the thematic content corresponds to the use of other practices in the care of children, valuing traditional medicine, with the recognition of the ease of access, especially to phytotherapy:

> [...] *I prefer to make the home medicine than take them there* [at a health service], *because they* [health professionals] *give these medicines from the pharmacy and, sometimes, it is difficult to buy, also because we do not have money sometimes to buy them, then we have to find our way* [...]. *The home medicine, we can borrow it, sometimes, even in the backyard, so I do the things I have here* (QC1).
>
> [...] *I think it's even easier to take care of it like this* [with home medicine], *because I get the leaves here at the worship place anyway* (QC13).

Among the popular care practices, essentially the use of teas and baths in different situations, prepared with leaves and roots, emerged. Most interventions were for the treatment of flu, fever, parasitic infections and intestinal problems. The dosage varies according to the indication, but, in general, the ingestion of teas and the application of baths replace the daily activities of drinking water and bathing:

> *For roundworm, I use Guinea rush and male papaya root. I put it to boil and give it as tea. We make it and, when it's time to drink water, we give tea* (QC3).
>
> *Sometimes he has the flu, he* [referring to the child] *gets his nose all blocked up, then I bathe him in the lemon leaf, leave it in the dew and bathe him with this water and, together, I keep giving him the lemon tea* (QC9).
>
> *He has a stomachache, diarrhea, I make him tea. There are several types that I make: boldo, which is for the liver, and there is also the paregoric elixir* (QC11).

Although the use of teas and baths is the main treatment for the reported changes, the association of this practice with chemotherapy medication was sporadically identified:

> [...] *when they* [children] *have the flu, I take the lemon leaf, which is that small lemon, I wash it to remove the soil* [...], *I put it to boil and, when it boils enough, there is that lemon smell, then I'm going to break a tablet of the acetylsalicylic acid drug, I throw it in, I wait for it to dissolve, that's how it is* (QC1).
>
> [...] *if he has a fever, I bathe him with peppermint and chamomile, give him a bath and also a nimesulide* [pill] *or an acetylsalicylic acid pill* (QC18).

In the case of fever exclusively, natural or biomedical therapy is started after one day of symptoms, as shown in the following statements:

> [...] *people say they can't give fever medicine on the first day, because the fever goes down, but then it comes back stronger. You have to wait a day to give the medicine* [...], *I wait the first day and give the medicine* (QC1).
>
> [...] *this fever in him* [...], *but it can only happen after a day of fever, because, if it happens before, he can disguise it* (QC16).

Other products used in child care are oils extracted from seeds, such as crabwood, and fats extracted from animals, such as chicken and jacuraru, called by caregivers as "lard". They are used to prevent or control edema, induce anti-inflammatory responses, and have a recognized healing action in wounds and in the care of the umbilical stump:

> [...] *sometimes, it also happens a lot of him hitting himself, then I see where he hit and take care of the things I have at home: chicken lard, jacuraru* [lizard] *lard* [...]. *The jacuraru lard is more difficult to obtain, because the jacuraru has only a little fat and it is also difficult to catch* [hunt] *it* [...]. *We use it to reduce inflammation, because it's very good, it's better than chicken lard* (QC1).
>
> *I first see what that thud is like, if it's a 'stupid' thing* [term used here to refer to a small lesion], *I just spread it with chicken lard, which is not to ignite, and I cover it with a clean cloth* [...], *and it heals soon. If it's more serious, jacuraru lard is better, because it's stronger* (QC6).
>
> [...] *I cleaned his navel with alcohol that they sent from the hospital and I also put crabwood to help it not get inflamed* (QC15).

The use of these oils and lards is sometimes also associated with a drug that has a similar or complementary therapeutic function, to obtain a cure or resolution of the condition:

> *They live with wounds, because they keep falling around. I take care of that with rifocina and with lard that I have here: chicken and jacuraru, but I also have crabwood* (QC11).
>
> [...] *he stepped on a nail, so I had to wash it well with soap and water, I cleaned it and then I put that rifocina on top so it wouldn't ignite, I kept applying chicken lard and crabwood. It was swollen, I was just applying the chicken lard with crabwood and also applied a macerated tablet of an antimicrobial drug to the wound site* (QC16).

Another type of care reported concerns the treatment for asthma, described by caregivers as "pulled", a disease associated by them with birth conditions, playing in rainy weather, sudden changes in body temperature and contact with dust:

> [...] *he gets wet in the* [exposes himself to] *rain,* [to] *dew and comes from the worship place, takes a bath with a warm body and we have to let it cool down so it doesn't get hard, which is that asthma they call it. The same has happened to them, they were crying and got sweaty, then they took a shower and it was hard* (QC3).

> […] *he has asthma, he's had it for a while. You want to see it when it rains and it gets that cold, then it gets really bad* [...]. *Asthma was left over from childbirth that didn't go away. So, people talk and they have to be careful, because anything ignites* (QC7).
>
> *Asthma, people here know it as a strain. The person is tired, short of breath, and the dust makes it worse* (QC18).

The treatment for asthma involves early actions, through the use of pulls and other preparations based on vegetables and insects. This use is shared and perpetuated in conversations that originate within social relationships, based on experiences in caring for other children:

> *The recipe she gave was to make powder from millipede, cockroach and scorpion, so I went to get these insects. She put them in the pan, roasted them until they were burnt, then kneaded them in the pestle until they turned to powder. I put it in water and he could drink it until he vomited, like a drool, which was the asthma coming out of his chest* [...], *that thick as a phlegm* [...]. *Today, he still has some of that asthma, but it's not strong* (QC1).
>
> *For asthma, I give green onion, which is like an onion. Cut it into three* [parts] *and throw it in the water to boil. My mother who taught. She lets it simmer, then you knead it and strain it, and give the child a liter to drink until he vomits. He's gonna throw up that drool, which is asthma* (QC3).
>
> [...] *can you imagine someone running out of air? It's a serious thing, and we went there to the woman who prays, she pulled his chest* (QC19).

Still in the community's daily life, caregivers reported practices based on religious assistance, especially in the blessing, as they recognized that the illness came from spiritual or mystical influences. Among the main causes are the spells caused by beings of nature, such as the Water Mother:

> *They feel down, they don't want to play and they just stay at home lying down, it gives a fever; sometimes it also gives me a stomach ache and a headache* [...]. *There are children, when the eye* [spell] *is very strong, who keep saying confusing things* [...] *then, we take it to the lady who blesses, she gives the prescription. Sometimes the recipes are difficult, but we do it, because it's a serious business when it's looked at by an animal* (QC1).
>
> [...] *I take him there a lot* [at the folk healer], *because there's this thing about the evil eye, he doesn't want to eat, he gets very thin* [he loses weight], *then she prays and it goes away* [...]. *I believe in her a lot* (QC4).
>
> [...] *the thud* [evil eye] *of animals, which are those animals from the creek, which have a Water Mother, which makes the child get a fever, headache, that mufinesa* [apathy], *then take it to the folk healer for her to bless the child, says the prayers and she passed the medicine* (QC13).

DISCUSSION

In the *Quilombola* community, care for children prioritizes native practices based on traditional knowledge; however, biomedical treatments are used in association with native medicine. There is recognition of the therapeutic effectiveness of home treatments, as they are used as a first option and on a large scale.

All caregivers are women, also observed in a study in which the woman was the main caregiver of children.[15] Among the participants, there was a predominance of the Catholic religion, income of up to one minimum wage from family farming and increased by income transfer programs, such as *Bolsa Família* (fixed monthly payment from the government to underprivileged families) and housing programs. In line with these results, a study carried out in a *Quilombola* community in Pará also identified a family income lower than the current minimum wage during data collection.[16]

Care, in the understanding of the women who participated in this research, is related to the domestic environment and the functions they perform to maintain this space, which includes the caregiver, the family and the house where they live. It is interesting to note that women refer to care, also relating it to the historically constructed gender role, which attributes to women the role of caretaker for the domestic space. In the case of black women, this stereotype is more accentuated, considering all the construction of racism and the difficulty of offering formal work, compared to white women.[17]

Another highlight refers to care practices understood as means for the prevention of diseases and injuries, valuing healthy habits. According to the recommendations of the Primary Care Report/Ministry of Health for monitoring the growth and development of children, promoting these habits, especially healthy, age-appropriate eating, is essential, not only for satisfactory growth and development, but also to prevent morbid conditions and their possible complications, such as episodes of anemia and malnutrition, in addition to increasing immunity.[10]

Regarding hygiene habits, its relationship with intestinal parasites is known, as well as the international recognition that personal hygiene practices and care in the preparation and handling of food are among the main preventive measures.[18-20] It is worth noting that this care tends to engender a limiting understanding of health as the mere absence of disease, considering the effort to prevent children from being ill. Such thinking is due to several factors, such as the understanding of health as the absence of disease, disseminated by the biomedical model and rooted in the social imaginary.[21]

For caregivers, the health offer in public services is reduced to checking children's weight and height, in addition to updating the vaccination schedule. This fact coincides with the results of a study carried out with *Quilombola* mothers from a community in the

state of Bahia, which investigated the meanings they attributed to childcare appointments identifying a strong relationship between the demand for the service and the actions to check weight and height as well as the demand for immunization.[22]

It is worth mentioning that children's appointments should not be restricted to the verification of anthropometric measurements, but should also consider social inequalities and the conditions in which families live, fully valuing aspects related to the assessment of growth and development. Thus, clinical follow-up must comply with the principles and guidelines of the Unified Health System (SUS – *Sistema Único de Saúde*), by treating the child as a biopsychosocial and spiritual being whose comprehensiveness must be respected in health services' daily life.[10,23]

According to the caregivers, access to childcare services is hampered by the distance between the community and the health unit, the hours of appointments, in addition to difficulties in scheduling appointments. In dialogue with this result, a study carried out in Ilha de Maré, Bahia, investigated the factors that interfere with the attendance of *Quilombola* children to scheduled appointments, noting that the juxtaposition of care with domestic activities and work occupations, the difficulties in scheduling appointments and the waiting time for care are factors that distance the community from the services.[24]

It is important to emphasize that access to health services, in the context of *Quilombolas*, is marked by fragility, inequity and omission by the government, which has the challenge of offering assistance based on the historical, geographic and cultural complexity of this population. It is also worth noting that, in the midst of conquered rights, there are health policies that value *Quilombolas*' particularities of life. Even so, it appears that the Brazilian scenario does not correspond to such peculiarities, intensifying the difficulties of accessibility and health care.[25]

The use of traditional medicine was mentioned as a priority care practice, attributed, above all, to the ease of acquisition the products used in the preparation of medicines. It should be noted that, throughout history, the use of plants and other herbal products has been closely related to health, culture and nature, and has been widespread among traditional peoples. In contemporary times, these practices are a therapeutic alternative for many Brazilians who do not have satisfactory economic conditions for the acquisition of medicines or, even, because they do not have access to the formal health system.[26]

Driven by the World Health Organization (WHO) recognition of the economic importance of traditional medicine, the Ministry of Health developed the Brazilian National Policy on Medicinal Plants and Phytotherapics (*Política Nacional de Plantas Medicinais e Fitoterápicos*) and the SUS Brazilian National Policy on Integrative and Complementary Practices (*Política Nacional de Práticas Integrativas e Complementares no SUS*), which, although implemented in the country, are not yet fully disseminated.[27] Among the popular practices cited by the caregivers, the use of plants was identified as a recurring resource, with leaves and roots manipulated for consumption being prioritized in the infusion presentation. This use, for therapeutic purposes, expresses a strong relationship with nature, integrating the different universes of traditional knowledge and practices, which are valued and which are used in situations of illness of children.

The option for leaves and roots was also identified as a priority in other studies, which addressed the use of medicinal plants in *Quilombola* communities, mainly for the preparation of teas, with greater indication for the treatment of flu symptoms and gastrointestinal problems.[28,29] In line with the findings of these studies,[28,29] it is noted that, in caregivers' report, traditional practices were used, above all, in cases of flu, digestive system problems and fever, and, for this last manifestation, practices occur with caution, i.e., from the second day of manifestation, without support in the scientific literature accessed.

It was also reported the use of vegetable oils, such as crabwood oil, to combat inflammatory processes, a natural property reinforced by different studies.[30,31] It is known that, in addition to this effect, crabwood oil also acts as an antiseptic, antiparasitic, emollient, healing, insecticide and antioxidant, being marketed all over the world as an active agent in pharmacological formulations.[30]

Animal fats, such as chicken lard and jacuraru lard, were identified as being commonly used in the community. The use of animals in folk medicine is known as ethnozootherapy, and has been related, since the dawn of humanity, to healing rituals, according to researchers at a university located in the state of São Paulo. These authors developed a study in a rural community, identifying the recurrent use of lard extracted from animals, with jacuraru lard being the most cited, due to its effectiveness, followed by chicken lard, used in the treatment of pain and for the elimination of phlegm, among other indications. Although it was not carried out with *Quilombolas*, it demonstrates that traditional practices are transversal to the construction of Brazilian society, constituting an important element of national culture.[32]

Although jacuraru fat has a notorious relevance for the population that uses it, the therapeutic indications are not scientifically proven, since tests have already been carried out to verify the composition of the fat of this animal.[33]

In this study, the use of popular practices combined with chemotherapy was identified as a resource in care, consistent with another research, whose findings revealed a combination of formal and informal medicine care resources in health problems.[15]

Another condition that requires care, according to the caregivers, is asthma, called by them as "pulled", and treated with native practices. It is worth mentioning that the way the disease is understood, associated with rainy periods, is endorsed in another study, which proved the increase in hospitalizations due to asthma during the winter, in children aged zero to four years, in the city of Belo Horizonte, Minas Gerais.[34] In the same way, two studies identified a relationship between asthma and climate change, especially in periods of falling ambient temperature, when air humidity is more pronounced.[35,36]

The search for a faith healer was mentioned as a care resource when the causes of illness are spiritual or mystical. The practice of blessing and its conception are intertwined in a religious, folkloric and cultural syncretism common among indigenous peoples, Africans and Catholics. In addition to the tasks of healing, faith healers are symbols of claiming and preserving memory and knowledge, whose action process involves the hybrid between the appropriation of nature's resources, religiosity and mysticism.[37]

In the studied community, the search for this resource occurs from the identification of a mórbido picture caused by beings of the nature, as the Water Mother. In the context of the cosmovision, caregivers perceive the forest as the home of beings capable of causing illness due to the lack of respect for their space, an imaginary that is justified, for instance, by the concern about not being in the streams at certain times. For them, these beings bewitch the child who, in the tangible reality, starts to show signs and symptoms that only faith healers and their mystical knowledge are capable of curing.

In this sense, an important study that contributes to the reflections presented, although not carried out with *Quilombolas*, highlights the cure by faith healers in the face of morbidities caused by the evil eye of beings of nature,[38] emphasizing the fact that the healers understand that their curative practices provide the opportunity to move away from the enchantments.[39]

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

This study made it possible to know the experiences related to the care provided by women to *Quilombola* children and the sociocultural context in which these experiences take place, at the same time, it made it possible to know the meanings attributed to the practice of care and its relations with health, with access to health services and the knowledge that guide traditional care.

In the unveiling of perceptions, it was found how caregivers deal with everyday conflicts, in the face of limitations in access to services, to maintain or obtain a satisfactory state of well-being for children that transcend biological aspects, as it also encompasses psychosocial and spiritual aspects. When offering care, caregivers' knowledge and actions actively expressed influences from their culture, beliefs and ways of interpreting and symbolizing reality.

Therefore, recognizing and problematizing *Quilombola* practices in the care of children is a challenge that goes beyond the biomedical, reductionist and stigmatizing discourse still in force in many academic-scientific spaces in the health area. From the perspective of interdisciplinarity, it is necessary to broaden the debate on the subject in the context of education and professional practice, encouraging the formation of study groups and the production of new research that contribute to overcoming this challenge and to strengthening the health care of this population, considering the particularities that characterize their condition as a group with ancestors from the African continent and demarcate their vulnerabilities.

It is understood that the development of this study in only one *Quilombola* community in the state of Pará may limit the generalization of its results, since human, environmental, organizational and operational factors influence the construction of subjectivities. However, its potential to support reflections and investigations in different scenarios is recognizable, aiming to contribute to promoting individual and collective health, especially *Quilombola* children's health.

AUTHOR'S CONTRIBUTIONS

Study design. Lauro Nascimento de Souza. Laura Maria Vidal Nogueira.

Data collection or production. Lauro Nascimento de Souza.

Data analysis. Lauro Nascimento de Souza. Laura Maria Vidal Nogueira.

Interpretation of results. Lauro Nascimento de Souza. Laura Maria Vidal Nogueira. Ivaneide Leal Ataíde Rodrigues. Ana Kedma Correa Pinheiro. Erlon Gabriel Rego de Andrade.

Writing and critical review of the manuscript. Lauro Nascimento de Souza. Laura Maria Vidal Nogueira. Ivaneide Leal Ataíde Rodrigues. Ana Kedma Correa Pinheiro. Erlon Gabriel Rego de Andrade.

Approval of the final version of the article. Lauro Nascimento de Souza. Laura Maria Vidal Nogueira. Ivaneide Leal Ataíde Rodrigues. Ana Kedma Correa Pinheiro. Erlon Gabriel Rego de Andrade.

Responsibility for all aspects of the content and integrity of the published article. Lauro Nascimento de Souza. Laura Maria Vidal Nogueira. Ivaneide Leal Ataíde Rodrigues. Ana Kedma Correa Pinheiro. Erlon Gabriel Rego de Andrade.

ASSOCIATED EDITOR

Aline Cristiane Cavachilli Okido

SCIENTIFIC EDITOR

Ivone Evangelista Cabral

REFERENCES

1. Cestari VRF, Moreira TMM, Pessoa VLMP, Florêncio RS, Silva MRF, Torres RAM. The essence of care in health vulnerability: a Heideggerian construction. Rev Bras Enferm. 2017;70(5):1112-6. http://dx.doi.org/10.1590/0034-7167-2016-0570. PMid:28977242.
2. Scorsolini-Comin F, Figueiredo IA. Concepções de saúde, doença e cuidado em *Primeiras estórias*, de Guimarães Rosa. Saude Soc. 2018;27(3):883-97. http://dx.doi.org/10.1590/s0104-12902018171009.
3. Silva IFS, Rodrigues ILA, Nogueira LMV, Palmeira IP, Ferreira MA. Behaviors related to Quilombola women's health: a social representations study. Rev Bras Enferm. 2020;73(supl 4):e20190427. http://dx.doi.org/10.1590/0034-7167-2019-0427. PMid:32965417.
4. Matos WS, Eugenio BG. Comunidades quilombolas: elementos conceituais para sua compreensão. PRACS: Rev Eletrônica Humanid Curso Ciênc Soc UNIFAP. 2019;11(2):141-53. http://dx.doi.org/10.18468/pracs.2018v11n2.p141-153.

5. Teixeira TG, Sampaio CAM. Budget analysis of the 'Brazil Quilombola Program' in the state of Maranhão and nationwide: the decline of a public policy. Rev Adm Pública. 2019;53(2):461-80. http://dx.doi.org/10.1590/0034-761220170323.
6. Portaria nº 1.434, de 14 de julho de 2004 (BR). Define mudanças no financiamento da Atenção Básica em Saúde no âmbito da Estratégia Saúde da Família, e dá outras providências. Diário Oficial da União [periódico na internet], Brasília (DF), 2004. 43 p. [cited 2021 Mar 25]. Available from: http://189.28.128.100/dab/docs/legislacao/portaria1434_14_07_04.pdf
7. Ministério da Saúde (BR), Secretaria de Gestão Estratégica e Participativa, Departamento de Apoio à Gestão Participativa e ao Controle Social. Política Nacional de Saúde Integral da População Negra: uma política para o SUS [Internet]. 3ª ed. Brasília: Ministério da Saúde; 2017. 44 p. [cited 2021 Dec 27]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_saude_populacao_negra_3d.pdf
8. Guimarães RCR, Silva HP, Ramos EMLS. Condições socioecológicas familiares nos primeiros dois anos de vida de crianças quilombolas no Pará: um estudo de base populacional. Cienc Saude. 2018;11(2):90-9. http://dx.doi.org/10.15448/1983-652X.2018.2.29521.
9. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Política Nacional de Atenção Integral à Saúde da Criança: orientações para implementação [Internet]. Brasília (DF): Ministério da Saúde; 2018. 180 p. [cited 2021 Mar 25]. Available from: https://portaldeboaspraticas.iff.fiocruz.br/wp-content/uploads/2018/07/Pol%C3%ADtica-Nacional-de-Aten%C3%A7%C3%A3o-Integral-%C3%A0-Sa%C3%BAde-da-Crian%C3%A7a-PNAISC-Vers%C3%A3o-Eletr%C3%B4nica.pdf
10. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Saúde da criança: crescimento e desenvolvimento [Internet]. Brasília (DF): Ministério da Saúde; 2012. 272 p. (Cadernos de Atenção Básica; no. 33) [cited 2021 Nov 7]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/saude_crianca_crescimento_desenvolvimento.pdf
11. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-57. http://dx.doi.org/10.1093/intqhc/mzm042. PMid:17872937.
12. Comissão Pró-Índio de São Paulo (SP). Santa Rita de Barreira [Internet]. São Paulo; 2021 [cited 2021 Mar 25]. Available from: https://cpisp.org.br/santa-rita-de-barreira/
13. Sousa YSO, Gondim SMG, Carias IA, Batista JS, Machado KCM. O uso do *software* Iramuteq na análise de dados de entrevistas. Pesqui Prát Psicossociais [Internet]. 2020; [cited 2021 Mar 25];15(2):e3283. Available from: http://www.seer.ufsj.edu.br/index.php/revista_ppp/article/view/3283
14. Resolução nº 466, de 12 de dezembro de 2012 (BR). Aprova normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial da União [periódico na internet], Brasília (DF), 13 jun. 2013 [cited 2021 Sept 10]. Available from: https://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf
15. Siqueira SMC, Jesus VS, Camargo CL. The therapeutic itinerary in urgent/emergency pediatric situations in a maroon community. Cien Saude Colet. 2016;21(1):179-89. http://dx.doi.org/10.1590/1413-81232015211.20472014.
16. Freitas IA, Rodrigues ILA, Silva IFS, Nogueira LMV. Perfil sociodemográfico e epidemiológico de uma comunidade quilombola na Amazônia Brasileira. Rev Cuid. 2018;9(2):2187-200. http://dx.doi.org/10.15649/cuidarte.v9i2.521.
17. Collins PH. Aprendendo com a *outsider within*: a significação sociológica do pensamento feminista negro. Soc Estado. 2016;31(1):99-127. http://dx.doi.org/10.1590/S0102-69922016000100006.
18. Nunes MO, Matos-Rocha TJ. Fatores condicionantes para a ocorrência de parasitoses entéricas de adolescentes. J Health Biol Sci. 2019;7(3):265-70. http://dx.doi.org/10.12662/2317-3076jhbs.v7i3.2244.p265-270.2019.
19. Navone GT, Zonta ML, Cociancic P, Garraza M, Gamboa MI, Giambelluca LA et al. Estudio transversal de las parasitosis intestinales en poblaciones infantiles de Argentina. Rev Panam Salud Publica. 2017;41:e24. http://dx.doi.org/10.26633/RPSP.2017.24. PMid:28614462.
20. Garraza M, Navone GT, Oyhenart EE. Desnutrición y enteroparasitosis en escolares del departamento de Guaymallén, Mendoza. Nutr Clín Diet Hosp. 2019;39(1):120-7. http://dx.doi.org/10.12873/391garraza.
21. Pettres AA, Da Ros MA. A determinação social da saúde e a promoção da saúde. Arq Catarin Med [Internet]. 2018; [cited 2021 Mar 25];47(3):183-96. Available from: https://revista.acm.org.br/index.php/arquivos/article/view/375
22. Oliveira EF, Camargo CL, Gomes NP, Campos LM, Jesus VS, Whitaker MCO. Follow-up consultations on growth and development: the meaning for quilombo mothers. Esc Anna Nery. 2018;22(1):e20170054. http://dx.doi.org/10.1590/2177-9465-ean-2017-0054.
23. Gaíva MAM, Monteschio CAC, Moreira MDS, Salge AKM. Avaliação do crescimento e desenvolvimento infantil na consulta de enfermagem. Av Enferm. 2018;36(1):9-21. http://dx.doi.org/10.15446/av.enferm.v36n1.62150.
24. Oliveira EF, Camargo CL, Gomes NP, Couto TM, Campos LM, Oliveira PS. Factors related to quilombola attendance to child follow-up appointments. Rev Bras Enferm. 2019;72(supl 3):9-16. http://dx.doi.org/10.1590/0034-7167-2017-0605. PMid:31851229.
25. Almeida CB, Santos AS, Vilela ABA, Casotti CA. Reflexão sobre o controle do acesso de quilombolas à saúde pública brasileira. Av Enferm. 2019;37(1):92-103. http://dx.doi.org/10.15446/av.enferm.v37n1.69141.
26. Silva AC, Lobato FHS, Ravena-Canete V. Plantas medicinais e seus usos em um quilombo amazônico: o caso da comunidade quilombola do Abacatal, Ananindeua (PA). Rev NUFEN [Internet]. 2019; [cited 2021 Mar 25];11(3):113-36. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S2175-25912019000300008&lng=pt&nrm=iso&tlng=pt
27. Habimorad PHL, Catarucci FM, Bruno VHT, Silva IB, Fernandes VC, Demarzo MMP et al. Implementation of Brazil's National Policy on Complementary and Integrative Practices: strengths and weaknesses. Cien Saude Colet. 2020;25(2):395-405. https://doi.org/10.1590/1413-81232020252.11332018.
28. Farias PS, Freitas RMO, Matias MIAS, Nogueira NW, Souza RN, Fernandes ACO. Plantas medicinais utilizadas por mulheres em comunidades quilombolas do Recôncavo Baiano. Res Soc Dev. 2021;10(12):e328101219916. http://dx.doi.org/10.33448/rsd-v10i12.19916.
29. Valeriano FR, Savani FR, Silva MRV, Baracho IPS, Santos MSC, Braga JA. Uso de plantas medicinais na comunidade quilombola do Veloso, povoado de Pitangui – MG. Braz J of Dev. 2020;6(12):100701-18. http://dx.doi.org/10.34117/bjdv6n12-529.
30. Carvalho SBA, Carvalho CC, Sirqueira BPC, Silva RA, Nylander BVR, Barros CAV. Estudo em bases de patentes sobre a andiroba e suas propriedades anti-inflamatórias. Pará Res Med J. 2019;3(2):e19. http://dx.doi.org/10.4322/prmj.2019.019.
31. Ninomiya K, Miyazawa S, Ozeki K, Matsuo N, Muraoka O, Kikuchi T et al. Hepatoprotective limonoids from andiroba (*Carapa guianensis*). Int J Mol Sci. 2016;17(4):591. http://dx.doi.org/10.3390/ijms17040591. PMid:27104518.
32. Prado DOP, Ramires M. Resgate do conhecimento etnozooterápico da Comunidade Barra do Una (Peruíbe-SP). Res Soc Dev. 2020;9(12):e4539126111. http://dx.doi.org/10.33448/rsd-v9i12.6111.
33. Ferreira FS, Brito SV, Ribeiro SC, Almeida WO, Alves RRN. Zootherapeutics utilized by residents of the community Poço Dantas, Crato-CE, Brazil. J Ethnobiol Ethnomed. 2009;5(1):21. http://dx.doi.org/10.1186/1746-4269-5-21. PMid:19656376.
34. Dias CS, Mingoti SA, Ceolin APR, Dias MAS, Friche AAL, Caiaffa WT. The influence of climatic conditions on hospital admissions for asthma in children and adolescents living in Belo Horizonte, Minas Gerais, Brazil. Cien Saude Colet. 2020;25(5):1979-90. https://doi.org/10.1590/1413-81232020255.04442018.
35. Alfaia VM, Gomes ACS, Mandú TB, Pinto JS, Sousa ELR. Estudo da ocorrência de internações por asma via variáveis climáticas na região Norte (PA). Rev Ibero-Am Ciênc Ambient. 2018;9(6):147-58. http://dx.doi.org/10.6008/CBPC2179-6858.2018.006.0016.

36. Souza A, Santos DAS, Kofanovski AZ, Kovač-Andrić E. Condições climáticas e o risco de exacerbação da asma. Saúde. 2017;43(1):244-53. http://dx.doi.org/10.5902/2236583423462.

37. Mendes DS, Cavas CST. Benzedeiras e benzedeiros quilombolas: construindo identidades culturais. Interações. 2018;19(1):3-14. http://dx.doi.org/10.20435/inter.v19i1.1568.

38. Wawzyniak JV. Assombro de olhada de bicho: uma etnografia das concepções e ações em saúde entre ribeirinhos do baixo rio Tapajós, Pará – Brasil [tese]. São Carlos: Programa de Pós-graduação em Ciências Sociais, Universidade Federal de São Carlos; 2008. 235 p. [cited 2021 Nov 7]. Available from: https://repositorio.ufscar.br/bitstream/handle/ufscar/1411/2147.pdf?sequence=1&isAllowed=y

39. Bezerra MJPS, Videira PL, Custódio ES. "Se eu não fizer o bem, o mal não faço!": o sagrado afroindígena vivenciado pelas benzedeiras do quilombo do Cria-ú no estado do Amapá. Rev Estud Relig. 2020;20(2):123-37. http://dx.doi.org/10.23925/1677-1222.2020vol20i2a9.