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Quality of life of women from a quilombola community in northeastern Brazil

Qualidade de vida de mulheres de uma comunidade quilombola do nordeste brasileiro

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Abstract

Quilombola communities are present in many Brazilian states living in precarious health conditions. This is due to geographic isolation, limitations to the access of the area in which they live in, and the lack of quality in the service when it is needed to be provided. Therefore, the aim of this study was to analyze the quality of life of women from a quilombola community in northeastern Brazil. It is an observational, cross-sectional and descriptive study. 160 adult women were first interviewed through a form to collect a profile and then it was applied the WHOQOL Quality of Life questionnaire – bref. It was observed that the women were on average 40.7 years old (±17.25), married, self-declared black, who did not finish elementary school, housewife, had no income, with their own masonry house, with up to 6 rooms, supplied by a box of community treated water. Quality of Life had median scores in the domains: physical (3.18), psychological (3.4), social relationships (3.45) and environment (2.59). With this research, it was possible to characterize the quilombola community of Santa Luzia do Norte-AL regarding the difficulties of access to health and income generation, issues that affect their health condition. The problems described in this study can contribute to health actions being planned and carried out in order to improve socioeconomic and health conditions in this community, considering the social, political and environmental context, valuing their traditional knowledge and practices.

Keywords: living conditions, vulnerable populations, access to health services.

Resumo

As comunidades quilombolas, estão presentes em diversos estados brasileiros, vivendo em condições de saúde mais precárias. Isto ocorre por conta do isolamento geográfico, das limitações de acesso e da falta de qualidade no serviço quando este é prestado. Nesse sentido, o objetivo do estudo foi analisar a qualidade de vida de mulheres de uma comunidade quilombola do nordeste brasileiro. Estudo observacional, transversal e descritivo. Foram entrevistadas 160 mulheres adultas, através de um formulário para a coleta de perfil e do questionário de Qualidade de Vida WHOQOL – bref. Foi observado que as mulheres tinham em média 40,7 anos (±17,25), casadas, autodeclaradas negras, com fundamental incompleto, do lar, sem renda, com moradia de alvenaria, própria, com até 6 cômodos, abastecidas por caixa de água comunitária, tratada. A Qualidade de Vida, apresentou escores medianos nos domínios: físico (3,18), psicológico (3,4), relações sociais (3,45) e meio ambiente (2,59). Com a realização desta pesquisa foi possível caracterizar a comunidade quilombola de Santa Luzia do Norte-AL quanto as dificuldades de acesso a saúde e geração de renda, fatos que repercutem na sua condição de saúde. Os problemas descritos neste estudo podem contribuir para que ações de saúde sejam planejadas e efetivadas com o intuito de melhorar as condições socioeconômicas e de saúde nessa comunidade, considerando-se o contexto social, político e ambiental, valorizando seus saberes e práticas tradicionais.

Palavras-chave: condição de vida, populações vulneráveis, acesso aos serviços de saúde.

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1. Introduction

Quilombos are communities formed by ethnic-racial groups, which follow the criteria of self-attribution, very focused on relations with the land, ancestry and history of slavery (Durand and Heideman, 2019; Leite, 2015). Quality of life (QL) is difficult to conceptualize and, therefore, there is no global consensus, although Muldoon et al. (1998) define that quality of life is not the direct reflection of the real and objective conditions of people's lives, but of the evaluation that each one makes about these conditions, thus involving subjective and objective elements, encompasses many meanings, knowledge, experiences, individual and collective values. The assessment of QoL, although a complex component is essential to measure the living conditions and the perception of them in a population (Oliveira, 2018).

Low education and subsistence agriculture, which do not offer constant income, reflects in poor nutrition, poor nutritional status leading to a poor health, impacting the quality of life of these communities (Cardoso et al., 2018). The low socioeconomic level associated with geographic isolation, together with the low living and housing conditions, is closely related to the precarious quality of life of these groups, even if these are guaranteed by Brazil's 1988 constitution, constituting relevant factors that influence the conditions of inequality social (Amorim et al., 2013).

In 2004 the policy of inclusion of the quilombola population began with the Ordinance of the Ministry of Health nº 1,434, of 7/14/2004, by creating a health strategy team for the quilombola communities. However, it is necessary to broaden the discussion of the right to health. Basic premise of the Unified Health System (UHS, or SUS-Sistema Único de Saúde), a comprehensive and universal access involves the social and economic conditions of the population and not just the ethnic condition. The full and equitable access to public health services, which is the universality of the SUS has not yet been implemented in practice (Silva, 2010).

Silva (2015a), in a review study, concluded that the number of studies on the quilombola population is scarce, and even smaller when it comes to studies on the health of this population. He realized that there is a high prevalence of health problems resulting from the poor housing conditions, sanitation and access to health services. Oliveira et al. (2015), observed in their research that the negative perception of health was evident in half of the population studied and that it was related to variables such as: sanitary conditions, physical activity, education and smoking.

Despite advances and improvements in Health, such as the reduction in mortality rates and increase in life expectancy, the black population still has high morbidity and mortality rates when compared to the general population. Furthermore, it appears that, despite the improvement in some health indicators, ethnic and racial inequalities still remain present (Silva, 2015b).

Quilombola women are inserted in an even more unequal context, as they occupy different positions in the community itself, working in agriculture, at home and in the city, providing family support. Knowing the health context of black quilombola women, associated with a socioeconomic and environmental perspective contributes to making them visible to the society, health professionals and public authorities (Prates, 2015).

The presence of risk factors or diseases have a direct or indirect influence on QoL. In this sense, Chronic Non-Communicable Diseases (CNCDs) stand out, represented by a set of cardiovascular risk factors and which have a possible explanation in the interaction between genetic, metabolic, environmental and behavioral factors. Among the most prevalent diseases for ethnic reasons in the Afro-descendant population, systemic arterial hypertension (SAH) and Diabetes mellitus (DM) stand out. However, Brazilian population surveys on living conditions and health carried out in quilombola communities are still scarce, and little is known about the influence of diseases on the QoL of its inhabitants (Bezerra et al., 2013). Thus, this study aimed to analyze the quality of life of women from a quilombola community in northeastern Brazil.

2. Material and Method

The research was carried out through a transversal, descriptive, exploratory and field study, carried out with quilombola women, from the community of Santa Luzia do Norte - AL. The sample was calculated from a universe of 350 adult women, who make up the quilombola community of Santa Luzia do Norte - AL. It was calculated a sampling error of 5%, 95% confidence level, population distribution in 80%, given the homogeneity of the group, reaching a total of 145 women, adding an increase of 10% in the loss of forms, arrived up to a total of 159.5, rounded up to 160 women. The study was made after approval by the Ethics and Research Committee (ERC) of CESMAC University Center, obtaining approval on 03/15/2019 under CAEE nº 07351019.5.0000.0039.

2.1. Data collect

Visits to the community were made to carry out the mapping, from April 2019 to November 2019. After scheduled meetings were held, and all the women were informed about the research data and agreed to participate in the research, the women were invited to sign the Free and Informed Consent Term (FICT), issued in two copies, one copy for the researcher and one for the volunteer. The FICT was based on the guidelines of resolution CNS/MS 466/12.

Older women over 18 years of age, with no age limit, quilombo resident, black ethnicity or who self-identified as black were considered to participate in the research. As an exclusion criteria: women who would only visit the quilombo community, women of non-quilombola origin, even if they were related, that is, those women who married quilombola men and started to live in the quilombo could not participate in the research.

2.2. Data collection instrument

The instruments to collect the data were applied individually, in a single meeting, with a maximum time

of 30 minutes per interviewee. A form was applied to collect sociodemographic data on health conditions, consisting of questions about sociodemographic aspects, environmental character, general health conditions and self-perceived health (PHC), with a Likert-type answer, tabulated in: 1 - excellent, 2 - good, 3 - regular, 4 - bad. It was considered as a negative perception of health status to refer your health as regular or bad and as positive to refer to health as good or excellent. Although it is subjective, PHC is considered effective and fast and accepted in the scientific world. The form still contained a question about what the interviewee would like to be changed in her environment, asked in this way: "What would I like to change in relation to the environment in which I live in right now?" that could be answered as wish.

The Quality of Life (QoL) questionnaire, The World Health Organization Quality of Life - WHOQOL-bref, comprising 26 questions, was also applied. The first question refers to quality of life in general and the second to satisfaction with one's own health. The other 24 are divided into the domains: physical, psychological, social relations and environment. The WHOQOL-bref has four types of response scale: intensity, capacity, frequency and evaluation, all graded in five levels. These scales are of the Likert type, from 1 to 5, with the intensity scale ranging from nothing to extremely, the capacity scale ranging from nothing to completely, the rating scale from very dissatisfied to very satisfied and very bad to very good and the frequency scale varies from never to always. This instrument does not admit a total QoL score, considering the premise that QoL. is a multidimensional construct, therefore, each domain has an independent form.

2.3. Data analysis

For data analysis, they were inserted into the Microsoft® Office Excel 2016 program, where they were tabulated and transformed into tables and graphs and analyzed using descriptive statistics, using the mean, percentage and absolute frequency.

3. Results and Discussion

The socioeconomic and demographic characteristics of the studied population are shown in Table 1. Quilombola women from the community of Santa Luzia do Norte – AL, had a mean age of 40.7 years (±17.25), predominantly adults, married (41.8%), who declared themselves black (51.8%), with incomplete primary education, working at home (63.1%), and with no income (35%).

The results observed for each age group, marital status and education corroborate the data presented by Santos et al. (2019). When evaluating the anthropometric indicators and socioeconomic factors of Amazonian quilombola women, the authors found an age group of these women between 30 and 39 years (31.25%), married marital status (53.12%), and incomplete primary education (49.99%), however, most Amazonian quilombola women (62.5%) work outside their houses (Santos et al., 2019), different from the results observed in the community of Santa Luzia do Norte – AL, where 63 .1% perform housework.

Table 1. Sociodemographic profile of women from the Quilombola community of Santa Luzia do Norte – Alagoas - Brazil.

VARIABLE		n- 160	%
		f	
Age	18-30	46	28.7
	31-42	42	26.2
	43-55	39	24.3
	57-80	33	20.6
Marital status	Married	67	41.8
	Single	56	35
	Stable union	15	9.3
	Widow	13	8.1
	Divorced	9	5.6
Ethnicity	Black	83	51.8
	Brown	65	40.6
	White	12	7.5
Education	Illiterate	34	21.25
	Incomplete elementary	83	51.8
	Incomplete high school	17	10.6
	Full high school	23	14.3
	Incomplete higher	3	1.8
Occupation	Housework	101	63.1
	Housekeeper	36	22.5
	Cook	6	3.75
	General Services Assistant	4	2.5
	Student	3	1.8
	Autonomous	2	1.25
	Seafood restaurant	2	1.25
	Retired	1	0.62
	Oral health assistant	1	0.62
	Nursing assistant	1	0.62
	Cleaner	1	0.62
	Artisan	1	0.62
	Gari	1	0.62
Family income	No income	56	35
	Relies on Social program	41	25.6
	< 1 minimum wage	17	10.6
	1 minimum wage	5	3.1
	> 1 minimum wage	41	25.6
Addictions	Denies addictions	152	95
	Alcoholism	4	2.5
	Smoking	1	0.6
	Did not want to answer	3	1.8

Caption: n = samble Number; f = absolute frequency; % = percentage.
Source: Survey data, 2019.

The high number of married women may be related to security and protection, given the inequalities and prejudices that these quilombola women suffer. In this case, marriage results in a social identity for these women. The low level of education observed is also in line with the findings by Kochergin et al. (2014), who, when evaluating five communities in the municipality of Vitória da Conquista in the state of Bahia, found that 31.6% of women did not have at least one year of complete education, 28.4% had 1 to 3 years of education and 28.6% had 4 to 7 years of education. In another survey conducted in a quilombola community in a northeastern state with 158 women, a low level of education was also observed among the women surveyed (31% without education and 43.7% with incomplete primary education), and a prevalence of married women of 71.5%. However, the number of women exercising outside was higher (43.7%) than the results found in this research (Tavares et al., 2018).

Data from the NSHS (National Survey by Household Samples), cited by (Tavares et al., 2018), highlights that the level of education recorded among quilombola women is much lower than the national average (51%) observed for people aged 25 years or more. According to the NSHS, incomplete education is frequent among the black or brown population, when compared to the white population, both with regards to complete higher education (8.8% against 22.2%) and illiteracy (9, 9% against 4.2%) (Tavares et al., 2018).

Women who affirmed an occupation "of the home" are occupied with household chores and taking care of the children. In line with these findings, Prates (2015) also observed in its work with quilombola women a portion of 84.61% of women who developed strictly domestic activities, as well as in the research by Bezerra et al. (2013). Another portion (25.6%) relies on a federal government social program, such as the Bolsa Família. These results are similar to those found in the study by Araújo (2017). Financial aid reduces the economic vulnerability to which these women and families are exposed, enabling better food and housing conditions. The unfavorable economic condition is an important social factor that negatively influences food, health and leisure in this community (Santos et al., 2016; Araujo, 2017).

Regarding these women's addictions, it was found that 95% of the interviewees denied any type of addiction, while 4 (2.5%) women claimed to drink alcohol as an addiction, and 1 (0.62%) claimed to be a smoker. The others (1.8% - 3 women) did not answer the question about addictions. In the study by Freitas et al. (2011) found moderate numbers of smokers (56.15%) and high rates of drinkers (82.31%), although the research does not differentiate the practice by gender, these results differed significantly from the findings of this research.

Oliveira et al. (2015) reports that the presence of non-alcoholics in their study was 68.4% and 75.9% of non-smokers, these data are similar to the findings of Melo and Silva (2015), when they reported that 50% of the studied group declared themselves non-smokers and 70% non-alcoholics and with the finding by Cardoso et al. (2015), who reported alcohol consumption by only 28.2% of the female population. This consumption is associated with male gender and cultural practices between generations.

Table 2 describes the living conditions and family members, in addition to the sanitation and trash collection system. It was found that Quilombola women from the community of Santa Luzia do Norte - AL, live in their own house (63.75%), with the majority of masonry (95%), with 4 to 6 rooms (81.25%) and with a family of up to 4 people

Table 2. Housing conditions, sanitation system and garbage collection.

VARIABLE		n=160	%
		f	
Type of housing	Masonry	152	95
	Taipa	6	3.75
	Wood	1	0.62
	Reutilized materials	1	0.62
Nº of family members	1-4	112	70
	5-8	44	27.5
	9-13	4	2.5
House ownership situation	Own	102	63.75
	Leased	31	19.37
	Assigned	25	15.62
	Invaded	2	1.25
Number of rooms in the house	1-3	23	14.37
	4-6	130	81.25
	7-9	7	4.37
Water supply	Community water tank	75	46.8
	Artesian well	74	46.2
	Natural	9	6.25
	Cistern	2	1.25
Water cleaning process	Supply system	81	50.6
	No treatment	42	26.2
	Chlorinated by the resident	32	20
	Filtered	5	3.12
Sewerage	Traditional cesspool	121	75.6
	Open sewer	36	22.5
	I do not know the answer	3	1.87
Garbage collection	Collected by the city hall		
	Buried	158	98.7
	Burned	1	0.62
		1	0.62

Caption: n = sample number; f = absolute frequency; % = percentage.
Source: Survey data, 2019.

(70%). When asked about the water supply, 46.8% of respondents said that the water came from the community water tank, treated by the city's supply system (50.6%). As for sanitary sewage, it was observed that it is carried out through a traditional cesspool (75.6%) and trash collection is carried out by the city hall, according to 98.7% of the interviewees.

Unlike the findings by Magalhães Filho and Paulo (2017) where most houses were owned, the predominance of masonry constructions demonstrates good structure in housing conditions, corroborating the results found by Araújo (2017), Silva (2015a), Araújo et al. (2017). Masonry houses in quilombola communities are not often found, many studies point to the predominance of mud or adobe houses (Bezerra et al., 2013; Cardoso et al., 2015; Araújo, 2017). In his research, Ferreira (2014), found an average of 4 to 5 rooms per house surveyed, however, this number is very variable, as Silva (2007) states, who found the presence of one to fourteen rooms in the residences surveyed.

Although a large portion of the interviewees stated that the water came from the city's supply system, added to all other sources of supply, which are sought by supply failures, such as well, spring and cistern, add up to a percentage of 53.7%. This finding corroborates the studies by Amorim et al. (2013), Santos and Silva (2014). According to data from the Brasil Quilombola Program (BQP.), 55.21% of quilombola households do not have running water (Silva, 2015b). The lack of piped water supply that leads to the search for other inadequate sources adds to the poor conditioning of the liquid (Ferreira, 2014).

The well mentioned by the residents is located at the back of the community's health center and is next to the unit's cesspit, the spring used for water collection is also used for washing clothes, bathing animals and leisure for the community, suffering contamination and can be a vector of contamination and proliferation of waterborne diseases. For Ferreira (2014), sources, streams and springs when associated with environmental degradation can suffer water contamination by parasites, such as schistosomiasis, a fact to be thought of, as the community is considered an endemic area for schistosomiasis. The perception that water is potable and that it is not treated has caused diseases through its various uses, mainly in rural areas (Magalhães Filho and Paulo, 2017). The addition of chlorine to water, an action performed by a minority, presents a series of benefits to human health, as the chemical element inactivates and kills micro-organisms (Ferreira and Pantaleão, 2016).

Although most women stated that the collection of waste was done by septic tank, it is common to observe in the community open sewers. The lack of adequate sanitary sewage contributes to the contamination of soil, water and crops, causing human contamination and the transmission of diseases through water and food. Basic sanitation is an important instrument to mitigate or prevent the contamination of environmental systems (Silva, 2015b; Santos and Silva, 2014; Magalhães Filho and Paulo, 2017). Garbage collection reduces the presence of house flies, mosquitoes, cockroaches, scorpions and rodents, vectors that contribute to human contamination (Ferreira and Pantaleão, 2016). Ceretta apud Silva (2015b) says that burning or burying garbage has a negative impact on the environment, as it can contaminate the soil used in agriculture, the basic livelihood of the communities.

The health conditions of quilombola women in the community of Santa Luzia do Norte – AL, was also researched (Table 3). The presence of some type of disease was reported by 51.25% of the women interviewed, with systemic arterial hypertension (SAH.) isolated or associated, being the most mentioned disease. When all forms of presentation of arterial hypertension are added, this percentage was 43.5%. These findings are in line with the data found by Bezerra et al. (2013), in their studies in a quilombola community, whose authors found an index of 38.5% for arterial hypertension. According to Borges (2011), the Brazilian population has been experiencing changes in eating habits, which has caused an increase in the prevalence of blood pressure and Diabetes Mellitus, and quilombola populations have been suffering impacts to a greater or lesser degree from Chronic Non-Transmissible Diseases (CNTDs), responsible for the increase in morbidity and mortality rates on the planet.

Table 3. Presence of diseases and perception of health among women surveyed.

VARIABLE		n=160	%
		f	
	Absence of any kind of disease	76	47.5
Self-reported diseases	SAH	45	28.1
	SAH+ D.M.	14	8.7
	SAH+ depression	6	3.7
	Heart disease	4	2.5
	SAH+ Heart disease	2	1.2
	Depression	2	1.2
	SAH+ D.M. + Heart disease	1	0.6
	D.M.	1	0.6
Health perception	Heart disease + verminose	1	0.6
	SAH+ verminose	1	0.6
	Arterial hipotension	1	0.6
	Osteoporosis + arthritis + Lung cancer	1	0.6
	Gastritis	1	0.6
	SAH + thyroid disease	1	0.6
	Did not answer	2	1.2
	Excellent	11	6.8
	Good	47	29.3
	Regular	79	49.3
	Bad	15	9.3
	Did not answer	8	5.0

Caption: n = sample number; f = absolute frequency; % = percentage; SAH = Systemic arterial hypertension; D.M. = diabetes mellitus.
Source: Survey data, 2019.

For Barros (2012), knowing the perception of the environment in which they live is important to know the expectations, desires and dissatisfaction of individuals, as well as the dissatisfaction and behavior absorbed by them. The perception of health was also surveyed among the volunteers, where the following question was asked: "How do I consider my health?", and 5 alternative answers were offered, namely: bad, regular, good, excellent and I don't want to answer. The answers were grouped as follows: negative perception (bad and fair) and positive perception (good and excellent), this grouping, in this way, allows the choice without an intermediate possibility (Oliveira et al., 2015).

As shown in Table 3, 15 (9.3%) women said it was bad, 79 (49.3%) of them answered that it was regular, 47 (29.3%) that it was good, 11 (6.8%) stated that it was excellent and 8 (5%) of them did not wish to respond. When analyzing the responses with the variables negative and positive perception, it can be seen that the prevalence was 94 (58.75%) women with a negative perception of their health. In a study carried out with quilombolas in Minas Gerais, an index of 46% of negative health perception was found. The perception of negative health is related to aging, and in the sample studied 20.6% was already in the elderly age group, another aspect that can be considered is the presence of chronic diseases as an aggravating factor for the negative perception of health (Batista et al., 2013; Loyola Filho et al., 2013).

The use of medication by quilombola women in the community of Santa Luzia do Norte – AL was also evaluated (Table 4). Regarding the use of medication, the majority (63.7%) of the women denied using it, but the use of antihypertensive, antidepressant, hypoglycemic, anti-vertigo, contraceptive, anxiolytic and bronchodilator were mentioned. The frequency of drug use by Quilombola women was approximately 30%, lower than that of the Quilombola population in Bahia, which was 41.9% (Medeiros et al., 2013; Morbeck, 2014; Bermudez and Barros, 2016). This fact can be explained by the high rate of women who denied taking medication, or by the use of medicinal plants by the community, a frequent and traditional habit, reported by the women surveyed.

Table 5 describes the results of the domain scores of the World Health Organization Quality of Life (WHOQOL-bref). The instrument is formed by two general facets on the self-assessment of QoL. (Quality of life) through the questions: "How would you rate your quality of life?" (quality of life facet) and "How satisfied are you with your health?" (global health facet), and 24 facets that make up the Physical, Psychological, Personal Relations and Environment domains. In the facet about QoL the score was 3.02 and the global health score was 3.08.

The general facets were represented by the Physical (Pain; Discomfort; Energy and Fatigue; Sleep and Rest; Mobility; Activities of Daily Life; Dependence on Medication or Treatment; Work Capacity), Psychological (Positive feelings; Thinking, learning and memory) ; Self-esteem; Body image and appearance; Negative feelings; Spirituality and religion), Social relationships (Personal relationships; Social support (support) and Sexual activity) and Environment (Physical safety and protection; Home environment; Financial resources; Health care and social; Opportunity to acquire new information and skills; Participation and opportunities for recreation/leisure; Physical environment - pollution/noise/traffic/climate and Transport).

When the score of the 4 domains were evaluated, it was noticed that they all had values close to 3, thus demonstrating a regular perception of QoL. When the physical domain was evaluated in isolation, it had a score of 3.18, a regular mean. The generated average represented the isolated scores of the researched components, namely: Pain and discomfort (2.71); Energy and fatigue (3.0); Sleep and rest (3,2); Mobility (3.5); Activities of everyday life (3.0); Dependence on Medication or Treatment (3,2); Work Capacity (3.1). It is noticed that the lowest score was

Tabela 4. Description of continuous use medications reported by research volunteers.

VARIABLE		n=160	%
		f	
Continuous use medications	Denies the use of medications	102	63.7
	antihypertensive	28	17.5
	Antihypertensive + antidepressant	9	6.6
	Antihypertensive + hypoglycemic	5	3.1
	antidepressant	4	2.5
	anti-vertigo	4	2.5
	contraceptive	2	1,2
	anxiolytic	1	0.6
	Bronchodilator	1	0.6
	I don't want to answer	4	2.5

Caption: n = sample number; f = absolute frequency; % = percentage. Source: Survey data, 2019.

Tabela 5. Quality of life scores of quilombola women measured by the World Health Organization Quality of Life instrument (WHOQOL-bref).

VARIABLES	n - 160	
General facets	**Average**	**Min-Max**
How would you rate your quality of life?	3.02	1-5
How satisfied are you with your health?	3.08	1-5
WHOQOL-bref domains	Average (SD)	Min-Max
Physicist	3.18 (0.69)	2.14-4.14
Psychological	3.40 (1.11)	1.66-4.16
Social relationships	3.45 (1.41)	1.33-5
Environment	2.59 (1.35)	1.24-4.1

Caption: n = number; SD = Standard deviation; Min = minimum; Max = maximum. Source: Author's data, 2019.

found in the component pain and discomfort followed by energy and fatigue, although when comparing the variables of diseases and medications, no diseases that directly contribute to pain are found, or there is no information on the use of analgesic medications. Perhaps this can be attributed to the lack of physical activity, the work performed, as most were housewives or maids, or even the presence of chronic diseases, which contribute to the perception of discomfort. The perception of the disease and how it can progress, or how the sequelae can be installed can become a relevant factor influencing activities of daily living (AoDL) and work. Chronic non-communicable diseases (NCDs) are responsible for a lower QoL due to the length of the disease or the specific changes of each one (Azevedo et al., 2013).

The psychological domain, represented by the following domains: Positive feelings (3.12), thinking, learning, memory (3.64), Self-esteem (2.8), Body image and appearance (3.65), Negative feelings (3, 54), Spirituality and religion (2.25). It is noticed that the lowest scores were in the items Spirituality and religion followed by self-esteem and the highest score was obtained in Body image and appearance. In this domain, the lowest score was for the item self-esteem, followed by spirituality and religion, and the highest was body image and appearance.

The African people, more specifically the enslaved, were prevented from practicing their religious cults, for this they were baptized and forced to participate in Catholic masses and religious festivals. One way to circumvent this prohibition was to cultivate their religiosity in the slave quarters and mix Catholic saints with orixás. Thus, religious syncretism was born, which became a way of survival for African cults (Oliveira, 2009; Jensen, 2011). Although it has survived and adapted, the African religion in Brazil has always suffered prejudice and went through many phases of persecution, where religious leaders and their praying sites (terreiros) were closed. This persecution strengthened prejudice and increased the religious root that was hidden and often replaced by other cults.

Studies show that 59% of evangelical churchgoers are black women (Balloussier, 2020). This may contribute to the explanation that the item spirituality and religiosity had such a low score in the sample. The community does not have space for the practice of an African-based religion, the terreiros. However, they have an evangelical church and had a space to celebrate the mass, which was later overturned with the promise of raising a Catholic church. During the interviews, it was noticed that the issue of religion was a sensitive point for the community, where some women complained about not being able to develop the practice of Candomblé due to the prejudice of the community itself and other residents of the city. For Silva (2017), religion could be a way of strengthening the relationship established between cultures, contributing to the improvement of social life and collective behavior.

For Cruz et al. (2011), low self-esteem may be associated with a negative mood, negative perception of disability and depression, especially by the elderly. It is also possible that low self-esteem is related to the precariousness of health conditions and infrastructure in the communities. The low self-esteem in the black population comes from racism, which cultivated an aversion behavior towards people with black skin, directly affecting black women and the way they see themselves. Low self-esteem affects mental health, generating feelings of inferiority, insecurity, depression and putting an end to the refusal of black identity (Queiroz, 2019). Lucena (2010) states that the higher the level of education, the higher the self-esteem, which may corroborate to explain the low self-esteem of the study group, where 73.05% of women were illiterate (21.25%) or had incomplete elementary school (51, 8%). Body image and appearance could be related to self-esteem, but paradoxically the score was higher.

The social relationships domain reached the highest rate, with a score of 3.45. This domain covers facets such as personal relationships (3.7), social support (3.3) and social activity (3.2). This can be explained by the strong kinship and support ties that involve the quilombola community, especially among women, who remain firm in daily support and routine activities (Sardinha et al., 2019). Corroborating the findings by Santos et al. (2016), who had higher scores in the social relationships domain, when researching elderly quilombolas in Vitória da Conquista – BA. For Silva (2015b), there is a need for socialization within the community. The relationship between relatives and friends, the proximity between families, guarded by kinship, increase the sense of belonging to the community, and consequently, raise the perception of better social relationships (Bortolotto, 2017; Torales et al., 2018).

The environment domain was the one that suffered the most negative impacts, reaching a total score of 2.59, being the domain with the lowest score amongst them all. It includes the items of physical safety and protection (2.98), home environment (2.92), financial resources (1.87), health care (2.73), opportunity to acquire information (1.86), participation and opportunities for recreation and leisure (2.72), physical environment (2.95). Quilombola communities are located in remote regions and even quilombos considered urban centers at a significant distance away from them. This distance influences the scarcity of opportunities, as well as access to information.

It was demonstrated by Maia (2011), in his study that the negative self-assessment of QoL is related to low income. Bortolotto (2017), states that domestic care, care with production, with the family, which do not generate income, exposes women to dissatisfaction and increase the probability of feeling discontent, in addition to the lack of transport and leisure. Corroborating with Freitas et al. (2018), who observed in their study that quilombola women work in a domestic environment, staying more at home, while men have leisure in sport. In the researched quilombo there are no spaces for leisure, except for religious festivities and some cultural activities developed by some of the members. In general, this domain is influenced by other factors, such as: lack of basic sanitation, difficult access to health, and low income.

4. Conclusion

The investigated population demonstrated to be composed of adult women, married, with low education,

with their own house, of few rooms and precarious infrastructure, responsible for the housework, without income or assisted by social programs, who believe that their perception of health is regular and desirous of changes that go from access to health, to water supply and basic sanitation. These women are a reflection of the reality found in many communities, demonstrating that the opportunities arising from recognition were not equal for all traditional populations, and many still suffer from invisibility and social inequity.

It was also noticed that the quality of life, being multifactorial, was affected in its various domains, where the highest score, despite the little difference between them, was in the social domain, certainly strengthened by the bonds and trust that unite the families of the community. It was also noticed that the domain with the lowest score was that of the environment, which corroborates the confirmation that the infrastructure, related to the lack of access to health, transportation, leisure, and mainly, income, negatively influence the QoL.

It is known that researches that profile and seek to know the quality of life of a population, can be used as indicators for social change, through public policies. But, it is necessary that not only public policies are thought out, but that they are fulfilled and directed to real needs, with regards to the difficulty of access to education, with the purpose of continuing to complete the educational cycle, that employment opportunities and income are generated, that access to health is equitable and that the availability of treated water at home is real.

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