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RESEARCH ARTICLE

Conceptions About Health and Care Practices of Black Men from a Quilombola Community

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Abstract:

Introduction:

Universal health coverage will be guaranteed to all individuals, safeguarding the rights of traditional communities, as in the quilombola population, respecting the dimensions of interculturality, gender and ethnicity.

Objective:

The aim of this study is to describe the conceptions of health and health care practices of Afro-Brazilian men from a quilombola community.

Methods:

This was a qualitative descriptive study conducted with Afro-Brazilian men from a quilombola community in Bahia, Brazil, where there is a significant concentration of black people and quilombola communities.

Results:

This group's conceptions of health are based on the combination of the individual body with the body that is socially and culturally situated in the community. Health care practices are anchored in cultural knowledge and strengthened by the bonds with nature, friends and religious leaders.

Conclusion:

The black men from quilombola communities are in a state of vulnerability due to the lack of access to health services.

Keywords: Descriptors, Health care, Men's health, Health of the male population, Health of ethnic minorities, Group of ancestors from the african continent.

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1. INTRODUCTION

Brazil is an intercultural country with an extensive, diverse and rich geographic territory occupied by an ethnically-racially mixed population, which has been experiencing expressive processes of transformation affecting the traditional communities, such as the indigenous, riverine, black and quilombola

populations [1]. This phenomenon leads to demographic imbalance, which reveals the impact of violence, land exploitation, water pollution, agribusiness, rural exodus, unbridled industrialization, genocide, and others [2].

Due to the political and social transformations in the country affecting the formation of the population's identity, being black has been synonymous with resistance to stigmas and structural racism, which is a historical and cultural legacy of slavery. In this sense, the construction of Black identity has

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been permeated by the silencing and denial of the self. This process has severe repercussions to the health of this population, with significant effects on mental health, due to mental suffering, hostility and iniquities, which persist to this day [3].

The Brazilian ethnic composition, which results from the confluence of people with different ethnic origins, permeated by immigration and colonization processes, reveals that the country has the largest black population outside of Africa, especially in the Northeastern region [4]. In spite of this, the country's black and indigenous populations still live at a disadvantage, having been heavily exploited since colonial times.

The quilombola communities symbolize the permanence and resistance of the Brazilian black population, which is determined to protect its ethnic and cultural values, rooted in African culture, surviving violence, xenophobia, racism, religious intolerance, persecution and domination [5].

Quilombos can be found in several Brazilian states, with 3,411 communities certified by the Palmares Cultural Foundation, 63% of them in the Northeastern region. Estimates reveal that there are 214 thousand quilombola families and 1.17 million quilombola individuals in Brazil [5]. According to these data, the identity of this population is directly related to the cultural, geographic and social context in which they are inserted.

Mostly rural, the quilombola communities suffer socioeconomic disparities, and live without the assistance of government agencies in large part of Brazil. Changing the dynamics of these traditional communities would cause a severe cultural shock, capable of modifying the social dynamics and the maintenance of their ancestral origins and existence [6].

The role of the Black Movement, the creation of policies of racial affirmation in Brazil (such as racial quotas in universities), the National Policy for the Provision of Comprehensive Care to the Black Population, and affirmative actions developed by groups of black individuals contributed to the reaffirmation of the Afro-Brazilian identity in all regions of the country. In the last demographic census, the number of people who self-reported as being of color grew, of whom 19.2 million self-reported as black and 89.7 million as brown/mixed race, representing 56.10% of the total Brazilian population [7].

Considering the magnitude of the number of black people in Brazil and the breadth of the social and health problems associated with the provision of care to traditional communities, health professionals need to be trained to culturally adapt the care provided to behavioral, family, affective, religious, housing, health and living conditions. Basing health care practices on ethnic, transcultural and/or cultural standards requires that the value assigned to health care and the beliefs about health, well-being and behavior expressed by populations are comparatively analyzed [8].

The use of theoretical frameworks such as the Transcultural Nursing Theory to support professional practice has revealed the particularities associated with cultural heritage, offering the opportunity to find a way of providing

care to a population that is consistent with its worldview, contributing to the maintenance or recovery of health, in socially-culturally adapted conditions that are accepted by this population and beneficial to its customs [8].

This premise implies that nurses should participate by transposing their theoretical knowledge about the provision of care to the transcultural field of human needs, values, beliefs and lifestyles, promoting cure-centered care practices while considering the dogmas, behaviors, social representations and living conditions that characterize the culture of individuals, families and groups.

Specificities, rituals, symbols, meanings and uniqueness should be recognized and respected so that it is possible to identify the health needs of individuals. When it comes to the health of black men, it is important to reflect on the way black masculinities are constructed in Brazil, in order to highlight the references and attributes on which the narratives, behaviors and practices shaping the identity of these men are based [9 - 12]. The National Policy for the Provision of Comprehensive Care to Men (PNAISH) was established in 2009 to recognize the multiple masculinities and promote the importance of expanding the male population's access to the Brazilian health care system [13].

This has allowed redirecting health education and promotion actions focused on men's health by raising the awareness of public managers, technical supporters and health professionals throughout the country, in particular the regions with a greater presence of Afro-Brazilians.

To plan, organize and implement the transcultural provision of care to quilombola men, this study was guided by the following research question: how do black men from a quilombola community perceive health and health care practices? Thus, answering this question is the aim of the present article.

2. METHODS

This was a qualitative descriptive study, conducted with black men from a quilombola community in Bahia, Brazil, where there is a significant concentration of black people and quilombola communities. The study is part of a larger project entitled: "Therapeutic Itineraries of Quilombola Men in a City in Bahia, Brazil".

The quilombola community Baixa da Linha self-defines as the remnants of a quilombo, being certified by the Department of Protection of the Afro-Brazilian Heritage. It is composed of 107 self-sustaining families living next to a railway line, which is considered an important archaeological site where funerary urns have been discovered [14]. Currently, there are 215 men, 181 women and 40 children and adolescents in the community, with a total of 119 households. The access to health care is inadequate due to the absence of a Family Health Unit and the distance from 24-hour Emergency Health Units (UPA) and hospitals [15].

Fifteen men who self-reported as black participated in the study, with ages ranging from 20 to 49 years. They had not finished primary education, were catholic, and worked as rural laborers, with an average family income of up to three

minimum wages. The participants were chosen for being the leaders and representatives of their community. It should also be noted that due to this being a traditional community with a small population contingent, this group of men also participated in the empirical investigation.

The study included adult men with quilombola ancestors who lived and actively participated in the community, while those with clinical symptoms and emotional instability were not included. The contact with the participants happened through the main researcher's involvement within the community, which was informed about the study and invited to participate during visits.

Since the men in the community are socially isolated, the participants selected were indicated by the community's leaders, and asked to sign the informed consent form prior to data collection. In addition to the records of the individual interviews with each man, field notes were also made. These notes were used to complement the analysis and interpretation of the results.

To ensure the quality and scientific rigor of the collection and analysis of the theoretical data [16], the study followed the guidelines of the Consolidated Criteria For Reporting Qualitative Research (COREQ). The data were obtained from in-depth interviews, which took place in the participants' homes and open spaces, with the presence of one of the community's leader, lasting from 15 to 40 minutes. All interviews were recorded and fully transcribed by one of the authors and a previously trained assistant.

The empirical material was organized and systematized with the support of the NVIVO Software11, and analyzed using the Discourse of the Collective Subject (CSD) method, which consists in the representation of the thoughts of a group based on the synthesis of the similarities identified in the discourse of different people.

In the CSD method, the data is subjected to a rigorous analysis that begins with the identification of Key Expressions, which reveal the concept or nuance of the investigated phenomenon. When grouped together, these Key Expressions outline the Central Ideas, which in turn are structured by the Anchors and represent the thoughts of a social group in a given historical context [17 - 19].

Based on this methodological structure, the findings presented in this study reveal the discursive fragments of a group, having been validated by the research team, composed of three PhDs, three MSc and one undergraduate student, and interpreted according to the Transcultural Nursing Theory [20 - 22].

In his study, Leininger observed specific aspects of culture and found significant elements of cultural differentiation between peoples, which allowed understanding their health care practices from the perspective of transculturality [23].

When considering that the participants of this research are Afro-Brazilian men who belong to a traditional community, with its own cultural-ethnic knowledge, norms, traditions, habits and behaviors, this theoretical framework has the necessary density and solidity to support the interpretation of

the findings of the study.

This research was authorized by the leaders of the quilombola community Baixa da Linha and by the Health Department of the city of Cruz das Almas, Bahia, Brazil, and approved by the Research Ethics Committee under opinion No. 1.787.351. To preserve the participants' anonymity, they were identified according to the CSD's coding system, that is: "CSD of black men from a quilombola community".

3. RESULTS

The men's collective discourse revealed expressions and health care practices structured within the ethnic and cultural dimensions. These expressions pertain to well-being, quality of life and institutional health care, while the health care practices consist of measures adopted to deal with health-threatening situations or the onset of illness, increasing the demand for health professionals and services.

3.1. Central Idea 1A: Conceptions of Health

The men perceived health as one of life's central meanings, manifesting as well-being, quality of life, calmness and happiness, and permeated by the concept of strength and absence of pain.

Health is everything in my life, without health, we are nothing. To be healthy means to be well, live well and feel happy and calm; to feel strong, and not know what it is like to feel pain. (DSC of black men from a quilombola community).

3.2. Central Idea 1A: Conceptions of Health care

When asked about health care practices, the men referred to institutional health care, characterized by the difficulties in ensuring their access to services and associated with distancing and lack of sanitation.

I rarely go to health services, because the health center we had here has closed down. We lack sanitation, support and health care. They do not offer us anything, even the Community Health Workers' support is lacking. (DSC of black men from a quilombola community).

3.3. Central Idea 1A: Health Care Practices Focused on the Promotion of Well-being and Quality of Life

The men's health care practices, on the one hand, are focused on the promotion of individual well-being; on the other hand, they seek a balanced collective life.

I eat well, sleep well, drink plenty of water and try to regularly exercise, as in, walking, jogging, playing soccer, trying to be active most of the time and going out with friends. I work and try to cut back on financial expenditures, which allows me to live in peace within my community, all of this thanks to God. (DSC of black men from a quilombola community).

3.4. Central Idea 1A: Health Care Practices Focused on Solving Health Issues

When they need to solve health problems, the men resort to vitamins, teas, friends, prayer and religious temples, only

seeking medical examinations after exhausting all other options.

To solve my health problems, I try to take care of myself by taking some vitamins and drinking a lot of tea. If I am in pain, I seek help from friends and sometimes from prayer. In situations like these, I also resort to the church, and only as a last option, I seek medical care. (DSC of black men from a quilombola community).

3.5. Central Idea 1A: Health Care Practices in Illness Contexts

The onset of illnesses leads the men to resort to health care practices centered on the consumption of teas and rest, with restricted use of medications and detachment from institutional health services.

When I get sick, my first choice of treatment is tea and trying to get some rest, and if this does not work, then I take some medication, but only in extreme cases. Since the health center has closed down, I seek medical care in the Emergency Health Unit, which lacks everything and is too distant from the community, so I rarely go there and just keep trying to solve the issue gradually, on my own. (DSC of black men from a quilombola community).

The conceptions of health and health care practices presented by the men in each category are illustrated in the

“word cloud” below (Fig. 1), which expresses the essence of the phenomenon based on the central ideas of the study:

4. DISCUSSION

The discourse of the black men living in the quilombola community has a dimension of totality, understood as essential to the maintenance of the human condition and capable of ensuring well-being, quality of life, calmness and happiness.

These aspects show a close relationship between the cultural practices of communities and special manifestations of health care, revealing their perception of well-being, understood from a theoretical point of view and based on the concept of sociocultural dimensions [1]. This context refers to the construction of dynamic, holistic and inter-related models of organizational factors present in a culture, which guide the decision-making process and allow health professionals to provide care to a population while considering its needs and customs.

Although the men revealed a positive perception of health, it was not necessarily correlated with their adherence to health care, when considering the sociocultural, political and territorial conditions of access to health resources, for example, as these communities are settled in a rural context, which implies geographic isolation, leading to social inequality, vulnerability and lack to access to health services and/or family health services with a transcultural focus [24 - 27].



Fig. (1). Word cloud created in NVIVO®, version 11 – Frequency of the words present in the collective discourses, 2020, Salvador, Bahia, Brazil.

Note: The English translation of the words in the figure is: health care, well, distant, everything, service, pain, tea, friends, health, soccer, support, feel, take, drink, seek, community, assistance, field, constantly, good, activity, food, help, active, absent, eat.

The discourses reveal the men's view of the concept of quality of life as a way to promote the well-being of individuals, interpreting a healthy lifestyle, which they associate with good nutrition, physical activity, adequate rest, spiritual development and respect for others, as a manifestation of the opportunity to live at peace with themselves and the community, being thus correlated with the notion of happiness [28 - 30]. As the perception of quality of life is based on the memories and daily activities of communities, it is associated with cultural cohesion and unification, giving new meanings to habits through permanent intercultural dialog, from a perspective of social equality [31, 32].

Considering the above, how do quilombola men express their health needs and incorporate them into their everyday lives? What is the influence of the conceptions of health expressed by them on their self-care practices? To answer these questions, it is important to recognize what a conception is, how the men express their conceptions of health, and how these conceptions reverberate in actions, attitudes and behaviors.

The men understand health as being associated with strength and the absence of pain, which demonstrates a masculinist thought process, permeated by the social construction of Brazilian masculinities. Although this perspective does not necessarily influence the subjects' actions despite being expressed in their discourse, it may still lead to the adoption of harmful attitudes, such as feeling invulnerable due to the absence of clinical symptoms, revealing its relevance to the construction of subjectivities and to the ways of caring for one's own health [33 - 36].

Regarding the men's perception of institutional health care, what is observed is a feeling of non-belonging and the absence of a bond with the local health facilities and professionals, as well as neglect of sanitary standards on the part of the health care network, and an insufficient understanding of the concept of universality of health. But ultimately, what are care-centered practices, and how are they structured? What is their specificity level when incorporated into the ethnic/racial, inter- and transcultural dimensions of the masculinity model?

Considering the men's sociocultural context and territorial, cultural and historical heritage, ethnic/racial markers and the influence of urbanization, technological progress and globalization, the health care practices adopted by them were revealed to be focused on the bodily dimension, involving physical exercises, social interactions (especially with friends), financial health (cutting back on expenses), and work. Additionally, some practices were structured within the spiritual dimension, involving religious temples and prayer as possible forms of treatment [37 - 43].

The association of these different dimensions allows the men to achieve inner peace and live in harmony with their community, supported by spirituality and their perception of God.

In this scenario, the concept of transcultural health care proposed by Leininger becomes relevant, as it is based on the notion that nursing professionals must use their praxis to transpose abstract notions into practical elements of the various

dimensions of social structure, ensuring cultural consistency in the provision of care. This requires understanding the paradigm's components in the light of the transcultural theory, without forgetting that the population's beliefs, values and health care practices must be recognized, accepted and assimilated. Furthermore, cultural competence is required to ensure the specificity, consistency, safety and reliability of care, according to the problems identified [20 - 24].

When experiencing health problems, the men living in the quilombola community primarily resort to alternative therapies such as the consumption of vitamins, plant-based medications and teas, as well as practices of a spiritual and religious character, such as visits to the church and prayer. Only after having exhausted these options, they adopt biomedical-clinical health care practices.

The development of cultural competencies, which requires knowledge of the culture of vulnerable populations, in addition to awareness, sensitivity, respect and compassion for unique and collective characteristics, is supported by strategies of elimination of discriminatory attitudes to overcome socio-cultural inequalities, thus contributing to the processes of intercultural adaptation or negotiation and promoting beneficial and satisfactory results [44].

The cultural dimension of the social structure and organization of quilombola communities includes the comprehensiveness and functional dynamics of their culture, in which men recognize the importance of filial kinship, social support, religion and spirituality, expressed in measures related to the health-disease process, with perception of the health system as a last resource, also due to the geographical context, which is pervaded by inequality and social vulnerability, with absence of local health care services [20 - 24].

Cultural competencies allow combining the traditional and professional health care systems in favor of human life, from a perspective of comprehensiveness of care, in which customs, health and disease converge. Moreover, they also allow providing nursing care to the community to restore its well-being while considering its beliefs, values and cultural environment, restructuring or maintaining cultural health care practices based on the association of cultural awareness with knowledge and skills [45].

When experiencing the onset of illnesses, the men also resort to alternative therapies, which are individually implemented at their homes and/or in social spaces, avoiding self-medicating and seeking institutional health services, mainly due to the precariousness of the health care system.

When studying the health indicators in the quilombola population, a study found that the masculinity model prevailed in the physical dimension, observing its direct influence on the male perception of health, associated with the absence of pain, sickness or physiological discomfort [46]. According to the authors, the onset of illness mediates the cultural practices and values present in the daily life of this population and in its relationships with the environment [47]. Thus, it necessary to emphasize, as argued by Leininger, that the environmental context guides the human expressions and decisions in specific situations, seeing as the provision of cultural health care is vital

to the well-being, health, growth and survival of populations [20 - 24, 48].

The men in this study combined their cultural knowledge and health practices with the knowledge obtained in the health units' formal subsystem. In this sense, despite the influence of biomedical knowledge, the geographical distance limiting the access of these men to health units led to their preference for the adoption of cultural practices and to the absence of synergy between both types of knowledge, making them vulnerable to health issues [49, 50].

This vulnerability is associated with the lack of access of the community to intercultural health care practices provided by a health care team, in particular the nursing staff, that values its cosmogony, *i.e.*, the customs, beliefs and other elements of its social organization, which would positively impact the process of adjustment of lifestyles to achieve better results and reduce health risks [51 - 53]. Therefore, the team needs to recognize the specificities of the target communities and cater to them.

Regarding the access to institutional health services, such as Family Health Units, the men reported their absence in the territory where the community is located. In addition to this problem, geographical barriers hindering the access to emergency services were also mentioned, revealing the negligence, inequalities, structural racism and disregard for traditional communities associated with the weakening of social health policies [20 - 24, 48].

Moreover, the quilombola community rarely seeks health services not only because of geographical factors, but also due to the population's unawareness of their right to universal and equitable access to the health system, the discrimination associated with racism and low education level, and the lack of primary care units and family health programs.

The development of intercultural nursing programs to promote the development of competencies that allow nurses to provide care in contexts of diversity and universality represents an opportunity to change the situation of inequality and vulnerability quilombola men currently find themselves in.

Nonetheless, it is important to highlight the importance of promoting this population's adherence to preventive practices, ensuring that it seeks health services not only upon the appearance of diseases, as observed in the findings.

The limitations of this study include it having been developed in a single community and collecting data exclusively through interviews. Further studies using the triangulation of methods to produce and analyze empirical material are recommended.

CONCLUSION

The black men from the quilombola community studied associated health with the absence of pain and with feeling at peace with themselves and within their community. In this sense, this group's conceptions of health combine the individual body and the body that is socially and culturally situated in the community.

The men's health care practices are anchored in their

cultural knowledge, strengthened by the bonds with nature, friends and religious leaders, revealing the absence of a biomedical subsystem due to the geographic distance from institutional health services, such as those offered in primary health care units. Further, highlighting the situation of vulnerability in which they find themselves in, as a consequence of the omission of the State and the shortage of health policies protecting this population.

The provision of culturally consistent nursing care requires more than professional training, but also the cooperation between training agencies and the movement in defense of the rights of traditional populations.

This study points to the need of understanding the paradigms in the relationships between people, the environment, health and nursing, so that transculturality is recognized as a representative structure that is able to sustain the professional practice of nurses, allowing these professionals to acquire cultural competencies on which to base the provision of care.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This research was authorized by the leaders of the quilombola community Baixa da Linha and by the Health Department of the city of Cruz das Almas, Bahia, Brazil, and approved by the Research Ethics Committee under opinion No. 1.787.351.

HUMAN AND ANIMAL RIGHTS

The fundamental ethical and scientific requirements for research involving human beings were met, according to Resolution 466/12 of the Brazilian National Health Council.

CONSENT FOR PUBLICATION

Informed consent was obtained from all participants.

AVAILABILITY OF DATA AND MATERIAL

Not applicable.

FUNDING

Not applicable.

CONFLICTS OF INTEREST

Not applicable.

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Not applicable.

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