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Social representations of health care by quilombola women[a]

Representações sociais do cuidado em saúde por mulheres quilombolas

Representaciones sociales de la atención de salud de mujeres quilombola

Ingrid Fabiane Santos da Silva[1]
Ivaneide Leal Ataíde Rodrigues[2]
Laura Maria Vidal Nogueira[2]
Hilton Pereira da Silva[3]
Iaci Proença Palmeira[2]

1. Universidade Federal do Rio de Janeiro, Programa de Pós-Graduação em Enfermagem. Rio de Janeiro, RJ, Brasil.

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

3. Universidade Federal do Pará, Programa de Pós-Graduação em Antropologia. Belém, PA, Brasil.

Corresponding author:
Ingrid Fabiane Santos da Silva.
E-mail: ingridenfermeir@gmail.com

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Abstract

Objective: To analyze the social representations of quilombola women about health care. **Method:** this is a descriptive qualitative study that was carried out between November 2017 and January 2018 in the quilombola community Abacatal/Aurá, in Ananindeua, Pará State, Brazil. Thirty women who experience health care participated. Data were produced via individual interviews, submitted to thematic analysis, and discussed based on the Social Representations Theory. **Results:** representations were organized into three dimensions: affective, the most representative, where relationships of affection and feelings were anchored; social, in which care was perceived as a practice inherent to women; and biological, with care being understood as general care for disease prevention and treatment. **Conclusions and implications for practice:** the representations of health care showed a strong affective charge, denoting a preservation sense of life and environment, referred to an identity of care for the female gender and, even though a minority, revealed habits and endorsed hygienist actions by the technical-scientific discourse intertwined with traditional knowledge. These aspects bring singularities that nursing must consider, as it acts and (re)produces comprehensive health care for individuals and their respective groups.

Keywords: Nursing; African Continental Ancestry Group; Women; Psychology, Social; Health of Ethnic Minorities.

Resumo

Objetivo: Analisar as representações sociais de mulheres quilombolas sobre o cuidado em saúde. **Método:** consiste em um estudo descritivo, qualitativo, realizado entre novembro de 2017 e janeiro de 2018 na comunidade quilombola Abacatal/Aurá, em Ananindeua, cidade brasileira do Estado do Pará. Participaram 30 mulheres que vivenciavam o cuidado em saúde. Os dados foram produzidos a partir de entrevistas individuais, submetidos à Análise Temática e discutidos à luz da Teoria das Representações Sociais. **Resultados:** as representações foram organizadas em três dimensões: afetiva, a mais representativa, em que se ancoraram relações de afeto e sentimentos; social, na qual o cuidado foi apreendido como prática inerente à mulher; e biológica, sendo o cuidado compreendido como cuidados gerais de prevenção e tratamento de doenças. **Conclusões e implicações para a prática:** as representações do cuidado em saúde evidenciaram forte carga afetiva, denotando um sentido de preservação da vida e do ambiente, identificando com o cuidado o gênero feminino e, ainda que de forma minoritária, revelando hábitos e ações higienistas referendadas pelo discurso técnico-científico entrelaçado com os saberes tradicionais. Esses aspectos trazem singularidades que devem ser consideradas pela enfermagem, uma vez que esta atua com o cuidado integral à saúde dos indivíduos e seus respectivos grupos e (re)produz esse cuidado.

Palavras-chave: Enfermagem; Grupo com Ancestrais do Continente Africano; Mulheres; Psicologia Social; Saúde das Minorias Étnicas.

Resumen

Objetivo: Analizar las representaciones sociales de las mujeres quilombolas sobre el cuidado de la salud. **Método:** estudio descriptivo, cualitativo, realizado entre noviembre de 2017 y enero de 2018 en la comunidad quilombola Abacatal/Aurá, en Ananindeua, Pará, Brasil. Participaron treinta mujeres que vivencian el cuidado en salud. Los datos fueron producidos a través de entrevistas individuales, sometidos al Análisis Temático y discutidos bajo el prisma de la Teoría de las Representaciones Sociales. **Resultados:** las representaciones se organizaron en tres dimensiones: afectiva, la más representativa, en que se anclaron relaciones de afecto y sentimientos; Social, en la que el cuidado se percibe como una práctica inherente a la mujer; y Biológico, en que se entiende el cuidado como cuidados generales para la prevención y tratamiento de enfermedades. **Conclusiones e implicaciones para la práctica:** las representaciones del cuidado en la salud mostraron una fuerte carga afectiva al expresar un sentido de preservación de la vida y del ambiente, al atenerse a una identidad de cuidado para el género femenino y, aunque de forma menos expresiva, al revelar hábitos y acciones higienistas refrendadas por el discurso técnico-científico entrelazado con los saberes tradicionales. Estos aspectos presentan singularidades que deben ser consideradas por la enfermería, puesto que, actúa y (re)produce la atención integral con la salud para los individuos y sus respectivos grupos.

Palabras clave: Enfermería; Grupo de Ascendencia Continental Africana; Mujeres; Psicología Social; Salud de las Minorías Étnicas.

INTRODUCTION

Throughout Brazilian history, quilombos have emerged as territories of struggle and resistance against the slave system, reaching numerous areas of Brazil. These communities originated from groups with ancestors from the African continent and are considered a solid social organization of the black population that favors rescuing their culture and humanization. These communities use a peculiar way of care based on traditional health practices historically developed and passed on from generation to generation.[1]

Care is a way of acting that emerges from everyday experiences and from the specific way of life, historically and culturally linked to women. This type of care involves values, customs, traditions, and beliefs provided by a particular culture and is defined as cultural care and subsidizes the collectivity for maintaining well-being and coping with illness, disability, and even death.[2-4]

Health care in popular groups is a set of actions established in the culture and daily life of individuals and their collectivity, which are used for health maintenance to prevent illness in oneself and/or others. These practices are passed on from generation to generation and have women as their main propagator and practitioner, given they perpetuate this practice, which is considered common within quilombola communities.[3,4] Thus, it is understood that this care, due to its characteristics of construction by circulating knowledge, requires an approach through the lens of the social representations theory (SRT), developed and structured within the scope of social psychology.[5]

Social representations (SR) are understood as a form of knowledge of the consensual universe and different from that produced by formal science, called reified knowledge. They have a symbolic value when guiding a particular thought about the object of representation and a practical value when determining how one will act towards it.[5,6]

Every representation is a form of knowledge and understood as knowledge arising from common sense, a practical knowledge referring to the subject's experience built and shared in a society or a particular group. The purpose of these representations is to create a common reality for all individuals belonging to a social group and to mediate social relations in the macro (society) and micro (individual) spheres, such as behaviors, communications, identities, among others. Moreover, they establish a relationship of symbolization and interpretation with the represented object, since particular meanings and analogies are attributed to individuals who (re)signify it.[7] To generate SRs, such an object must transpose the sensory and cognitive spheres of representation to be consciously interpreted by the collective, which reproduces this object and gives it new meaning and significance from the universe surrounding the collectivity.[5]

Thus, it is understood that health care is an object of SR for quilombola women because it has cultural relevance in this group due to care being an essential element for the social role of women in the context of these populations. It is also considered that traditional health knowledge represents a way of thinking about the object, and the widespread practices related to it are the conformation of this object in the group's daily life because they are exercised and put into practice on a daily basis.

The study of SRs is a way to access the basic knowledge of people's daily lives. The practical objective is to understand and interpret the world around them as they carry with them the mark of belonging to the group and bringing their identity, on which their history, place, and function in society, as well as their collective and individual experiences, have an impact.[8]

All these issues influence the way of thinking of the subject, and it can be considered that thinking is not isolated from the social. Hence, the conception of health care goes through the consensual universe of people since each group establishes its way of caring for its health, adopting practices that directly influence the way this care is understood, implemented, and shared within the community. This conception is also a way of affirming the group's identity.[8]

It is crucial to investigate the SRs in the health care of quilombola women as there is little research in health and nursing on this theme. In addition, it is understood that there is a need for greater visibility for this group, public health policies aimed at them, and greater insertion of nursing in the production of health care that considers their knowledge and practices to contribute to improving the indicators of living conditions and health of ethnic minorities.

Quilombola populations have historically been vulnerable, and their health situation reflects the social, economic, and political conditions in which they have survived. In general, the remaining quilombola groups have some of the worst national epidemiological indicators, such as the prevalence of hypertension,[9-11] low education, and poor sanitation conditions.[12,13] However, there is still little data dedicated to this population segment that can help plan public policies more appropriate to their needs. In addition, it is noteworthy that, historically and socially, women have assumed the role of the caretaker of the home and family.[14]

In this context, this study aimed to analyze the SRs of quilombola women about health care.

METHOD

This qualitative descriptive study has the procedural strand of SRT for theoretical support and was based on consolidated criteria for reporting qualitative studies (COREQ).[5,15,16] The research complied with Resolution Nr. (CNS) 466/2012 and obtained institutional authorization from the Municipal Health Secretariat of Ananindeua/Pará and the Association of Quilombola Residents and Producers of Abacatal/Aurá (AMPQUA). The project was approved by the Research Ethics Committee of the Nursing course of the State University of Pará.

The study was conducted in the quilombola community of Abacatal/Aurá, which was certified and recognized as a quilombola territory in 1999 by the Land Institute of Pará (ITERPA). The community is located in the municipality of Ananindeua, roughly eight kilometers from its administrative center, and inserted in the metropolitan region of Belém, the capital of Pará State (northern Brazil).

The community was initially founded from the relationship between a sugarcane mill owner, Count Coma Melo, and one of his slaves, Olímpia, in the mid-eighteenth century. Three daughters were born from this union: Maria do Ó Rosa de Moraes, Maria Filistina Barbosa, and Maria Margarida Rodrigues da Costa, which originated the "Rosa," "Barbosa," and "Costa" family branches of the community. The territory of the old mill was left as an inheritance to the Count's daughters, and, until today, the descendants of these families are known as "heirs" because of the historical and consanguineous connection between the slave and the Count.[17]

Prior contact was established with the community in March 2017 from a health action by the Health Secretariat of Ananindeua (SESAU). At the time, an initial conversation about the research project and interest in carrying out the study in the community was planned with the community leader. The main author of this article conducted the research, and the approach to the participants was mediated by the leader, who had previously indicated the families and women using a nominal list. Thus, she collaborated as the key informant who, in research situations, can help researchers by providing important and precise information about a particular group, acting as a link between this group and the researchers.[18]

The participants were approached at home and invited to participate; the objectives, risks, and benefits were explained, and the informed consent form (ICF) was read and signed, which ratified their agreement to participate in the study. The interviews were recorded with prior consent and identified with an alphanumeric code, using the letter W for "woman" followed by a number corresponding to the order in which the interviews were conducted to preserve the participants' identity.

Quilombola women who met the adopted inclusion criteria were allowed to participate, being adults, over the age of 18, residents of the Abacatal/Aurá community, and descendants of the three original families of the community (i.e., "Rosa," "Costa," and "Barbosa," the so-called heirs). The universe of potential participants was 62 women, among whom 32 met the inclusion criteria, and 30 accepted and composed the study, representing 48.38% of the total universe. Two were excluded as they were not located in their homes after three attempts. We also considered the saturation criterion, considering that, besides the fact that the statements did not bring new aspects to generate differentiated analysis, the scientific literature foresees a saturation in qualitative research of between 20 and 30 interviews.[19,20]

Individual interviews were conducted using a semi-structured script whose questions explored the object of study using as guiding themes the meanings of care in general and health care and the practices of this care and who performs it. Data was also sought to group the women, including education, religion, marital status, and income. The interviews were conducted on weekends from November 2017 to January 2018 moments in which the researcher was welcomed into the community and stayed at a resident' house throughout the data production stage, thereby living with the community's routine. A total of 28 interviews were conducted in the participants' homes, in a quiet and noise-free environment; two interviews were performed at the AMPQUA headquarters by their choice. Each interview lasted an average of 40 to 50 minutes.

Simple and percentage statistics were applied to the sociodemographic data, and for the corpus of the interviews, the thematic content analysis technique was applied following its three phases: pre-analysis, exploration of the material, and treatment of the results.[21] Initially, the interviews were transcribed to make up the corpus submitted to pre-analysis. The statements were carefully read in the material exploration and result treatment phases and analytical charts were assembled in the Microsoft Office Excel 2007 software, consisting of the instrument's questions in the horizontal column and the registration units extracted from each participant's statements in the vertical column.

In the horizontal analysis, the content of the answers of all participants for each question was mapped to identify common themes. In the vertical analysis, we identified the themes in occurrence and co-occurrence in the individual statements for the set of questions. In all, 390 context units were registered in which themes, expressions, and metaphors were highlighted to identify the contents that made sense to elaborate the SR of the women about the object.

Based on the themes identified, the categories were organized into three dimensions that encompassed the women's ideas and thoughts. The first category is the affective dimension of care, the second is the social dimension, and the third is the biological dimension. These dimensions were organized convergently and never in a fragmented way. As the women expressed their knowledge about health care, the dimension to which the themes extracted from the statements were associated was organized based on their occurrence and co-occurrence. The incidence of the themes in the categories was indicated by the absolute number and corresponding percentage of participants who addressed them in their statements. In this way, each theme and dimension considered the total number of women as the presence of themes related to more than one dimension was identified in the same statement. Thus, the percentages that add up in the three dimensions may exceed 100%.

RESULTS

As for the profile, the predominant age bracket was 18 to 29 years old (9/30%), showing that many participants were young, more than half were in a common-law marriage (17/56.6%), and almost all of them were mothers (27/90%), with an average of 1 to 2 children (14/46.6%). Regarding religion, Catholicism was predominant (26/86.6%), and in schooling, incomplete elementary school (9/30%). Half (15/50%) declared themselves farmers/rural producers, with an average personal and family income below or equal to one minimum wage (equivalent to USD 285,00).

In the context of the affective dimension, most (20/66.6%) referred to health care with mixed feelings. Hence, words like "love," "respect," "care," "attention," "protection," and "affection" were verbalized as synonyms of this care, whether with family

members, non-family members, or even with the environment surrounding them:

> [...] *Caring for me is the same as preserving, loving* [...] *it is protecting above everything else* (W6).
>
> [...] *For me,* p*rotecting means* [...] *caring means loving,* [...] *because if you love, you care, if there is no love, if there is no respect, there is no care* [...] *for me, caring means love and respect* (W8).
>
> [...] *when we talk about caring, I think it is when we like people, we want people to be well, then we will take care so that they are well, whether people are family or not, something we like we take care of* [...] *so, I think that caring is this, it's liking, it's loving* (W19).
>
> *[...] General care, cleaning things in general. I like my things very clean. We have to be very careful with the environment too. I also don't like that you are cutting down (the trees) to destroy nature; you have to preserve the environment. I take this as care too* (W11).

In the social dimension (12/40%), the responsibility that they signaled in caring for themselves and others is determined as a duty assumed by the women to take care of their family and children and to be good mothers. This shows that the conception of health care is parallel to the social role of women in society and seen as the one with the responsibility of caring:

> [...] *Taking care of the family, the house, the grandchildren too. Housework, shopping, I do all of this* (W22).
>
> [...] *Taking care of my children, taking care of my health, taking care of my home* (W4).
>
> [...] *For me, caring is being a good mother and being attentive 24 hours with them* (W6).

The biological dimension (8/26.6%) of health care was observed in the statements when the participants raised concerns for food, care to prevent illness, hygiene care, and the need to seek health professionals, take medication, and maintain their own health and of others:

> [...] It *means keeping regular health care; it's checking the health status by consulting a specialist in the area and having information on prevention and how I can take care of myself* (W1).
>
> [...] *Preventing children from putting dirty hands into their mouths, eating things that are bad for their health, bathing daily, brushing their teeth, always living clean and in a healthy environment, not letting the child run around barefoot* (W10).
>
> [...] *Taking care of health is prevention, preventing diseases* [...] *the care is in you, in prevention, preventing, always do the medical check-ups* (W12).

DISCUSSION

The affective dimension was the category that stood out in the participants' speeches and presented the highest density of results, making it possible to access the subjective connotations that the representation of care has for the women. They are endowed with singularities and subjectivities arising from their life stories, daily experiences, worldviews, and historicity, which are (co)producers of the reality shared within their social group and individually. It is noteworthy that history, the participants' position in the group, and affections collaborate for the (con) formation of the social object; thus, it must have relevance for the group that represents it.[6]

The SRT considers the subject to be active, capable of making decisions and organizing and reorganizing images full of representations using situations that demand an attitude or even the emission of conceptions.[22] In this way, the women built their representations of care by anchoring them in feelings that denote affectivity, including love, respect, care, affection, protection, and preservation. These feelings give meaning to the object because caring is understood as the attitudes and expressions of love and affection, as evidenced by another study on the SRs of caring, in which the central core of the representation was composed of love, affection, and patience.[23]

The affections predominated in constructing the SRs and are supported by memory and experience because the object is provocative and invites one to talk about it; by talking about the object, one talks about oneself.[8] It is based on the affective dimension that choices are established and practices are defined. It is important to recognize, then, the role of emotions and affections in the functioning of representations since the insertion of the repertoire, arising from representations of care, occurs precisely in women's daily lives. Moreover, their practices are based on their social identity and the way they feel in front of it, entangling knowledge and affection, in such a way that they mutually influence each other, that is, the subject (re)invents himself as they (re)present and (re)elaborate the object, thereby producing subjectivities.[8,22]

The affective charge caused by the object directly affects the production of social representation in all its processes and stages, including the other dimensions. This is because the movement is constant and provides feedback because affection is perceived as a vehicle to promote knowledge.[8] Affections are also elements with which the quilombola women reaffirm and strengthen themselves, allowing them to experience health and well-being.[24]

It can be noticed that, in addition to the affective implication between people, this dimension reaches other fields and also encompasses the environment in which one lives; there is a relationship between subject and environment, as expressed in the speeches by the word "preservation," which is associated with care. Other participants indicated that caring involves keeping the environment clean, living in a pleasant environment, and taking care of their surroundings, whether the house, the land, or even the community.

Thus, when health care is represented by maintaining the natural landscape of the place, the existence of transposition of the women to the environment is observed because they are part of it, and the awareness that caring for the environment implies taking care of oneself and of others who, like her, make up the local scene. Understanding this belonging, of the "environmental self," also makes health care happen. For the quilombolas, the environment is where the diversity and possibilities of exploiting plant and animal resources and medicinal herbs and plants are found, which are also used in health care and, therefore, part of the affective dimension in which the representation of this care is built.

This dimension is the most representative and even more significant together with the other dimensions, showing that, for these women, care is sustained much more in their relationships and in their interaction with everything that moves them and surrounds them. This has direct repercussions both on the care demanded by them and the care perceived as necessary for the entire family and community. Furthermore, the affective aspect confers the most singular characteristic to the group's social representation of health care.

In the social dimension, caregiving is considered a female responsibility and identified by the quilombolas as fulfilling a duty that fosters a bond and attachment in the relationship with the person being cared for. This identification of the female gender with caregiving can be explained by the historical and cultural contextualization of family relationships, in which women were assigned the roles of reproduction and caring for their offspring.[25,26]

In a study conducted with quilombola women to shed more light on the meanings, feelings, and care practices, comparable results were found since the meaning attributed to health care was related to the daily activities performed by women in the family context. Moreover, the authors also highlighted the possibility of these women contributing to performing tasks not only in this domestic setting but also in activities directed to the community's well-being.[4]

In line with this, one study investigated the social formation of the roles of father and mother and identified that mothers assumed the leading role in providing care to their children. In contrast, care was a secondary function for the fathers as they were seen as supporters/auxiliaries or material providers for the family. These issues are anchored in the notions that understand maternity as synonymous with care while reinforcing and legitimizing care as a female attribution.[10,27]

Regarding the domestic chores themselves, as reported in the statements, the findings are similar to those of a study that sought the SRs of men and women about women's work in the Cajueiro community in Bragança, a city in Pará State (northern Brazil). The authors reported that women's work was associated with domestic activities, such as cleaning the house and yard, raising animals, caring for plants, the elderly, children, and the sick in the community, and shopping and washing clothes. In several rural segments of the Amazon, house chores are considered women's practices. Since the woman is the "housewife," these practices are considered "natural" and belong to the private sphere, while the man is given the public space.[28]

The argument that care is expressed in this social dimension does not exclude the presence of affection because the care provided by women in the family context is surrounded by affection, primarily due to the condition of maternity. In the results achieved in this study, as in those of other authors,[27] caregiving has an exclusively female connotation. Therefore, it should be assigned to the woman/mother, a concept anchored in memories engendered in society and conveyed and propagated to other women.

Given this scenario, if health care incorporates a social dimension by being linked to the social role of women, it is because these SRs are linked to previous ways of thinking about the object. In the quilombola universe, due to the absence of other forms of historical preservation, orality and memories operate as forms of resistance and fulfill the social function of affirming a cultural identity against the global massification of indifferent cultures. Remembering and resisting work as elements of representation must be reconstituted in the practices of action, acting, and belonging as they result from variations or perpetrations that occur over time, being transmitted or imposed to the generations and directly influencing them in terms of their ways of thinking and representing the object.[6,29]

Furthermore, the variation of SRs is due to the social insertion of individuals in the collectivity. In this way, their forming processes do not derive from only one representational field, meaning the collective does not prevail over the individual and vice-versa; nonetheless, this logic has been overcome by SRT.

Currently, the social role of women in the family and society has been transformed because new roles have been attributed to them (involving work, politics, economics, among others) and because the concept of a nuclear family exclusively composed of a father, a mother, and children has been modified.[30] Nevertheless, it was possible to verify that this context has changed little for the quilombola women of Abacatal/Aurá.

Making this explanation in the light of SRT requires remembering that SRs are embedded in a pre-existing context and depend on the traditions, values, and beliefs associated with the represented object. In this sense, the object can be reincorporated to explanations familiar to the individuals and their group, being composition and at the same time exchange, essential for constructing consensual thoughts and the sharing of these with the social group, which will enable social belonging (in this case, being a woman and a quilombola).[6]

The social dimension is anchored in the representation of care as an attribution of the female gender, connecting to the stereotype of the woman as a born caregiver and being strongly linked to the private family sphere. Therefore, care continues to be tied to women and linked to the domestic and family environment, as was evident in this dimension. It is also noteworthy that despite women's achievements in society, this conception is not only predominant in the quilombola context but also in society.

Lastly, with regard to the biological dimension, a study conducted with women of a quilombola community in southern

Brazil reported that the meanings of care were strictly linked to biological mentions to maintain or generate health to ensure other daily activities.[31] In turn, the findings demonstrated herein revealed that this dimension was a minority, with the affective and relational aspects of care standing out.

Another study showed that representations of health care for elderly women and men were strongly associated with the biological aspects of the object. Women referred to this through permanent acts and actions that generate health and obedience to prescriptive norms guided by the doctor, including hygiene, food, and rest, among others.[32] The conceptions based on these biological elements reveal that this representation of health care, anchored in hygienist habits and actions, was disseminated over time by the biomedical model, although today the conception of health care has evolved to integral and collective practices.[33,34]

These conceptions are similar to those evidenced by this study, although the representations of quilombola women about health care shown herein acquired connotations that went beyond the exclusive field of health, with the biological aspect of the object being only one of the dimensions that make up its representation. It is worth reflecting if these differences found in other studies may be related to the social belonging of these women, considering that the aspects of urban and rural daily life can influence these SRs.

In this biological dimension, we identified in the statements that there is a predominance of the reified discourse to build the representations of health care, since the knowledge exposed here concerns the field of biological and health sciences, with the evocation of prescriptive norms that guide how to take care of health and stay healthy. The knowledge from the Sciences belongs to the reified universe and seeks to give impartial explanations based on the quantifiable mathematical logic of experimentation. However, SRs address the consensual universe,[6] a universe that is the locus of familiarity. In this case, it can be said that the reified conception of health care was re-signified into common sense because a transposition from reified to consensual knowledge was clearly perceived so that the object is (re)presented and renewed, and new meanings are given to it.

It is important to emphasize that the transition of fields of knowledge (from reified to common sense) happens through beliefs, myths, and even popular knowledge. Yet, these factors do not present levels of hierarchy or degrees of importance that allow the superimposition of one over the other. On the contrary, these pieces of knowledge indicate knowledge and purposes and belong to different fields, albeit they indicate pluralities in thinking and respond to the context in which the bits of knowledge are produced.[8]

Thus, when investigated by the SRT, health care acquires the status of a psychosocial phenomenon by grouping reified knowledge since it is produced by scientific knowledge and demarcates it as an object of knowledge and practice in the health field. Moreover, by consensus, this field manifests ways of being and acting from cultures with their own particular attitudes to deal with the body and health.[35]

From this perspective, it can be said that quilombola women, when constructing and expressing their thoughts about health care, resort to the two fields that influence the conformation of the object: reified knowledge and consensual knowledge. This representation, which is linked to the context of knowledge, proved to be relevant because it revealed different ways of thinking and conceiving the object, although these ways converge to similar practices that could be organized through the dimensions addressed here.

It is understood that knowing these contexts and representations is of utmost importance to organize care that meets these populations' real needs and specificities, considering the cultural and representational dimensions acquired by care in their lives and the universe of knowledge and representations that surround them. In this study, the aspects of the representation of care in the biological dimension were small and the attitudes and practices derived from it. The constitution of SRs by the three dimensions in the quilombola context implies complex health care surrounded by subjectivity and sociocultural identity typical of the quilombola universe, showing interconnections between traditional knowledge and reified knowledge.

In this sense, it is worth reflecting on the type of care provided, the organization of the health service, and how it is presented to the public in question. The reason for this is the demand for care that expresses an affective and relational character, which overrides biological demands, and the fact that health services are organized mainly by the biomedical model, in which every clinic is focused on the diagnosis of specific health situations, such as symptoms objectified in the individual's physical body.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The SRs of health care by quilombola women shows a comprehensive understanding of this type of care that goes beyond specific activities. They encompass qualities of human relations, meanings of preserving life, a significant identification of care with the female gender, and hygienist habits and actions endorsed by the biomedical model, which strongly portrays the intertwined technical-scientific discourse with traditional knowledge.

For the women of Abacatal/Aurá, there is a demand for care based on building bonds, affection, and listening, as these are the pillars of health care and permeate the entire set of representations established in this work. These aspects bring singularities that health professionals must consider and, above all, by nursing professionals, since this area works with the comprehensive health care of individuals and their respective groups and (re) produces this care.

Considering that this study was developed in only one quilombola community, the representations discussed here may not be able to be generalized, which is a limitation of the study. The ways of representing social objects relate to the universe of the groups that build such representations from their practical experiences in everyday life and are particular to each group.

However, the connections with realities of other quilombola communities or even with analogous situations in other groups may be subject to investigation. It is understood that these findings can contribute to a better understanding of the universe of care representations in the group studied and stimulate reflection in similar studies and/or on other communities that share the same characteristics.

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AUTHOR'S CONTRIBUTIONS

Study design. Ingrid Fabiane Santos da Silva. Ivaneide Leal Ataíde Rodrigues.

Data collection or production. Ingrid Fabiane Santos da Silva. Ivaneide Leal Ataíde Rodrigues.

Data analysis. Ingrid Fabiane Santos da Silva. Ivaneide Leal Ataíde Rodrigues. Laura Maria Vidal Nogueira. Hilton Pereira da Silva. Iaci Proença Palmeira.

Interpretation of results. Ingrid Fabiane Santos da Silva. Ivaneide Leal Ataíde Rodrigues. Laura Maria Vidal Nogueira. Hilton Pereira da Silva. Iaci Proença Palmeira.

Writing and critical revision of the manuscript. Ingrid Fabiane Santos da Silva. Ivaneide Leal Ataíde Rodrigues. Laura Maria Vidal Nogueira. Hilton Pereira da Silva. Iaci Proença Palmeira.

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