The concepts of health care according to women from a Quilombola community in the metropolitan area of Fortaleza, in the State of Ceará: an investigation via affections

As concepções de cuidado em saúde de mulheres de uma comunidade quilombola da região metropolitana de Fortaleza (CE): uma investigação a partir dos afetos

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Abstract

This study aims to investigate the health care settings by interviewing women from a Quilombola community in the metropolitan region of Fortaleza, in the State of Ceará. We highlight the importance of discussing the dimensions of affection within health care practices based on the daily lives of communities, considering socio-political issues, such as the ethnic-racial debate. We aim to identify the participants' health care concepts and demands and, discuss new ways to think and act in health. The Affective Map Generator Questionnaire was used to capture issues related to health care according to affections. In total, 13 women aged from 38 to 77 years participated in this survey. We categorized four health care settings based on their answers: evangelical churches, home, community spaces, and commercial centers. Participants gave less important to other spaces, which showed greater variability. We found that collectivity, access, territory, and affections are relevant in the development of participants' health processes. Finally, we discuss ways of conducting institutionalized care in health services and we raised some considerations for the construction of more dialogical processes that value autonomy.

Keywords: Health Care; Quilombolas; Ethnic-Racial Issues; Affectivity

Resumo

Este artigo foi construído junto a mulheres de uma comunidade quilombola situada na região metropolitana de Fortaleza (CE), a partir da investigação sobre lugares de cuidado em saúde. Destacamos a importância de debater a dimensão afetiva das práticas de saúde com base nos cotidianos das comunidades, considerando questões sociopolíticas como o debate étnico-racial. Nosso objetivo foi reconhecer concepções de saúde e demandas trazidas pelas participantes e, a partir disso, discutir modos de fazer saúde. Foi utilizado o Instrumento Gerador dos Mapas Afetivos para captar questões relacionadas ao cuidado advindas dos afetos. Contamos com 13 participantes, mulheres com idades entre 38 e 77 anos, e, baseadas em suas respostas, categorizamos quatro lugares: igrejas evangélicas, casa, espaços de convivência comunitária e centros comerciais. Outros espaços foram citados secundariamente e tiveram maior variabilidade. Percebemos a relevância que a coletividade, o acesso, o território e os afetos têm na construção dos processos de saúde das participantes. Por fim, discutimos os modos de fazer cuidado institucionalizados nos serviços de saúde e apontamos questões para a construção de processos mais dialógicos e pautados na autonomia.

Palavras-chave: Cuidado em Saúde; Quilombolas; Questões Étnico-Raciais; Afetividade.

Introduction

The health of the Quilombola population as a socially relevant topic, focused on public policies, has been widely discussed by social movements that debate ethnic-racial issues in Brazil. Government actions aimed at improving the living conditions of these populations have been insufficient against the attacks and the precariousness to which they are subjected. In what refers to the Brazilian Ministry of Health, it is only with Ordinance No. 1,434 of July 14, 2004, that resources were directed toward the expansion of health strategy teams for the Quilombola communities (Brasil, 2004).

Several studies reported on the precarious living conditions, the lack of access to health services, the scarcity of public policies, and lack of professionals prepared to deal with their specificities, as well as issues of racism that directly affect the health of the Quilombola population; thus exposing the effects of social inequality on health-disease processes (Batista; Rocha, 2020; Fernandes, Heaist. Santos, 2016; Freitas et al., 2011).

Moreover, the resistance to conducting this debate within various social sectors generates scarcity in scientific production on the subject. Freitas et al. (2011), in a study regarding the literature produced on the health of the Quilombola population in Brazil, report that this subject has only been recently debates within the field and that many advances are still required, given the inequalities and inequities within the health care experienced by this population.

In this study, we aim to contribute to the scientific production on the health of the Quilombola population, starting from a broad understanding of health. For this purpose, we focus on the ethics of care based on affectivity and on the population's bond with the territory. We also emphasize the ethical-political commitment present in the foundation of the Brazilian Unified Health System (SUS) by declaring access to health as a right to all and as a duty of the State.

This study was produced from the development of health actions with a Quilombola community in the municipality of Caucaia, located in the

metropolitan region of Fortaleza, in the State of Ceará. The community was approached via the territorialization process of health care, in which several health professionals from different fields, who were part of a residency program, were involved. Thus, we established a dialogue with the community leaders and developed group activities with the association of the elders of the territory. Notably, the association was predominantly composed of older women, despite the participation being open to any member of the community. During the meetings, we learned part of the history of the foundation of the community, we heard about their struggles for rights and for access to health and culture, a discussion that was imbued with the ethnic-racial issues. It is also necessary to highlight the presence, within the community, of the Indigenous population of the Tapeba ethnic group, which was explicitly included in the statements of the group participants and some even identified themselves as Indigenous and Quilombolas.

We spent 14 months with the group of women, holding fortnightly meetings. This period favored the creation of affective bonds with the people of the community, which marked the development of the research's proposal, which sought to map out the spaces that the participants related to in their experiences in health care, via the creation of affective maps (Bomfim, 2010). We synthesize the category of **place of health care** as a structuring element of the study, in order to articulate between territory and affectivity.

Place of health care

The category "place of health care" was based on studies that consider care as an organizing element of health services, associating it with the concept of integrality. Furthermore, we used studies on environmental psychology and urbanism to understand the notion of place.

Schneider (2015) draws on several fields of geography to discuss the concept of place. According to the author, in phenomenological geography, a place can refer to not only as a space of physical location but to a meaning attributed by human experience. This perspective works with the concepts of belonging and identity to understand a place in relation to the meanings that surround it.

The author also mentions the humanistic geography when quoting Yi-Fu Tuan and his differentiation between space and place. For him, place is a space endowed with symbolism. That is, a place is built as such by a person or a collective from their bonds. Sá (2014) discusses the conceptions of place and non-place by Marc Augé and points out that, for the author, the "anthropological place is loaded with social meaning" (p. 215; our translation). It is a space permeated by memories, which is bound to the past, it is the result of processes of appropriation, bounding, and identification. It is according to these conceptions that we understand place as a space of life and affections.

Thus, care is a category that has gained relevance within the discussions about work processes and health services. We refer to a conception of care that is distant from the biomedical model, centered on the procedure and in which the subject is seen only as an object of intervention. Carnut (2017) differentiates intervention and care, stating that the former refers to an interaction with the users of the health services that does not consider subjective aspects, while the latter brings the dimension of the subject in its integrality within the health-disease process.

Bond and affections play a critical role in this proposal to understand the relationship between the professional and the subject of care. To be affected by the care of others is to immerse oneself in their territory, in their experiences in search for a development of a contextualized care articulated by dialogue.

The act of care is woven in interpersonal relationships, and it should facilitate processes of self-knowledge and autonomy. Carnut (2017) affirms: "Hermeneutically speaking, the 'caregiver' and the 'care' are not symbols of any interactions, but rather of a special interaction, in which the 'affecting of oneself' is consolidated in the 'do good' to others" (Carnut, 2017, p. 1178; our translation). The author also points out that the 'do good' to the other does not concern the paternalistic posture but speaks of experiencing the world from the other's place, seeking to approach their worldview.

It is important to point out that health, seen as something only the professional caregiver would have knowledge and means to restore, carries with it the effects of domination. From this perspective, Contatore et al. (2017) cite Illich's ideas in **Medical Nemesis: The Expropriation of Health**, a work that discusses the effects produced by the specialized language used in the doctor-patient relationship, which generates greater asymmetry during the contact and relegates to the professional the monopoly over health care knowledge.

These authors situate, from Foucault and Canguilhem, the construction and use of the concept of disease to establish the "patient" in a passive place. Thus, the disease becomes the true *raison d'être* of interventions, while the subject is neglected. In this conjuncture, normality is set as a health reference, which is, at the same time, objective and the founding construct of the medical knowledge of the time.

To build another form of health care, it is necessary to break with these traditions and understand health from the meaning attributed by the subject. To transpose the biomedical discourse also means to affirm the clinic of the individual, in detriment to the focus on the disease and on normative standards. This is the debate on the ethics of care.

Carnut (2017) refers to the Foucauldian concept of "self-care" by reporting an ethics of care that launches itself into freedom and autonomy, thinking about those who receive care as "a producer of well-being, due to the functions of desires that lead them in their life experiences" (p. 1179; our translation). Care must then be an agent of creative processes and autonomy.

Thus, the category "place of health care" is based on this perspective, which encompasses affection and desire. The categories of place and care converge in this study from the concept of affection, which we will deal with in more detail.

Affectivity, territory, and health

To discuss affection and care, we will start from the discussions raised by Franco and Galavote (2010) in the article **Em busca de uma Clínica dos Afetos**. In this paper, the authors deal with the conceptions of body and affectivity from Espinosa's work. Espinosa's notions of affection and good encounters are also used by Bomfim (2010) in the elaboration of affective maps.

Bomfim (2010), in the construction of the Affective Maps Generator Questionnaire (AMGQ), raises the debate on affectivity based on the contributions by Bader Sawaia. The authors use Espinosa's notion of affectivity from an ethical perspective, and they suggest for reality to be conceived by means that destabilizes the Cartesian rupture. Bomfim (2010) expresses that "researching passions is a way of seeking the real possibilities of men and, consequently, of their emancipation. To free oneself from the bonds of an instrumental rationality would be the ultimate goal of the therapy of emotions" (p. 64; our translation).

The validation of knowledge and social organization from the primacy of instrumental reason is consolidated in our way of existing. Espinosa is a rationalist, but believes reason to be associated to affections, the body attached to the mind, and feelings connected to knowledge. For Espinosa, affectivity is ethical and encompasses the subject's movements towards themselves and the other. Passions should enable the search for freedom (Bomfim, 2010).

Espinosa proposes to think on the different ways of existing in the world that propel the human into action. Affective experiences would then be understood as potentializing or de-potentializing. Thus, there are affections that make up the **sad passions**, which can paralyze and depotentialize the individual. In opposition to this, the author talks about **good encounters**. Bomfim (2010) points out that "good encounters are those that allow for the composition of an individual with others (bodily diseases) that potentialize action" (p. 63; our translation).

According to Espinosa (2010), a body affected by good encounters is tempted into action and search for autonomy. For him, the body is mainly relational, being therefore built by the encounters, the exchanges, by their actions on the world.

Throughout history, the hegemonic conception of health practices departs from the practices

of collective care, popular knowledge, and the production of autonomy. From the eighteenth century on, studies began to look within the body for the cause of the diseases. Medicine seizes the knowledge that was once collectively shared and makes it less accessible and farther from the illiterate population (Franco; Galavote, 2010).

According to Franco and Galavote (2010), "Whoever sees the body reduced to the geography of organs is unable to perceive the complexity this same body has in producing itself, as life or death" (p. 14; our translation). For the authors, these processes entail the creation of the world and the collectivity in its various possibilities of recreation or paralysis and of death. We highlight in this study the importance of building a place for the sensitive, in which affections can be listened to within the relationship between health professional and user, expanding and resignifying the possibilities of health actions.

A care based on autonomy, freedom, and respect for the history and particularities of collectives and individuals must be established. To do so, we delimit care in its political aspect, which aims to not only deal with health inequities but to guide an emancipatory collective proposal.

Methodology

We chose to use the Affection Maps Generating Questionnaire (AMGQ) idealized by Bomfim (2010) in her doctoral thesis, which seeks to bring tangibility to the study of affections. The affection map has bases in social and environmental psychology. It is a proposal that deals with the subject's involvement with the environment. Its focus is not on guidance, although it can act in this function, but rather it is closer to the primacy of representation, which, in this case, focuses on affectivity and esteem of a place. It is based on objective and experiential spaces and elements surrounded by the meanings and the senses attributed by the subject, and it can be elaborated in different ways, according to the respondent's desire.

The AMGQ is composed of eleven items: drawing, meaning of drawing, feelings, synthesis words, what you think of the city, Likert scale, comparison of the city, paths traveled, participation in association, eventual participation in social movements, sociodemographic characteristics. In this research, only the qualitative items of the AMGQ were used, thus we removed the associated Likert scale. We also chose to remove the component of the instrument that questions the participation of respondents in community associations, considering that all participants were from the community elder's association. AMGQ is a flexible and dynamic instrument, allowing these transits without loss of quality for the study. The AMGQ is directed toward the study of the relationship between subjects and various environments. Initially, the place (health unit, home, neighborhood, community, city, country, etc.) is chosen with which the subject has some link so that the instrument can be applied. For this study, however, we decided not to specify a restricted spatial category, leaving to the participants to elect the place or places that belonged to their health care paths. Thus, we use the broad concept of **health care place**. The AMGQ is directed to enable the categorization of images that synthesize the expressed affections and meanings to help achieve an understanding of the person-environment relationship. The main images are: belonging, pleasantness, insecurity, destruction, and contrast. Given the flexibility of the instrument, other images can be elaborated from the demands of the context (Pacheco, 2018).

The application was made with 13 women from the community, aged from 38 to 77 years, who participate in the community elder's association. Regarding the moment of application, the participants of the group were told about the proposal of the activity, and they were invited to participate. The application happened collectively, but we emphasized for the instrument to be answered individually. The participants received and signed the informed consent form distributed along with the AMGQ. The research was funded with its own resources and was duly approved by the Research Ethics Committee of the School of Public Health of Ceará (ESP-CE), under the number CAAE 13794519.3.0000.5037.

In this work, the category "place of health care" was used to locate the institutional and non-institutional health spaces sought by the participants and investigate their affections toward them.

Map Analysis

A total of 13 affective maps were gathered, among which some places were repeated by the participants. Thus, the maps were divided into four groups defined by the main spatial choice: church or religious centers; home; community spaces, and shopping center. Below is a roundup of the contents on the maps organized according to the four identified groups.

Chart 1 – General classification of applied maps, Caucaia-CE, 2019

	Number of maps	Structure	Feelings	Category
Church or religious centers	6	They have similar characteristics to Lynch's cognitive structure and two also presented characteristics of metaphorical structure	Peace, joy, love, tranquility, friendship, gratitude, charity, disunity, neglect of public power.	Belonging (2)
				Pleasantness (1)
				Contrast (2)
				Insecurity (1)
Home	4	Characteristics of Lynch's cognitive maps and three also with metaphorical characteristic	Longing, peace, love, beauty, family, nature	Belonging (3)
				Pleasantness (1)
Community spaces	2	All Lynch's cognitive and one also metaphorical	Longing, nature, belonging, collectivity	Belonging (1)
				Contrast (1)
Commercial center	1	Lynch's Cognitive	Joy, emotion	Contrast

The category **meaning** present in the charts below is developed from a synthesis elaborated by the researchers based on what is tacitly brought by the instrument. All other categories are transcribed as being placed by respondents. Subsequently, we separately characterized each of the categories identified in the maps.

Church as a place of health care

The maps representing the church (all evangelical) revealed that these are places that generate relationships of support ("*where I feel good, with peace in the heart"*- respondent 2; "*shelter"* - respondent 1), providing community coexistence, and positive ("*of welcoming, of the brethren, of the word of God*" - respondent 4) and negative ("*disunity"*- respondent 3; "*lack of members in obligations and responsibilities"* - respondent 6) feeling in relation to their religious companions. These are places that provide individual well-being and search for care, being placed by some respondents as "*emergency room"* (respondent 3) or as a place of "*cure"* (respondent 5). Moreover, one participant placed in opposition the church and public hospitals. In this case, the hospital was represented as insecure and helpless, and the church appeared as an alternative to this experience ("*between the hospital and the church, I prefer the church. The hospital as a last resort*," "*My drawing represents a public hospital. Waiting to schedule an exam. The patient dies before the consultation,*" "*Evangelical Church by faith you can be healed by the power of God.*" - respondent 6).

In four of the AMGQs, the respondents stated that they could not compare the church to anything ("*something very good, hard to imagine*" -

respondent 2; "*you can't compare it to anything because there it is everything. That's where God is*" - respondent 3), placing it on an idealized level. In some answers, the expectation of health care is raised as something that the church can perform in its entirety ("*Being there I take care of all my physical and spiritual health*" - respondent 2; "*it's my emergency room*" - respondent 3; "*a place of peace, healing, and miracles*" - respondent 6). Two maps (Maps 1 and 6) explained this opposition and we analyzed that the images that best classify them are of contrast and insecurity, respectively.

Churches are also represented as accessible places ("*very close to my house*" - respondent 5; "*two blocks from my house, very close*" - respondents 2 and 4). We observed that a characteristic of the community is the numerous presence of evangelical institutions. Many of the participants at other times declared to be evangelical. We also noticed, however, a significant presence of syncretism in the community since treatment with plants and some traditional and ancestral knowledge perseveres. Additionally, cultural and festive practices linked to the Quilombola movement are present, such as the commemoration of November 20, a date in which the locals move to another Quilombola community (located in Tururu-CE), where an event related to Black Awareness Day takes place.

The chart below shows the analysis of one of the maps that make up the category.

Chart 2 – Map of the church category (belonging) Caucaia-CE, 2019

Identification	Structure	Meaning	Quality	Feeling	Metaphor	Meaning
Number 4	Lynch and metaphorical	Church; where I feel good and solve my problems	Welcome, brothers and the word of God, where I seek my improvement; two blocks from my house, very close	Peace, joy, love, happiness, gratitude	There's no comparison, because this place is wonderful	Place that causes individual feeling of well-being and search for problem solving, generating support. It's a meeting place, it's accessible, and it's incomparable
Female						
52 years of age						
Lives in the community for 11 years						

Source: Elaborated by the author.

Home as a place of health care

The maps that represent the environment of the home refer to family memories, longing, and to nature ("*paradise of love and nature*" - respondent 9; "*missing mother and father who died*" - respondent 7). They represent dreams, achievements, and deep affections, being places of encounters ("*a happy home because it is the way I dreamed*"- respondent 10; "*my home is big. You can fit everyone when they arrive*" - respondent 7). It was also demarcated by some respondents dissatisfaction with external spaces, such as roads and sidewalks, due to structural issues (respondents 8, 9, and 10). At other times, the participants also revealed that they felt that the community is currently more unsafe, opposing feelings of well-being and security regarding the home. There is also the desire for change in the community. Some of the participants pointed to the way the community was in the past and the desire to revive the space as before, in addition to the demand for leisure areas, such as squares, outdoor gyms, and street markets. These maps evoke memories and desires, both regarding their own home (longing for family members who died), as well as the community. The home evokes the relationship with the collectivity and with ancestors (ancestry).

The chart below provides information regarding one of the maps that makes up this category.

Chart 3 - Example of a map of the category home (belonging) Caucaia-CE, 2019

Identification	Structure	Meaning	Quality	Feeling	Metaphor	Sense
Number 8 Female 63 years of age Lives in the community for 63 years	Lynch and metaphorical	Good memories of the pond and the trees where, every day, I took bath on the reservoir and pond that was close to home	A lot of emotions, it's wonderful	Joy, longing, peace, love, affection, friendship	With Grandma's home because there it is just like that, filled with joy.	Grandma's home is the place of **contact with nature, and which produces well-being**. It is a place of **longing** and one that refers to affective **memory**.

Community spaces as places of health care

Maps that represent community spaces bring the presence of nature and vegetable gardens and are spaces that generate bonding, memory, feeling of protection, and contact with their roots. They have a strong connection with places that generate identity and cultural issues since they represent popular and ancestral knowledge, while being part of everyday activities. These are threatened spaces, and one that evoke longing for those who they have already lost, revealing memories and intense affections. They also provide community and family coexistence and may involve the space of the home. They are places of great significance for the local culture, comprising the production of knowledge and symbolic exchanges. One of the respondents pointed out the importance that *raizeiros(as)*, *rezadeiras(os)*, *benzadeiras(os)*[1], and midwives have in strengthening community practices. However, according to the participant, there is no recognition or articulation on the part of health care services with these popular practices. These are the places that raises the issue of identity. Chart 4 shows the map Number 13 for the contrast image. This image may indicate an estimate of a potentializing or depotentializing place depending on the possible movements for the subject in relation.

Chart 4 - Example of a map of the category community spaces (belonging) Caucaia-EC, 2019

Identification	Structure	Meaning	Quality	Feeling	Metaphor	Sense
Number 13 Female 39 years of age Lives in the community for 39 years	Lynch	Ancient wisdoms	Family, community, traditional herbs, collective gardens. Wisdom of the collective and humanized care	Collectivity, belonging, ancestry, wisdom, learning, preservation	With a big city. Because there is no peace and quiet of Mother Nature.	The place of ancestral wisdom provides encounter with people and the formation of **bonds**, but not everyone values their **roots**. It is place of **memory** and popular knowledge and is characterized as being in opposition to the big city.

Source: Elaborated by the author.

1 Translator's note: *raizeiros* are those who are recognized within their community as having extensive knowledge on the prescription and preparation of medicinal plants. *Rezadeiras* and *Benzadeiras* are folk healers who practice healing by means of rituals and prayers, allied with medicinal plants.

Shopping center as a place of health care

The map that represented a commercial center evokes the desire for novelties and new relationships. What we situate as a commercial center refers to the city center of Caucaia, a neighborhood in which shops, pharmacies, snack bars, supermarkets, fairs, and lottery agencies are concentrated. It is, therefore, a space of intense circulation of people, goods, and activities related to consumerism. This place is not far from the community and there is a public transport line that allows the movement between the two places.

It is a place that also thrills by the decoration and by the surprises it provides, but has polluted streets, causing predominance of an image of contrast. It is more related to consumer practices and commemorative/commercial dates, while also allowing for meetings; and is compared with more intimate spaces, as we will see in the synthesis chart below. Only one person brought this place into the instrumental, hindering further exploration.

Chart 5 – Map of the category commercial center (contrast) Caucaia-EC, 2019

Identification	Structure	Meaning	Quality	Feelings	Metaphor	Sense
Number 12 Female 38 years of age Lives in the community for 20 years	Lynch	Caucaia city center, shopping, novelties, and Christmas atmosphere. I like to see the novelties and meet more people.	Very special; does well, I forget about my problems, too much garbage	Joy, exciting	With my room. Because it is big and has the person I love the most, my daughter.	A place that represents a bond with spaces that provide **new encounters and emotions** despite being **polluted**. At the same time, it refers to their own home because it is large and special.

Source: Elaborated by the author.

Secondary health care sites

We added to the instrumental a question referring to other spaces accessed for health care. We define these as "secondary places of health care" because they do not represent the main choice triggered in the instrument, although they allow the expansion of the recognition of spaces that encompasses care function. The chart below exposes the locations and the number of instruments in which they were referenced.

It is interesting to point out that the institution "health post" appears in the options of the participants, however, it integrates a universe of many other places. This demonstrates that the participants brought to their instruments a broad understanding of health and care. From the charts we can understand health as: access to school, specific health services, leisure spaces and community coexistence, places with nature, and cultural manifestations. It seems to us that, for the participants, the understanding that health is where life happens is evident. This perception approaches the notion of integrality.

Chart 6 - Secondary health care sites Caucaia-CE, 2019

Own home	4
Churches/services	4
Medical station	3
Elder's group/association	3
School	2
Squares	2
Shopping (Caucaia/Fruit Market)	2
Dam/beach/lake/hospital/CRAS (Social Assistance Reference Centers)/ neighborhood sidewalk/cultural and traditional spaces/quilombos	1

Source: Elaborated by the author.

Results

In a considerable part of the maps, we identified that the participants relate health care to spaces that allow symbolic and affective exchanges. This expresses the desire to be cared for and to think about health through collective experience.

Some studies on therapeutic itineraries in Quilombola communities have also found among traditional and collective practices, in contact with nature and in the sharing of memories, experiences that provide the promotion of health and prevention of illness (Aciole; Silva, 2021; Batista; Rocha, 2020; Fernandes, Heaist. Santos, 2016, 2019). These same studies pointed out the difficulty of access to health care services as something common in the daily lives of these communities.

Notably, in the affective maps analyzed the place "home" triggered some characteristics in common with the community spaces. Both were related to contact with nature, ancestry, and affective memories. The home appears as a shared space, but also as a refuge from the insecurity found in the external spaces. Both showed an image of contrast. When the subject feels involved with the place and manifests desire and search for improvements, creation of strategies, and expansion of critical perception, it is understood that the image of contrast may be related to potentializing affections (Pacheco, 2018). We noticed this characteristic in the map referring to community spaces.

The participants cited, at various times, the lack of dialogue between health system and community practices. Alves and Seminotti (2009) use the notion of **openness to dialogue** to bring out the responsibility of health services to establish a dialogue with the popular practices and traditional therapies of the community without hierarchizing knowledge.

We identified in the maps that, for an expressive number of participants, the Neo-pentecostal churches are perceived as producers of care. It is historical fact that during the period of Colonial Brazil, Indigenous and African peoples in diaspora were forced by the process of catechism to abandon their beliefs in the conversion to Catholicism. Do Nascimento and Abib (2016) report that Neo-pentecostalism today has entered the Quilombola territories and carried out a similar project. They point out that "Resistance in Quilombos involves the affirmation of identity in the activities, in rites, in celebrations, as well as by the denial of this same legacy as a form of defense and preservation" (p. 37; our translation). Thus, the traditions and beliefs of communities go through processes of resignification, mixing with other references, sometimes being camouflaged or denied.

Some authors (Fernandez et al., 2018; Valla et al., 2004) talk about the protective capacity of religions since they produce spaces for social support and self-appreciation. Valla et al. (2004) discuss that the situation of poverty damages the self-esteem and dignity, pointing to religious centers as spaces in which they can be rescued. The authors make references specifically to evangelical religions. They highlight, however, that although they constitute spaces that favor bonding and social support, they do not discuss or promote the search for an effective social transformation. We observed in the contents brought by the maps, that by presenting themselves as an alternative to so many demands and occupying an idealized place, as representations of opposition, churches can present themselves as depotentializing mobilization for the search of improvements in public services, for example.

Thus, it is understandable that these spaces become a reference for people of the community since they play a role of listening and welcoming when they are often denied in various other spaces in a phenomenon characteristic of colonial dynamics. Studies point to religious spaces as expressive components of the therapeutic itineraries of Quilombola communities, also referring to the lack of access to health services and precarious living conditions in these territories (Fernandes; Santos, 2016, 2019).

Nascimento and Abib (2016) discuss the discrepancy between Quilombola cultural practices and evangelical discourse. They point out that these religions "classify their secular rites and actions as actions linked to evil and the devil" (p. 34; our translation) when referring to religions of African origin and other cultural and ritualistic

practices linked to the Quilombola and Indigenous people. On this, Santos reports that:

> the process of enslavement in Brazil tried to dismiss afro-pindoramic peoples from their main bases of sociocultural values, attacking their individual and collective identities, starting by attempting to replace polytheistic paganism with monotheistic Euro Christianity. (Santos, 2015, p. 37; our translation)

Kilomba (2019) talks about racism and colonization and its impacts on the life, health, and subjectivity of Black people worldwide. In addition to dealing with violence and trauma produced by colonial dynamics, he points out that the lives and voices of Black people are still neglected and silenced in the current context. The author reflects the effects of racism on the production of knowledge and construction of practices in different fields. This can be observed without great difficulties in Brazil, in the experience of Black, Quilombola, and Indigenous people.

Santos (2018) points to the forced arrival of African peoples in the context of colonization as a factor present in the sickening of the Afro-Brazilian population. The author reports on the loss of cultural references, the violence imposed by racist culture, and the loss of family memory as determinants for the current sickening of the Black population.

Kilomba (2019) and Hooks (2010) report on the importance for the populations affected by racism to base their knowledge and practices from a perspective of survival and emancipation. On the maps we could see how the cultivation of knowledge and ancestral memories are vital for respondents.

Moreover, Santos (2018) points out that another conception of health needs to be discussed in accordance with the production of a new world and addresses this by betting on care practices that consider the trajectory of Black people.

> Those who recover the memory of our history and our resistance, consider the cultural and civilizing clash in which the diasporic population finds itself, realize that the Black population and their mental health have no way to receive an individualizing and medical approach. Our mental health wants for a restructuring of the world. (Santos, 2018, p. 248; our translation)

To understand care from an integral perspective is to understand it also within the political sphere, allowing for the existing practices within the territory to be questioned and strengthened for the production and promotion of health. To consider health as a way to break with colonial logic is a challenge that requires services and professionals to rethink their knowledge and practices.

Final considerations

In this study we found evidence that point to the construction of health projects that are abundant in collectivity and meaning, which also provide shared resistance in a rhythm that encompasses autonomy. Thus, places of health care deal with notions that also encompasses the types of sociability that are established as practices and understandings of the spaces in which care is built.

Notably, an effective social transformation, in articulation with health practices, needs to be characterized from a plural perspective. Discussions about race, ethnicity, and gender are still not very expressive in the services and spaces of training of health professionals.

This puts us in the face of the perception that in addition to the institutional recognition of these topics, there is work to be done regarding the training, in the daily routines of the services, in team discussions, and in the construction of new health practices. Research and practices are necessary for the proposition of movements and strategies aligned with the production of a rooted health that embraces the Afro-Brazilian, Indigenous, Quilombola, peoples of *terreiro*, Roma and riverside peoples, among others. May they be open to dialogue and may them break with the hierarchical structure of health care with services that take into consideration the sufferings and inequities in health that comprise the sickening condition of these populations stricken by the history of colonial violence and racism.

Thus, as agents of care, we must seek to break with the colonizing discourse. Care is also political.

Care needs to come from affection, only through affection will a flow of creative life be able to emerge.

Finally, it is necessary to direct efforts in building an anti-racist and counter-colonial corporate project (Santos, 2015). To consider such issues is to promote an integral health service, placing them not as secondary discussions, but as reordering of the way health care is thought and constructed.

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