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SOCIOECONOMIC AND HEALTH CHARACTERISTICS GROUP OF WOMEN IN A QUILOMBOLA COMMUNITY

CARACTERÍSTICAS SOCIOECONÔMICAS E DE SAÚDE DE UM GRUPO DE MULHERES DE UMA COMUNIDADE QUILOMBOLA

CARACTERISTICAS SOCIOECONÓMICAS Y DE SALUD DE UN GRUPO DE MUJERES DE UNA COMUNIDAD QUILOMBOLA

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ABSTRACT

Objective: to identify the socioeconomic and health characteristics of a group of women from a quilombola community. ***Method***: a descriptive study with a qualitative approach, carried out through semi-structured interviews with 13 women in a quilombola community, located in southern Brazil. The analysis of the information was simply descriptive. ***Results***: the women were 14-56 years old, most had consensual relationship developed and not paid employment. The monthly family income was between R$ 70.00 and R $ 800.00 reais. On average, menarche occurred between 12 and 14 years old, first sexual intercourse between 17 to 18 years old, menopause between 40 and 51 years old. Most of them accomplished prenatal, with no complications during pregnancy and postpartum period and nursed between 15 days and five years. Most did not use any contraceptive method. ***Conclusion***: many of these features were conditioned to the context of life and consisted of peculiarities. ***Descriptors***: Women's Health; Ancestry Group of the African continent; Population Characteristics.

RESUMO

Objetivo: identificar as características socioeconômicas e de saúde de um grupo de mulheres de uma comunidade quilombola. ***Método:*** estudo descritivo, com abordagem qualitativa, realizado por meio de entrevista semiestruturada com 13 mulheres de uma comunidade quilombola, localizada no Sul do Brasil. A análise das informações foi a descritiva simples. ***Resultados:*** a faixa etária das mulheres era de 14 a 56 anos, a maioria apresentava relação consensual e não desenvolvia atividade remunerada. A renda familiar mensal concentrou-se entre R$ 70,00 e R$ 800,00. Em média, a menarca ocorreu entre 12 e 14 anos, a coitarca entre os 17 aos 18 anos, a menopausa entre 40 e 51 anos. A maioria realizou pré-natal, não apresentou complicações no período gravídico-puerperal e amamentou entre 15 dias a cinco anos. A maioria não utilizava nenhum método contraceptivo. ***Conclusão:*** muitas destas características estavam condicionadas ao contexto de vida e consistiam em particularidades. ***Descritores:*** Saúde da Mulher; Grupo com Ancestrais do Continente Africano; Características da População.

RESUMEN

Objetivo: identificar las características socioeconómicas y de salud de un grupo de mujeres de una comunidad quilombola. ***Método:*** estudio descriptivo, con enfoque cualitativo, realizado por medio de entrevista semi-estructurada con 13 mujeres de una comunidad quilombola, localizada en el sur de Brasil. El análisis de las informaciones fue la descriptiva simple. ***Resultados:*** el grupo de edad de las mujeres era de 14 a 56 años, la mayoría presentaba relación consensual y no desarrollaba actividad remunerada. La renta familiar mensual se concentró entre R$ 70,00 y R$ 800,00 reales. En media, la menarquia fue entre 12 y 14 años, la primera relación sexual fue entre los 17 y los 18 años, la menopausia entre 40 y 51 años. La mayoría realizó prenatal, no presentó complicaciones en el período gravídico-puerperal y amamantaron entre 15 días a cinco años. La mayoría no utilizaba ningún método contraceptivo. ***Conclusión:*** muchas de estas características estaban condicionadas al contexto de vida y consistían en particularidades. ***Descriptores:*** Salud de la Mujer; Grupo con Ancestrales del Continente Africano; Características de la Población.

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INTRODUCTION

Although the color/ethnicity issue appears in numerous official documents (statement of live birth, birth certificates and marriage, voting cards, police reports, death certificates) and numerous national health information systems (information system on mortality; information system on live births; information system of notification of diseases; monitoring of violence and accidents in urgent and emergency guard services, hospital information system, etc.), it is clear that this item, most of the time, it is not completed or the information declared does not correspond to reality. Thus, it is clear that there are still few population data in Brazil, considering the ethno-racial perspective.[1-2]

Nevertheless, the few existing data already help determining that there are numerous differences related to conditions of life, illness and death, depending on the color/ethnicity of the population.[3] If aspects were considered, for example, ethnicity and gender, observing the productions in the literature, some considerations were already unveiled since over the years, some specifics of the black population in health area, especially among women, have been revealed.

In this sense, there was initially that black women traditionally is below the poverty line, with insertion difficulties in the labor market, illiteracy situation, leading without spouses and families with many children. They also have less access to good quality health services, gynecological care and care during pregnancy and puerperal period, being more vulnerable to certain diseases, such as type II diabetes, high blood pressure, uterine fibroids, sickle cell anemia, glucose-6-phosphate dehydrogenase, hypertensive disorders in pregnancy; cervical cancer and infection by human immunodeficiency virus.[1]

Also, it is emphasized that maternal mortality, which is a health indicator that faithfully shows the health and quality of life, and it could be modified from access to prenatal care and/or a better quality prenatal care,[4] among black women, having a higher rate compared to white women.[4-6]

In this context, aspects such as the precarious living conditions of black women, poor access to health services, low quality of care, the difference in treatment received, the lack of actions and/or health professional training geared to the specific risks to which these women are exposed, are listed as causes for the high incidence of death in this population segment.[1-2,5,7]

When these women belong to certain groups, such as the quilombolas communities, socioeconomic and health data allowing to know their health conditions, are practically non-existent in the literature.[8] However, it is considered that information like that should not be discarded, but explored and analyzed, as they are fundamental in the concept, implementation and monitoring of policies and actions that meet specific needs of individuals, particularly quilombolas women. In this context, it is worth clarifying that the quilombola communities include organized camps in rural areas, from the Colonial Brazil and Imperial Brazil, where they took refuge slaves, former slaves and people of other ethnic groups. Individuals residing, and who continue to reside in these places are called quilombolas.[9]

This study is related to the scarce scientific literature on the characteristics of quilombola women and the ability to better direct health actions to these people, from this survey. Thus, this study aims to identify the socioeconomic and health characteristics of a group of women from a quilombola community.

METHOD

Descriptive study with a qualitative approach. The participants were 13 women of a quilombola community, located in southern Brazil. Quilombola women living in the community were included in the survey where the study was conducted, at least 12 years old (defined as the age of early adolescence)[10] and presenting psycho-cognitive conditions to participate in the survey. It is noteworthy that the selection of participants was intentionally considering the inclusion criteria and study objectives.

Data production, which allowed the identification of the profile of the quilombola women who were the study participants, was obtained through semi-structured individual interviews. The interview consists of an information gathering technique about a particular topic that may be of semi-structured type, in which there is a combination of closed and open questions, enabling at the same time using previously formulated questions and also freely addressing the proposed theme.[11]

The data generated in the interviews were submitted to simple descriptive analysis. The research project was approved by the Research Ethics Committee, on December 13, 2013, under the case number 25345113.7.0000.5346 and developed in February 2014. The women, over 18 years old

individually received all guidelines related to the research and signed the Informed Consent Form (TCLE). Concerning the adolescents under 18 years old, they signed the Consent Agreement Form, as well as their caregivers signed the Informed Consent Form.

RESULTS AND DISCUSSION

The community consists of 28 families, totaling 101 individuals, of which 51 (50.49%) were men and 49 (48.51%) were women. Of these, 26.53% (n=13) formed the group interviewed in this study. Opposite to existing studies in the literature, it is possible to see that the number of individuals and families, as well as their composition vary from one community to another,[12] being possible to identify communities that have 90 families and approximately 500 individuals,[13] as well as other with seven families, totaling 57 people.[14] Considering the gender, the distribution of the girl group in the studied community was similar the other, like a study[15], in which women represented 49.81% of the population of their community and in another study,[16] women corresponded to 55% of the total population.

Concerning to age, it was clear that the age of the study participants ranged between 14 and 56 years old, not being identified a predominant age group. However, the group ages, according to international age grade (10-14 years old; 15-19 years old; 20-29 years old; 30-49 years old; 50-59 years old; and so on), it can be found that the majority (53.84%, n=7) corresponded to the group of 30 to 49 years old. In another study[17] it was also found that this was the predominant age group among women of the place, which corresponded to 48.9% of the group.

As for marital status, five said they were single, five said they were married, two had a consensual relationship and one was divorced. Therefore, it was observed that most of them (53.84%) had a stable relationship in the same way as the quilombola women from other studies[17-18] mentioning that most of them (69.34%) were married or with a stable union, and quilombola men and women of other research[19-20] stated that most of them also were married or in with a consensual union. However, this marital status differs among respondents (men and women) of a quilombola community, located in the Cerrado region in the northeastern state of Goiás, where most of them claimed to be single.[21]

Regarding education, it was not identified any illiterate, and most of them (61.53%, n=8) had incomplete primary education; the others had completed high school (23.07%, n = 3) or complete elementary school (15.38%, n=2). Concerning education, some authors[18] who developed a study with quilombola women, in Minas Gerais, highlighted the following findings: 9.97% (n=41) had never attended the school environment; most of them (39.17%, n=161) had between one and four years of education; 20.68% (n=85) have five to eight years of education; and 30.17% (n=124) had education higher to nine years. Although the results have been grouped differently, it is observed that they are similar between this study and research in the literature.[18] Other authors[21] also found that, in the quilombo investigated, most people had only primary education, however, they already completed it.

Another study[20] developed with 121 quilombola women and 97 quilombola men also highlighted the low level of education in the communities, distributed among 11 states (Bahia, Ceará, Goiás, Maranhão, Mato Grosso, Minas Gerais, Pará, Piauí, Rio Grande do Sul, Rio Grande do Norte and São Paulo). There were 29.5% of the population never attending school and 6% completed elementary school. In addition, it was found that 3% of the population could read, although they never attended school, and only 2.3% attended higher education.

Considering the group of women interviewed, they have a reasonable education. Moreover, although some of them, especially the younger ones, wanted to go to higher education, they consider this a very distant possibility of their reality, mainly due to the difficulties of moving to the urban area.

Regarding religion, it was verified the existence of Catholic (53.84%, n=7) and evangelical (46.15%, n=6). Different found by an author,[22] in their study, that the community, located in Bahia, was predominantly Catholic. It was sought by other studies carried out with quilombola women or quilombola populations, to identify the religions of the participants. However, it was found that the religion is little explored in the research tools used by the authors.

With regard to the professions/occupations, most of the participants (84.61%, n=11) reported developing “home” activities. Two said they performed craft activities and also worked in the community bakery, and both activities were remunerated. Compared to a study conducted with 797 quilombola women and men, it was found that 51.19% (n=408) of respondents did not develop any activity in data collection period.[23] Other studies

conducted with 1837[19] and 218[20] quilombola women and men, identified different occupations. In the first study, the following occupations became clear: farmer (45.54%), housewives (20.33%), student (13.23%) and other (20.88%). In the second study there were: fixed employment (11.82%), "gig" (14.51%), farmer not employed (23.11%), unemployed (10.21%), student (1.61%), housewife (10.21%) and others (18.81%).

The monthly household income of participants in this study was focused between R$ 70.00 and R$ 800.00 reais. In the literature,[20] there were also found household incomes similar among quilombola communities investigated. A study carried out with 348 quilombola women found that 74.7% had consistent income less than half the minimum wage, which, at the time of the survey the minimum wage was R$ 545.00 reais.[17] Other authors[24] developed their research on quilombola communities in the State of Tocantins, and also found that family income, which showed insufficient for the maintenance of the families consisted of little more than one minimum wage.

In 2004, through a survey of about 150 quilombola communities, it was found that the income of most families did not exceed R$ 240.00 reais per month. After more than ten years, there is the reality of many quilombola families not changing significantly this issue.[25] However, special attention should be paid to the financial condition of these individuals, as this may influence their access to food, education and health.[24]

Other information collected during the interviews was to family members who lived with the women. Thus, four said they resided with her partner and their children; two lived with their parents; one with parents and siblings; one with parents and children; one with parents, children and partner; one with her partner, her sons and her granddaughter; one with her partner, her sons and her daughter; one only with her children; and one lived alone. It is observed a variety of the responses of study participants. However, the composition of the Quilombola families is not an aspect considered in the studies, which hampered the analysis of this item in this research.

Some of the women participating in the study reported that they lived in the community until a certain age, they left the place for a short period of time, searching for better job opportunities in the city, but then they returned to the Quilombo and lived there since then. Thus, the time lived in the community, considering this return varied between one month and 51 years. When observing the literature to confront these findings, as already evidenced in relation to other data collected in this investigation, it was found that this is not an information considered by the researchers in their productions. However, it is believed that, considering the difficulties faced by women, men and children in numerous quilombos, it is essential to investigate how long individuals reside in these locations, identifying possible migration processes and why they occur.

In addition to the socioeconomic data, information on the health characteristics of participants was also collected. Initially, they were questioned about menarche, which was observed to have occurred in various age groups. So women reported having presented the first period between 10 and 14 years old, with prevalence mainly at 12 years old (38.46%, n=5) and 14 (30.76%, n=4). It is worth noting the existing production in the literature, with some findings that approximate those seen in this data collection. In one of the essays found, for example, the author found that menarche occurred among the quilombola girls from 11 to 17 years old, and the average was at 13.87 years old.[26]

Other authors found in their studies that 13 and 14 years old respectively as the age groups of the menarche (16.27). In a thesis produced in nursing, it was clear the interval between nine and 19 years old.[28]

In terms of age presented by the participants at the first intercourse, it was obtained the interval between 12 and 21 years old, with a prevalence to 17 (30.76%, n=4) and 18 (15.38% , n=2), also highlighting that one of the participants said not having sex yet. These findings are in part similar with those presented in the thesis mentioned above, in which ages presented by adolescents in their first sexual intercourse were 13 (14.28%, n=1), 15 (14.28%, n=1), 16 (28.57%, n=2) and 17 (42.85%, n=3) years old, with a prevalence also at 17 years old.[28]

The women were also asked about the experience of menopause. Thus, it was highlighted that three of them said already entered in the menopause. They claimed that the first modifications, linked to this phase took place after 40, 48 and 51 year old. Thus, it is clear that the onset of menopause, as well as menarche varies from one woman to another. In this sense, a research developed with 363 quilombola women, pointed out that the menopause ranged between 29 and 58 years old, with an average of 48.30 years old,

demonstrating a wide variation in the occurrence of this event.[26]

As for the obstetric history, among the 11 participants who had been pregnant, the number of pregnancies ranged from one to nine, pointing out that two of the thirteen participants had never been pregnant. Most of them (30.76%, n = 4) reported having three pregnancies. In a research conducted in quilombola communities in northern Minas Gerais, it was identified a much higher number of pregnancies. Thus, it was found that most of them (35.0%, n=144) had four or more pregnancies, the rest gave birth one (18.7%, n=77), two (18.0%, n=74) and three (16.5%, n=68) babies. Also, 11.7% (n=48) said they had never been pregnant.[18]

As the number of vaginal deliveries of the study participants, this ranged between one (30.76%, n=4), two (30.76%, n=4) and six (15.38%, n=2) and the number of caesarian sections were between one (38.46%, n=5), two (15.38%, n=2) and three (7.69%, n=1). In the literature, there are no studies that have been considered the way of delivery in the quilombola women. However, authors[29] pointed out that there is a cultural perception that black women are tougher and support more pain than other women. Thus, the care offered to them often direct them to vaginal delivery, unlike white women, who are often guided and also opted more for cesareans. In the quilombola community of this study, vaginal deliveries were more than cesarean deliveries mainly because they reside far from the hospital and also by vaginal delivery be a practical culturally accepted and valued among these women.

Furthermore, additional data not considered in this study, but in others, were age at first pregnancy (18, 26-27) and the interval between pregnancies.[26] In terms of age, although the participants have argued that teenage pregnancy was common in the community, in the data collection instrument were not anticipated questions about these aspects.

It was also noted the occurrence of miscarriage in women, one reported having had an abortion and the other two, which is a low incidence at this location. In contrast, a study[26] developed into a quilombola community of Goiás, found a high incidence of abortions, which represented 8.32% of all pregnancies.

As regards the number of live births, most of them (38.46%, n = 5) reported having three children. The others had reported having one (15.8%, n=2), two (15.8%, n=2), five (7.69%, n=1) and seven children (7.69%, n=1). In other articles evidenced in the literature, there was an average of 4.5 and 5.4 children among the women interviewed, respectively.[16,27]

It was also asked to the participants if they had performed prenatal care and only identified one participant who did not perform it. It was also questioned the number of consultations and the time when the monitoring began, however, most of them experienced their pregnancies for many years, so they were unable to provide this information in a reliable way. Nevertheless, it is clear that prenatal care is done for much of the quilombola women, as authors pointed out, which found that 92.1% of women in their study, conducted consultations in this period.[27]

It was also investigated if women have any complications during the pregnancy and puerperal period, and the majority (53.84%, n=7) said they did not. Among those who said they had some complications. As complications, there were mumps, back problems, varicose veins and hypertension during pregnancy. They argue that the perception of women about what may or may not be a complication may be influenced by many factors, such as socioeconomic status, level of education, the family and community environment, the meaning of pregnancy for the woman and her family, beliefs regarding this event, among others.

Regarding breastfeeding, all participants who were pregnant said they breastfed their children. The duration of breastfeeding ranged from 15 days to five years, and the average time was between six and nine months. By questioning the reasons that led to discontinue breastfeeding, it was found that they converge with the reasons mentioned by other women, either quilombola or not.[30]

The women in this study mentioned several reasons for weaning, among them, the baby did not want to breast milk; the baby was hospitalized; milk was over/dried; did not have milk; belief that breast milk feeding the child or not was not enough; the posture adopted during breastfeeding generated pain of women. It is noteworthy that among the interviewed, there were beliefs of lack of milk, weak milk or little milk. The belief of weak milk, little or not enough has been culturally used as a reason for the failure with breastfeeding.[30]

It is also noteworthy that although the participants have listed the reasons for stopping breastfeeding, when asking if they had experienced any complications during the breastfeeding period, only two women said they had problems, one saying that the “milk

was not going down" and the other woman said that "the milk dried". Thus, it appears that although most did not present any complications associated with breastfeeding, they opted for weaning.

Regarding the preventive examinations for cervical cancer, three (23.07%) had never performed the examination, and the majority (53.84%, n=7) had conducted the examination in 2013. The remaining conducted the last examination in 2012 (15.38%, n=2) and 2010 (7.69%, n=1). It is clear, therefore, that the examination performance varied among women.

In this context, a cross-sectional population based study, conducted with 348 quilombola women, found that 56.3% (n=196) had conducted the examination for more than three years, 16.4% (n=57) held it less than three years ago and 27.3% (n=95) never did it. Compared to those who never were examined, the authors attributed to the following factors: age between 18 and 29 years old and 50 to 59 years old, little education, do not have spouse, seek health care in different services of their place of residence and have performed clinical breast examination three years ago or more and never have it performed it.[17]

Concerning the use of contraceptive methods, five said did not use any method; five claimed that they had performed tubal ligation; two used oral contraceptives and condoms; and, one as mentioned, had not yet sexual intercourse. To relate these findings with another study, it is possible to infer that women consider that the use of condoms is only necessary to avoid an unwanted pregnancy, disregarding its importance in preventing sexually transmitted diseases.

Of the 363 women interviewed, only 10% claimed to have used contraceptive methods (oral contraceptives and teas) before the first pregnancy. After birth, the number of women who started using some method rose to 12.5% (26). In addition, another research conducted with women of quilombola communities, located in Minas Gerais, indicated that 29.2% (n=120) used oral contraceptives, 10.7% (n=44) used other contraceptive methods, 24.3% (n=100) had performed tubal ligation, and 60.1% (n=247) did not use any method.[18]

FINAL REMARKS

The design of this study allowed to identify the socioeconomic and health characteristics of the women, noting similarities and differences between women and men in some cases, quilombola other communities across Brazil. Thus, it can be seen that this group has its particularities and peculiarities, which must be observed by management, as well as by professionals and health services.

It was found that many of the characteristics presented by the women are conditioned to the context of life in which they live. In this scenario, they are experienced numerous difficulties and inequalities that influence directly in their living conditions and health.

There were barriers of this study about some questions that required women rescued some experiences long ago, especially those related to pregnancy and puerperal period. Thus, it considers that some answers may not have been provided with the necessary precision, hindering to develop this study.

Also, it was highlighted the lack of studies on the socioeconomic and health characteristics of existing quilombola communities, particularly to data investigated in this study. It was shown for example, the absence of related articles with distribution of subjects by gender and age, religious preference, household composition (considering members of the family group residing in the same household), migratory movements of individuals to the urban areas of cities or other scenarios, and the delivery mode chosen by quilombola women.

It is hoped that this study awakens thoughts and stimulates the development of health strategies that consider the characteristics displayed by this group of women, and value and respect their specificities and life stories. It is considered that research like this can give visibility to the quilombola women, contributing more actions before resolving action before the problems experienced by them.

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