

Access in a quilombola community: dimensions of health equity

O acesso em uma comunidade quilombola: dimensões da equidade em saúde

El acceso en una comunidad quilombola: dimensiones de la equidad en salud

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ABSTRACT

Objective: The study's purpose has been to discuss the quilombola women's access in social vulnerability to health equity attainment. **Methods:** It is a qualitative research linked to the methodological benchmark of Paulo Freire, during the achievement Culture Circles with ten quilombola women. **Results:** The following relevant themes of the access were then revealed: the transport, urban mobility, health information and the racism. The community strengthening is indispensable for the achievement of equity in health. It is necessary to deepen such thematic since the embarrassment, insecurity and culpability of these women in reporting some omissions about their health remain present. It is evident the women's empowerment when there are actions towards health and self-care. **Conclusion:** It is important to promote the citizen's awareness, the emancipation and strengthening of individuals, aiming to guarantee universal and equitable access to construction and right for all.

Descriptors: Access equity, African continental ancestry group, empowerment, social vulnerability, women.

RESUMO

Objetivo: Discutir o acesso de mulheres quilombolas em vulnerabilidade social para o alcance da equidade em saúde. **Método:** Pesquisa de abordagem qualitativa articulada com o referencial metodológico de Paulo Freire, durante a realização de Círculos de Cultura com dez mulheres quilombolas. **Resultados:** Como temas relevantes do acesso são desvelados o transporte, a mobilidade urbana, a informação em saúde e o racismo. O empoderamento comunitário é imprescindível para o alcance da equidade em saúde. Instiga-se um aprofundamento desta temática, pois se percebe que o constrangimento, a insegurança e a culpabilidade destas mulheres ao relatarem algumas omissões sobre sua saúde ainda se mantêm presente. É visível o alcance do empoderamento ao terem atitudes perante a sua saúde e autocuidado. **Conclusão:** Destaca-se a importância de se impulsionar uma consciência cidadã, a emancipação e o fortalecimento de sujeitos a fim de garantir o acesso universal e equitativo como construção e direito de todos.

Descritores: Equidade no Acesso, Grupo com Ancestrais do Continente Africano, Empoderamento, Vulnerabilidade Social, Mulheres.

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RESUMEN

Objetivo: Discutir el acceso de mujeres quilombolas en vulnerabilidad social para el alcance de la equidad en salud. **Método:** Investigación de abordaje cualitativo articulado con el referencial metodológico de Paulo Freire, durante la realización de Círculos de Cultura con diez mujeres quilombolas. **Resultados:** Como temas relevantes del acceso se desvelaron el transporte, la movilidad urbana, la información sanitaria y el racismo. El empoderamiento comunitario es imprescindible para el logro de la equidad en salud. Se instiga una profundización de esta temática, pues se percibe que la constreñimiento, inseguridad y culpabilidad de estas mujeres al relatar algunas omisiones sobre su salud aún se mantiene presente. Es visible el alcance del empoderamiento al tener actitudes ante su salud y autocuidado. **Conclusión:** Se destaca la importancia de fomentar una conciencia ciudadana, la emancipación y fortalecimiento de sujetos a fin de garantizar el acceso universal y equitativo como construcción y derecho de todos.

Descriptor: Equidad en el Acceso; Grupo con Ancestrales del Continente Africano, Empoderamiento, Vulnerabilidad Social, Mujeres.

INTRODUCTION

Presently, we seek access as an essential part when entering something that is either needed or inherently sought to achieve. Access is a complex concept, sometimes used in a confusing and multifaceted way. Related to its inequalities, it is described as one of the main problems to be faced in order for the *Sistema Único de Saúde (SUS)* [Unified Health System] to function effectively, according to established principles and guidelines.¹

The various approaches to access analysis related to health services demonstrate the level of plurality and complexity of the topic, emphasizing entanglement and inaccuracy.¹

Bearing this in mind, the term accessibility is described as a condition of possibility for the transposition of obstacles aimed at the effective participation of individuals in the various spheres of social life. It is presented as an essential condition for all social inclusion processes in their various natures, being they attitudinal, technological, informational, communicational, linguistic, pedagogic, among others.²

Although the right to universal and equal access is a strong principle guaranteed in the guidelines of the *SUS*, barriers and outcomes are perceived in practice. According to article 196 of the Federal Constitution (1988),³ “health is the right of everyone and the duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other diseases and equal access to actions and services for their promotion, protection and recovery.”

The *SUS* enshrines the principles of Universality, Equity and Integrality of the health care of the population, thus guaranteeing universal access to goods and services that guarantee their health and well-being, in an equitable and integral manner.⁴

For the optimization of health resources, the quality of assistance focused on the population dimension is anchored in the triennium of equity, efficiency, and cost, again establishing equity as a strong foundation for the system and this may enable access to health care.⁵

Equity is a social justice dimension of access, while resources are mobilized to address the need for a particular population. They stand out for the importance of taking into account the variations of needs within unique geographical configurations and also within different sociocultural and economic subgroups,⁶ thus offering greater access to those who most need it.

Therefore, reference is made to communities in social vulnerability that include quilombola populations. Social vulnerability implies a set of characteristics, resources, and abilities inherent in individuals or groups, which may be insufficient or inadequate to take advantage of the opportunities available in society. Thus, this relationship will define a greater or lesser degree of wear and tear on the subjects' life quality.⁷

From this perspective, the Pro-Indian Commission of *São Paulo* defines the remaining quilombo communities as social groups whose ethnic identity distinguishes them from the rest of society.⁸ The term “*quilombo*”, which in its Bantu etymology means “warrior camp in the forest”, was popularized in Brazil to refer to the mutual support units instituted by the rebels to the slave system and to their reactions, organizations, and struggles for the end of slavery. This word also had a special meaning for the freedmen, in their trajectory, conquest, and freedom, reaching wide dimensions and contents.⁹

Access to health must be guaranteed by the Brazilian constitution to the entire population, including the quilombola communities, understanding and putting into practice equity as a foundation of care to promote their health.

A study referring to the social representation of 146 users in relation to *SUS* reveals as a central characteristic a biomedical, hospital-centered and medicine-centered dimension, reinforced by the perspective of the medicalization of health care.¹⁰

Traditional health care, called biomedical, is based on a Cartesian view of body and mind fragmentation, reducing the individual to a biological organism and thus disqualifying psychological, social and environmental aspects involved in the process of living and becoming ill. Moreover, it has also been questioned the inadequate preparation of health professionals to perform their duties, the high cost of health services and the inability to meet the true needs of the population.¹¹

Nursing is included as a profession that seeks to overcome the current dichotomy in traditional teaching models, seeking to adapt to the current designs of the globalized world which demands new forms of knowledge construction as well as changes in the process of professional training, ensuring a integral assistance and focused on transdisciplinarity.¹²

Hence, it is believed that community access to actions, services, and information related to health, they are priorities for Health Promotion of the population, impacting on the organization of daily life of individuals and enabling choices to be made and thus, to provide a better quality of life. With this, the access faces damages that become explicit in some contexts and deserve an important look.

Therefore, this article aims to discuss the community access of women from a Quilombola community to achieve equity in the issue of accessibility and mobility, health information and relationship with the health professionals.

METHODS

This is a qualitative research with a participatory and dialogical character, which was carried out next to Paulo Freire's Itinerary of Research that has as its stages thematic research, codification and decoding and critical unveiling.¹³

The investigation of the themes occurred during the development of the Culture Circles from April to June 2016 during six meetings. Ten women over 18 years old living in the *Morro do Fortunato* quilombola community, *Garopaba* city, *Santa Catarina* coast.

The group of women from the *Morro do Fortunato* quilombola community has been meeting for eight years and has the participation of twelve women, all belonging to the community. Its objective is the accomplishment of artisan activities which receive the assistance of the secretariat of social service of the municipality. In it, they all work their skills both in the area of gastronomy and handicrafts.

After agreeing with the participants, the Culture Circles were held concurrently with the meetings of the women's group. To obtain the themes, we had the support of two research assistants who contributed during the process together with the records in the field journal and application of the socio-demographic instrument. The subjects were recorded with the appropriate authorization and transcribed by the researcher who used an attentive and directed transcript, based on the research question, as well as on the objectives of the study.

In the first and second meeting there was an approximation in the relationship between researcher and participants, promoting both the knowledge of the research proposal and the attentive listening of the group's trajectory.

The survey of the generating themes took place in the third meeting with the participants. In order to have them investigated with the group, a dialogue was made on Dahlgren and Whitehead's model¹⁴ on the Social Determinants of Health combined with some concerns related to their health and the interference of these factors in being a quilombola woman.

In order to do so, it was used the dynamics of clipping and collage, raising the survey of the generative themes which were distributed in two posters composed of the figures selected by the women.

In the fourth meeting, the twenty themes raised in the Thematic Research were presented in the form of cards and discussed by the group. As a result of this dialogic moment, these first themes were reduced to eight, which were selected by the participants of the Culture Circle, and one of them was chosen to be discussed in this report: access/mobility.

This generating theme was unveiled and analyzed in the fifth meeting where a critical look regarding the access and mobility related to this community was sought, being worked and translated into three different dimensions: access to transportation, access to health information, community and health professionals relationship.

At the sixth and last meeting of the Culture Circles, facilitated by the bond and empathy of all participants, the critical unveiling was accomplished in an empowered way and with a real possibility of exposing oneself and facing their

anxieties and weaknesses, which allowed the analysis of the themes raised during the phases of the Research Itinerary.

This study was submitted to the Ethics Committee on Research with Human Beings and approved by *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 53143216.6.0000.0121. The anonymity of the participants was respected and participation in the study was considered by signing the Free and Informed Consent Term. In accordance with the Resolution No. 466/2012, from the National Health Council, involving human beings; furthermore, the principles of beneficence, non-maleficence, justice and autonomy, as well as the principles of the Nursing Code of Ethics were respected.

RESULTS AND DISCUSSION

When we started the discussions with the group related to the theme of access and mobility, a naive and "non-reflexive" thinking was perceived in front of the community accesses experienced by this community.

Based on the dialogue, we come to revisit a new and critical look at their realities. In addition to precarious transport mobility, there was a lack of information about self-care as well as a gap between these women in relation to professionals and health care.

In this context, when rethinking the nuances of access to health, nursing stands out as a strong and pertinent profession related to care and promotion.

Concerning the profile, ten women within the age group from 24 to 54 years old and belonging to the *Morro do Fortunato* community have participated in this study. With regards to the schooling, only one did not study, five finished elementary and four high school, one of which is ending this year. Of these ten, eight have children, two have one son, two have two children, three have three children, and one has four children. *Vis-à-vis* the profession, one is a clerk, three are vendors, one is general service assistant, one artisan and housewives. Regarding the religion, seven are Catholic, one evangelical, one "attends" all religions and one is wilka and Celtic.

Access to transport versus accessibility and community mobility

Primarily, arriving at the hill requires curiosity and insight to find the women in this community. Distant on average eight kilometers from the center of *Garopaba*, it is necessary to travel sinuous and unpaved ground roads.

Nowadays, when approaching the community, a small narrow stone road was built for the last roads before arriving at the place.

With all these obstacles, it is confirmed the difficulty of access and mobility raised together with thematic research by the participants in the development of the Culture Circles, clearly expressed in Flower's speech:

"Access... schedules... when it rains then? It's much harder... For students who cannot miss classes, there are few bus schedules and they have to go. We ended up having to take them around" (Flower).

Corroborating with the speech of Flower, it is highlighted in a study the underutilization and suggestive greater difficulty of access by the quilombola populations. They also justify that a probable explanation for this reality is that the iniquities faced by the quilombolas go far beyond the difficulties in access and use of health services, being proclaimed above all by the worst social and economic conditions.¹⁵ Access is an essential condition to improve the quality of life, and it is included in the positive concept of health.

Given this perspective, together with the Brazilian black population as a whole, it is possible to identify that the group of quilombola communities is still neglected. Most of them located in rural areas, originally made up of descendants of slaves, resisted the fringe of social benefits, preserving the dependence of the land for its physical, social, economic and cultural reproduction.¹⁶

Alongside this, the residents highlight the difficulties of moving to and from their homes. They report that for the children to arrive at school as for all the residents who need any trade, they depend on own vehicle or to wander to the place, since the offer of public transport is quite outdated:

“There is no pharmacy here... everything is down there... when there are no buses we have to walk up with several bags...” (Passionate).

So, it is urgent to adapt the services used by the community to the dynamics of work, highlighting the need for a greater supply of public transportation in keeping with their realities, a greater infrastructure and the possibility of commerce and income for this group populational.

Access to health information

The difficulty of access to public transport as a restricted accessibility and community mobility allowed us, during the Culture Circles, a new and reflective reading regarding access to information and the relationship between it and racial issues.

Although there is still considerable debate about the concept of access to health information, part of the literature recognizes that access is not equivalent to the simple use of health services and education. Access has been described as the opportunity to use the services in circumstances that allow the appropriate use of the services and assist in the evaluation of health equity.¹⁷

The debate carried out in the course of Culture Circles allows the researchers to be more close and interrelated with the participants, allowing a true insertion in their daily lives and a reading guided by the perception, the empathy and the experience of the wheels. With this, as the meetings were being developed and the themes generated coded and decoded, a deficit related to the health information of the participants was identified, together with a growing and real interest of the group in the issues related to self-care, quality of life, autonomy and Health Promotion, thus allowing the unveiling of the theme of access and mobility.

In this aspect, Health Promotion is considered universality and integrality, prioritizes the collective approach and aims at reducing social inequalities, empowerment, autonomy, and social participation. It also plays an important role in the community development process, seeking to relate the Determinants of Health and empowering the community to expand its achievements and improve its quality of life.¹⁸

Like so, this is translated into Flower's speech:

“Actually, we speak a little of everything... access issue... because many other things we do not have access... education, health...” (Flower).

“The most we talked about was access to transportation... which is very precarious here for people.” (Hard working).

And with a reflexive look, she reinforces:

“But if we think about everything we have difficulty accessing even to get information.”

The dialogue produced in the Circles demonstrates a new look under the reality of these women's lives, allowing them some consideration of their needs and reflections for decision-making. They come to understand that the difficulty of access transcends access to transportation and community mobility, including a deficit in health information and education.

In this sense, access is related to four main elements: availability, acceptability, payment capacity and information, affirming a confusion and proximity to the concept of equity in health. They reinforce studies that converge to a common reflection where the problem of access to health and, consequently, of equity, needs to be confronted through intersectoral actions and transversal to various governmental areas, encompassing public and economic policies, allowing a better distribution of income, citizenship, better education and housing conditions, and not only through actions limited to the level of performance of health systems.¹⁹

Information is paramount for understanding each of the dimensions of access. Being well informed is a result of the communication process between the health system and the subjects.¹⁹

These elements stand out as tools linked to Health Promotion that strengthen and empower individuals to make decisions and be active in the construction of their life trajectories.

It is essential to broaden the discussion of the right to health, which is one of the basic premises of the SUS, emphasizing that access also passes through the social and economic conditions of the population and not only their ethnic status. Universality must be seen as full access to public health and quality services for the whole population, but it has not yet been implemented in practice.²⁰

Access and racism in health services

The relationship of information with racism in health has identified that crucial issues are undressed day by day and

various confrontations are experienced by these women. In Flower's emphatic and reflexive speech:

"Racism also generates a difficulty of access... even to get a better job, to get out of the informality... Then they end up having to have jobs as a cleaning woman, mason... the husbands without a formal job... The daughter of her, for instance, began to go to college but was in Tubarão city, so it was very difficult, then she gave up... then all this is difficult to access... even to have a better future... Then the theme that we took everything entered the difficulty of access because it encompassed everything..." (Flower).

Discrimination by color and race, often perpetrated in a veiled way by virtue of the laws that condemn it, leads to enormous differences in access and assistance in the different social spheres, such as the less opportunity for schooling, justice, as a reflection of the lack of information and the relation with a better economic profitability as well as in housing and housing conditions.^{21,22}

Between the lines of the Culture Circles are pointed out in the unfolding of dialogues, strong and subjective constructs resulting from a veiled and prejudiced past in which, in a "funny" and subtle way, it comes to the surface and is exposed in the wheel.

"These days they spoke on the radio... they offered the songs... One for the people on the coast... and then he said: That goes to the black people up there! Do you believe it??? But I'm going to charge him... It's not that we are ashamed of our color, but why did not he say: '... people from the Morro do Fortunato?' (saying it laughing...). if it were not for racism... Maybe because of custom, but it is a insult." (Flower).

The above speech denotes the feeling of revolt and sadness with collective questions and a self-justification for the understanding of the social prejudice experienced in simple situations of day to day, as in this case, in local radio messages. In this interim, it is emphasized that prejudice interferes with the health condition. The health professional can contribute to softening this reality by contributing to the empowerment of this population.

In this same direction, racism, multifactorial racism, sexism, and socioeconomic and cultural conditions of guaranteeing universal and equitable access to health as well as the use of services are ratified. Access - utilization of health services and inputs - is an important condition for the maintenance and reestablishment of health, although it is not the only factor responsible for a healthy and quality life.²³

The authors go further:

black women experience different types of race and gender discrimination, which, when intersected, compromise their insertion in society as a subject of law, especially in health, where the inequalities imposed by racism and sexism differentiate women in the access to health services as well as in the process of becoming ill.^{23:572}

When we understand the difficulty in accessing health information and its relation to the racial issues unveiled in the Culture Circles, the participants begin to see a new need to be sought. They perceive a greater and growing interest in learning and understanding their lives and their rights as protagonists of their stories.

Access to health professionals and the empowerment of quilombola women

Access to mobility and health information, it was still necessary, through the reports of the participants, to discuss the relationship with health professionals and the empowerment of quilombola women.

The relevance of this approach to the participants involved in this study feels the need to discuss this relationship and to deepen the theme. Restricted access to health professionals or the lack of skills to use or question their desires indicate their vulnerability related to the health and disease process.

Facing this, the importance of training is focused on dialogic practices among the actors involved, pointing to the understanding of the determinants of health as well as the development of actions that result in an improvement in the living and health conditions of the population and consequent greater professional accountability results of their actions.²⁴

In this way, intersectoral actions, involvement of social control and listening to the needs of the subjects should be articulated in the context, aiming to constitute commitments and partnerships to improve the conditions of the population's access to health services.²⁵

It corroborates with the above thought the speech of Violet when it says:

"(...) Actually, people feel that nobody listens to us or I do not know, they think that what we are feeling is silly and they only give us a prescription and gave..." (Violet).

And yet, it is strengthened by Violet's speech:

"It's so easy what you're talking about here, but no one spoke in our way about the importance of doing these exams." (Honey).

Based on this viewpoint, one can see the eminent urgency of a differentiated attention, contemplated with committed professionals and who exercise an active listening and connected with the individual reality of the communities in which they act.

In the health area, the importance of knowing about the information provided by the professionals to the subjects is related to the respect to the autonomy of the same and to exercise it is essential that they are well informed about their health and all the factors that are inserted therein.²⁶

The participants' speeches also portray the issue of care and demonstrate the fragility of the relationships between those who receive (or seek) care and those who offer (or deny) care/education:

“In the consultations I’ve attended, I’ve never heard of taking a contraceptive, more high blood pressure, much less the age issue and the risks of continuing to take it...” (Violet).

In this speech, the importance and risks generated by this distance, often resulting from an increasingly pharmacological, biological and “fast” assistance, are stated, allowing many gaps and consequences that are often irredeemable.

With this, we can see the imminent need for a more attentive and holistic look linked to an active listening and meetings based on empathy and dialogue.

In this sense, the imperative need to agree with the participants who seek in the system a true co-responsibility, encouraging them to become true protagonists of their health, managing their lives with care with food, physical activity, leisure activities and, thus integral care that encompasses your body, spirit, and mental health.²⁵

It is confirmed that people are waiting to be consulted in order to express their anxieties, nonetheless, at times they do not have room for dialogue and the professional-patient relationship does not materialize, which negatively affects the continuity of their self-care.²⁵

Given the aforesaid, when one perceives the discomfort and embarrassment pointed out by the participants of this study when discussing issues related to women’s health and especially when explaining the pathologies related to being black/female, such as a high rate of cervical cancer, it has been noticed that there are innumerable times when prevention is not effective due to the absence of health education activities.

This is characterized in the statements of some participants when asked about the Pap test:

“Hmmm... My last time was over four years ago... It’s horrible...” (Flower).

“I think it’s bad... Because it’s humiliating for people... I have to prepare a week before... But I still do it every year... Although this year I have not done...” (Violet).

“I always tell my community agent that I do, but in fact, I do not... I did it in my prenatal... In this prenatal thing, I am very strict... Now the preventive I find very embarrassing...” (Flower).

And when asked about the time she did not take the exam, Flower answers:

“Ten years ago... But I did not realize that it was so important to take this exam...” (Flower).

The above dialogue expresses the sense of embarrassment, guilt, and lack of knowledge that women represent. With this, still inserted in the Freireana proposal of exchange and collective learning, we dialogue in the Culture Circle before the importance of the annual realization of the cervical cancer preventive examination and the possibility of early diagnosis if it is carried out every year. We take advantage to demystify and soften the feelings of embarrassment and exposure, seeking

to give a well-deserved emphasis on self-care, self-esteem and consequent quality of life.

Corroborating with the above-mentioned dialogue, we share the critique of the insistent prevalence of self-care as a plausible and desirable result of educational actions in health (...), is related to the ideology of individualism, where the notion of individual autonomy is central. The strong influence of this ideology in the field of health is related to training. Still heavily impregnated by the biomedical paradigm, away from socio-anthropological understandings about health and based on cognitive-behavioral theories that configure learning processes focused on the transmission of information and changes of attitudes, neglecting, for the most part, the social and cultural determinants of health, individualizing the processes of illness.²⁷

So, it is easy to explain some professional positions where trained in this context and exposed to care practices based on quantitative and epidemiological assessments, they invest in the Health Promotion of the “other” from verticalized actions, with little space for listening and saturated with those knowledge determined by science as unequivocal appreciation for the care of oneself.²⁷ This statement is expressed in the following speech:

“I waited eight months to get the consultation and when I got there he barely looked at me and gave me a medicine to calm down... Actually, I left just like I entered...” (Friendship).

The above speech allows us to reflect the prioritization of active listening in our day-to-day care provided as a care practice and a greater possibility of approximation between the professional and community binomial.

Therefore, when we listen to the other and value their singularities, we experience care and advance in strategies to strengthen the autonomy of the subjects and consequent promotion of their health, indicating a process of empowerment with greater openness to listening and some kind of transformation in practices towards the empowerment of the population.²⁸

The access scenario that refers to the multiple dimensions of the vulnerability of quilombola women reinforces the imminent importance of individual and community empowerment strategies in an equitable approach and endorses practices and discussions that promote the health and quality of life for these women.

FINAL CONSIDERATIONS

This study pursued to discuss the community access of women from a quilombola community to the achievement of equity in terms of accessibility and mobility, health information and the relationship with professionals, based on ethnic and racial issues. Concerning the accessibility as a synonym of mobility and displacement, the participants unveil the theme as transcendent needs that enable the new and fruitful reflections narrated in this study.

Given the aforementioned, in the course of this process of subliminal listening and reading, a silent and imperative

opportunity is awakened directed at the various invisible communities that cry out for deserved and still obscure access possibilities. Access to which refers to tools rarely exercised such as respect, equity, care, health education, autonomy, quality of life and empowerment.

Considering the difficulties and reflections showed here, it is highlighted as consensual the urgent need to think about strategies of engagement and social participation, sensing greater accessibility and mobility for this and many communities in social vulnerability.

Therefore, it is instigated a deepening of this subject, since it is perceived that the embarrassment, insecurity, and culpability of these women when reporting some omissions on their health and a probable shame in reporting them still remains present. On the other hand, their empowerment is visible when they have attitudes towards their health and self-care, especially when reporting their actions already done, such as examination schedules as well as healthy practices in their daily lives.

Also worthy of note is the strong relationship with a deserved visibility and appreciation of this population. Producing changes in ducts that are often plastered and also reproduced allows for credibility and strengthening of equity, allowing the exercise of care as a strategy of autonomy, empowerment and health promotion.

Hence, despite some atrocious realities related to access and/or lack, we believe in the possibility of constructing critical and reflexive collectives. It is important to promote the citizen's awareness, to overcome social conformism through the emancipation and strengthening of empowered and committed individuals and, ultimately, to guarantee universal and equitable access to construction and right for all.

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