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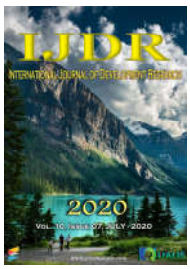

RESEARCH ARTICLE OPEN ACCESS

INTEGRATIVE AND COMPLEMENTARY PRACTICES: EXPERIENCES AND REFLECTIONS IN *QUILOMBOLA* COMMUNITIES

[1]Walkelândia Bezerra Borges, [1]Janaína AlvarengaAragão, [1]Evandro Alberto de Sousa, [1]Juliana Barbosa Dias Maia, [1]Jeisy dos Santos Holanda, [1]Virna Rodrigues Leal Moura, [2]Patricia Maria dos Santos Batista, [2]Verônica Lourdes Lima Batista Maia, [1]Mariluska Macedo Lobo de Deus Oliveira, [1]Luciano Silva Figueirêdo, [1]Elvis Gomes Marques Filho, [1]Rodrigo Ferreira de Morais, [2]Leonardo Fonceca Maia and [2]Fernanda Bezerra Borges

[1]Uniersidade Estadual do Piauí
[2]Universidade Estadual do Piauí

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Corresponding author:
Walkelandia Bezerra Borges

ABSTRACT

According to the World Health Organization, 80% of the population makes use of traditional practices in Primary Care. Brazil's National Policy of Integrative and Complementary Practices considers medicinal plants to be the most inserted practices in society, because they have continually been present to the family and religious environment, which apply their knowledge. The objective of this work was to know the usual integrative and complementary practices in *quilombola* communities of the semi-arid region of Piaui. This is a descriptive research with a quali-quantitative approach.The research participants are mostly female, married and depend on subsistence agriculture. The data showed that the use of medicinal plants in the form of teas, mostly using the leaves, comprise the most used practices in the communities in a prophylactic way, or for the treatment of diseases. Some of the respondents reported having respiratory diseases, such as asthma and renitis that are caused or aggravated by the use of smoking, or even by the fact that they are a passive smoker. In addition, the consumption of alcohol that causes diseases such as liver cirrhosis, gastric problems, and behavioral problems that interfere with the well-being. In this perspective, the development of new researches is essential to deepen knowledge about this theme in traditional *quilombola* communities, as it provides subsidies for health education interventions in these communities.

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INTRODUCTION

Always present in the historical context of human existence in the art of care, integrative and complementary practices, over time, have gained significant prominence, based on scientific proofs of their effectiveness. For the Ministry of Health, the Integrative and Complementary Practices (ICP) are therapeutic resources based on traditional wisdom, with the objective of preventing various pathologies and treatments for palliative or non-palliative purposes (BRASIL, 2015). In this perspective due to the strong growth and structuring of ICPs, the World Health Organization (WHO) in the late 1970s instituted the traditional medicine program, encouraging the development of public policies that promote the integration of traditional and complementary medicine in developing countries. Due to about 80% of the population making use of traditional practices in the field of primary care, and about 85% use plants or some preparation in the search for better living and health conditions (BRASIL, 2015). However, in Brazil, the Ministry of Health (MH) in 2006 launched the National Policy of Integrative and Complementary Practices (NPICP), inserted in the SUS with emphasis on primary care (MATTOS *et al.,* 2018). With the objective of implementing the NPICP, to offer a humanized, continuous and integral service with expansion of resolvability, safety in use and stimulate social participation (BRASIL, 2015). The NPICP brings medicinal plants as one of the most inserted practices in

society, resisting and standing out between generations promoting the aggregation of knowledge about the different forms of use and purposes of use, as well as phytotherapic medicines that are characterized by being herbal pharmacological preparations in different forms of presentation (BRASIL, 2015). Regarding the popular domain, it is noted that continuously the care actions related to the family environment have been present. Friends and neighbors that apply their knowledge, emotional support and religious conventions to carry out care bringing together even the use of centuries-old sacred practices such as blessing (KLEINMAN, 1981), which over time have become a form of coexistence and inclusion in society , as a global fact indispensable for subsistence (WALDOW, 2012). The communities that make up this study are in the municipality of the city of São José do Piauí-PI, considering that the Saco da Várzea community is legally certified by the Fundação Cultural Palmares (FCP), but the Afrodescendant community of Negros *Quilombolas*from Alto da Boa Vista is in the process of obtaining certification. Within the context of health, during the study it was possible to observe the existence of numerous deficiencies present within these communities, fromeconomic and social instability, in addition to the devaluation of culture by the authorities.Beyond the prejudices faced, many factors lead the population to choose or have for many times as the only option the use of practices for the provision of care within the family environment, or for the promotion of disease prevention and treatment. The development of this work sought to know the usual integrative and complementary practices in *quilombola* communities Saco da Várzea and Alto da Boa Vista, São José do Piauí (PI).

MATERIAL AND METHODS

The present study was carried out in the municipality of São José do Piauí. The city of São José do Piauí is a new municipality, emanated on April 12, 1963, and its area extends for 364.9 km², is located about 30 km from the city of Picos and 300 km from the capital Teresina (CIDADE-BRASIL, 2019). According to IBGE data, São José do Piauí has 6,710 inhabitants, with a population density of 18.06 inhabitants/km² and a municipal human development index of 0.552 (IBGE, 2011). With regard to health, the city has a Mixed Health Unit and three Family Health Strategy teams in addition to a family health support center (FHSC) team that meets the demands of the entire municipality. The *quilombola* communities object of the study Saco da Várzea is located 2 km away and the Afrodescendant community of Negros *Quilombolas*from Alto da Boa Vista, is located 4 km in the rural area of the municipality of São José do Piauí. These communities Saco da Várzea and Alto da Boa Vista, are located in the municipality of São José do Piauí-PI, considering that one of the communities is duly certified by the Fundação Cultural Palmares, however one is still in process to obtain the title. The *quilombola* community Saco da Várzea obtained its certification by the Fundação Palmares in December 2012, currently has registered about 80 families, who sporadically receive benefits through social projects conceived by the community itself. It is also close to this, the Afrodescendant community of Negros *Quilombolas*from Alto da Boa Vista, which is currently in the process of obtaining certification by the Fundação Palmares, it has 26 families registered, and the families of these communities are strongly united by bonds of consanguinities and adding to this there is family farming. This is a descriptive research, which was carried out by means of a qualitative-quantitative approach. Data were collected with individuals who make up the families registered in the respective associations of the *quilombola* communities Saco da Várzea and afrodescendant communities of Negros *Quilombolas* from Alto da Boa Vista, to be over 18 years of age, to have preserved cognitive capacity. Before starting data collection in the community, a meeting was held for the previous presentation of the research project with the *quilombola* leaders and the population, and as accepted, a letter of consent was prepared. First, data were collected through bibliographical research (Gil, 1999), based on access to scientific articles, books, among others. The interview was promptly conducted with the *Quilombolas* in order to know socio-demographic aspects, anthropometry, clinical data and health care by the *quilombola* family health strategy and raw materials and resources used by communities in the development of practices. The questionnaire used wassemi-structured, elaborated by theresearcher. For the collection of anthropometric data, a Digital Anthropometric Scale and portable stadiometer were used. To evaluate anthropometric data, the weight and height of the participants were measured as described in the Manual of Guidelines for the collection and analysis of anthropometric data in health services: Technical Standard of the Sistema de Vigilância Alimentar e Nutricional - SISVAN (BRASIL, 2011). After data collection through the questionnaires, the analysis was performed through the reading of the collected material, and the data collection was elaborated, for the classification of the information collected in Microsoft word spreadsheets. The relationships explored by the informants were verified by Pearson's Correlation analysis ($p \leq 0.05$) (Callegari-Jacques 2004). The Past 2.17 softwarewas used. The research proposalwas sent to the Ethics and Research Committee of the Universidade Federal do Piauí through the Plataforma Brasil respecting the Resolution 466/2012 of the Conselho Nacional de Saúde - CNS. Each member of the research received a copy of the Termo de ConsentimentoLivreEsclarecido-TCLE.

RESULTS AND DISCUSSION

The *quilombola* communities Saco da Várzea and Alto da Boa Vista, had their origin with the arrival of refugee slaves who obtained the land by appropriation, because the land of these localities until then were not demarcated, currently the two communities have 106 families registered in the associations of these communities. Among the interviewees, 89% reported having *quilombola*family ancestors (mother, father, grandparents) and 11% said they have non-*quilombola* ancestors. We also found that the recognition of *quilombola* ancestors decreases with age ($r = -0.85$ and $p<0.001$). Other studies show the predominance of individuals who self-declare themselves 100% black as that of Oliveira *et al.*,(2019) however, it is possible to observe in traditional communities the presence of non-*quilombola* people as observed in a study conducted by Silva et*al*.(2016) as well as Siqueira, Jesus & Camargo (2016). Ordinance No. 344, of February 1, 2017 of the Ministério da Saúdehas a parametersof self-declaration in which the individual themselves define what is their race/color trough the declaration of Afrodescendants according to theiridentity affinity. This declarationis fundamental for the development of public policies aimed at this practice,taking into account thesocial vulnerabilities faced by this public,in order to promote actions according to knowledge, practicesand other specificities (BRASIL,2017). Theself-declaration provides the guarantee ofmeasured rights in thefaceof the

promotion ofpoliciesaimed at this population, as well as their access to policies and programs. The study included 90 informants, of whom 77.7% are female and 22.22% males aged between 18 and 96 years, the mean age of the participants was approximately 46 years. The predominance of female presence was also pointed out in other studies such as Aragão,Bos& Sousa 2014 among its interviewees composed of an audienceof 63.3% female and 36.7% male, also verified by (LISBOA et *al.,* 2017) with 59% female and 41% male.Considering marital status, most informants are married (54 %) and have consensual union (20 %). In a similar study conducted by Siqueira, Jesus & Camargo (2016); Prates *et al*.,*(*2016) the number of individuals married or with stable union corresponds to more than 50% number lower than those found in this study, confirmed by Oliveira & Caldeira (2016).Inthe studied communities, therewas a higher occurrence of *quilombola* marriages; however, unions between *quilombolas* and non-*quilombolas*were also verified, with each family generally composed of the father, mother and an average of 4 to 5 children. We observed that 14% of the informants stated that they work outside the community and 86% did not work outside. Family income for 54% of informants is less than one minimum wage and for 46% of informants between one and two minimum wages. In the *quilombola* communities Saco da Várzea and Alto da Boa Vista the main source of income is obtained from the work performed by the family in agricultural production for the consumption and sale of the obtained products such as beans, corn, and cassava flour.Also, they have only social benefits, retirement and work outside the home, the family income for the most part is less than three minimum wages as confirmed in the literature (FREITAS*et al.,* 2018; CHEHUEN NETO*et al.,* 2015; PRATES *et al*., 2016). As for education, 36% of the informants were not educated and 31% have incomplete primary education. The low schooling rate may be related to school dropout due to the need for labor in the agricultural activity, thus making it difficult to reconcile study and work, leading them to choose work.

Despite the current regulations, captained, among others by Resolution CNE / CEB No 08/2012 and the Plano Nacional de Educação - PNE (Law No 13,005 / 2014) -, to promote the implementation of policies aimed at education in *quilombola* territories and the molding of teaching that addresses the valorization of history, culture and practices of its people, there is a noticeable lack of implementation of public policies aimed at *quilombola* education in these communities. Studies developed in *quilombola* communities in the Northern Region of Brazil show the prevalence of low schooling as observed by Favacho *et al* (2019) where about 45% have incomplete 1st degree. In the study analyzed by Silva et *al* (2016) was identified at least 76.2% with incomplete 1st degree and 23.8% never attended school, however, a survey conducted by Mussi, Queiroz & Petróski (2018) with*quilombolas* of the middle São Francisco Baiano, Brazil verified that 89.3% of the informants reported being literate. Despite the existence of educational public policies aimed at *quilombola* communities, there are still few *quilombola* communities that are assisted by them.Resolution No. 8 of November 20, 2012 of the Ministério da Educação establishes the National Curriculum Guidelines for *Quilombola* School Education in Basic Education, based on collective memory, remaining languages, civilizing frameworks, culture among others (BRASIL, 2012). Custódio& Foster (2019) in a national research on the production of didactic materials for *quilombola* school education found that in Piauí, as well as in most states of the Northeast, with the exception of Maranhão, there are no records of productions aimed at the study of the implementation of public policies of this nature.This reality is a reflection of a state policy delineated byour structural racism, which tends to make the knowledge and history of the black people invisible, denying their culture, people and identity as a form of support for a hegemonic discourse, centralized intheEuro-Western white supremacy aimed at invalidating the ethnic, racial, cultural identity, and the social experience of the remnants (GÓES, 2017). The data showed that 45% of the interviewees had adequate BMI, however, 31% were overweight and 21% were obese (Figure 1).

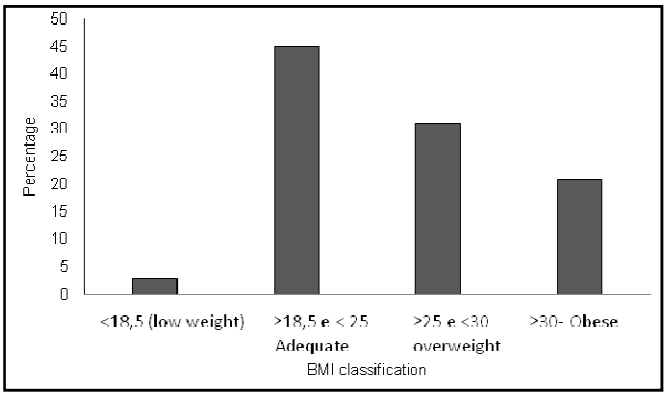

Figure 1. Body Mass Index (BMI) of the residents of the *quilombola* comunnities Saco da Várzea and Alto da Boa Vista, São José do Piauí (PI)

In the informants who were overweight, it was found that BMI tends to decrease with increasing age ($r = -0.98$ and $p<0.001$) and for informants with obesity this relationship was not significant ($r = -0.10$ and $p>0.05$). The BMI data of this study revealed mostly the presence of eutrophic individuals, thus showing that most of the interviewees were with adequate weight within the normality parameters established by the Sistema de Vigilância Alimentar e Nutricional - SISVAN (BRASIL, 2011). In a study developed in the *quilombola* community of northeastern Brazil by Mussi; Queiroz & Petróski (2018) verified the majority of eutrophic informants, result also verified by Cordovil& Almeida (2018). Inthe present study, it was observed that 85.10% of *quilombola* women are overweight or obese, showing a high Body Mass Index, a very high number in relation to men who only 14.9% had overweight or obese BMI. This high rate may be related to the fact that women do not perform physical activities regularlyand still do not have adequate nutrition for their body needs.

The *quilombola* woman is responsible forperforming the tasks of the house, such as cooking, washing and caring for the children (FERNANDES & SANTOS, 2016), however, the men are usually in charge of agricultural production mainly cassava and rice (MELO & SILVA 2015). In the studied localities, the predominance of the cultivation of beans, corn and cassava was observed for the production of gum and flour. The number of people who underwent tests for the diagnosis of chronic or endemic diseases decreases with age ($r = -0.91$ and $p< 0.001$). An explanation for this reality may be due to the unavailability of access to public or private resources for the performance of diagnostic tests, since the population of the communities under study is mostly low-income, in this sense, Freitas *et al* (2018), in a study, found that only 11.76% of the interviewees reported doing routine tests. According to the

informed, itis statedthat the number of people with chronic diseases decreases with age (r= -0.96 and p<0.0001), which also remains in relation to the family history of chronic diseases (r = -0.95, p<0.0001). The data showed that both the prevalence and history of chronic diseases are more present in younger individuals, and may be directly related to sedentary lifestyle, inadequate diet, which is sometimes aggravated by the lack of adequate public resources to diagnose and follow up appropriately. In the literature according to the study by Oliveira & Caldeira (2016) the prevalence of chronic diseases in individuals over 40 years of age is noted, however, For Melo & Silva (2015); Freitas*etal*., (2018), chronic diseases are strongly relatedtothe vulnerabilities existing in the communities, besides social and environmental factors. Regarding theoccurrence of chronic and/or endemic diseases in certain periods of the year,the number of cases wasdescendingaccording totheincrease of age(r = -0.92 and p<0.001). Among the main pathologies mentioned in the communities under study are diabetes, hypertension, asthma, dyslipidemias, flu and viruses. From the perspective of the interviewees by Freitas *etal*., (2018) the incidence of influenzawas reported by 6.25% as one ofthe mainreasons that lead them to the searchformedical consultation, ontheother hand,Santos*etal*., (2019) had observed in a *quilombola* community in northeastern Brazil the prevalence of 26% of arterial hypertension. Despite Aragon, Bós & Sousa (2014) observed the prevalence of metabolic syndrome in at least 55.4% of the informants.

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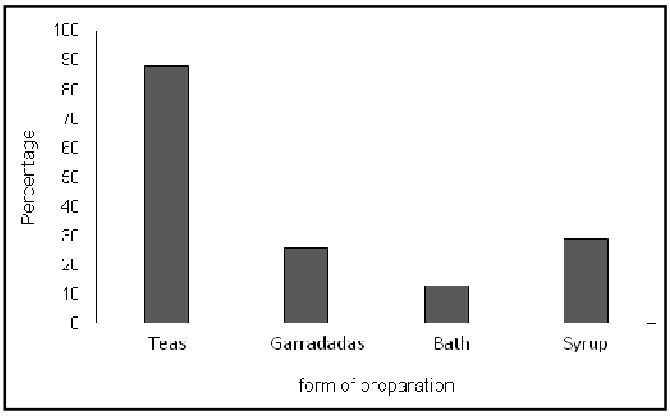

Figure 2. Form of preparation of the medicinal plants, Communities Saco da Várzea and Alto da Boa Vista, 2019

We found that the parts of the most used plantswere: leaves (79%), bark (43%), seeds (40%) and root (21%).In this path, the use of leaves (r= -0.84 and p<0.01), bark (r=-0.80 and p<0.01), seeds (r= -0.83 and p<0.001) and root (r= -0.89 and p<0.001) decrease with increasing age.These dataare partially in agreement with Oliveira (2015) who verified in his study the prevalence of 56% in the use of leaves in preparations, bark 14%, seeds 6% and root 2%. Lisboa et al (2017) also obtained similar data. A hypothesis for the predominance of leaf use can be explained by its easy access and cultivation, thus being present in most homes of the communities. During the study, 63% of the interviewees reportedusing some religious practices as a means of treatment or cure while 37% reported not usingit.As observed,the practice of rituals tends to decrease with increasing age (r= -0084 and p<0.001). According toVilanova, Ewerton& Pereira (2019), in a study conducted with families from a *quilombola* community only 3.8% reported usingreligious practices,such as, blessing, for treatment and healing purposes. Oliveira (2015) observed in his research the occurrence of only 10% of affirmative cases for the use of religious rituals.For Mendes &Cavas (2018), the role of the*benzedor* is to take care of the diseases of the

Quilombola population, whether physical or spirituals, typifying and performing the treatment. The focus in basic integral health has been the basis for the regimental principle of the duty--being of health systems since the International Conference on Primary Health Care, consolidated with the Alma-Ata Declaration in 1978. From then on, a more comprehensive concept of health has been formalized for the world than the mere absence of illness or treatment. From then on, the idea of the need for primary care is promoted as a means of ensuring health as an integral well-being at the physical, mental and social levels (Alma-Ata Declaration, 1978). Thus, in the light of the new Brazilian constitutional order, art. 196 of the fundamental text ensures the right to health as universal, and must be guaranteed by the State in order to reach all people who are in national territory, materializing loyally through the Law to the SUS (Law No. 8,080/90), which regulates the Unified Health System to be developed and provided universally throughout the national territory to those who need it. In this sense, the national primary care policy (Ordinance No. 2,436, of September 21, 2017) brings based on the guideline of regionalization and hierarchization of health care with a view to precisely promoting a softening of the reach of health services, providing the SUS user with efficient contact, in a timely manner and in the most previous way possible. Thus, the Family Health Program (FHP), created in 1994 and later transformed into a Family Health Strategy (FHS) system, presents itself as a materializing means of the basic regimental guidelines of the national health system (GOMES *et al*., 2020). In this path, aiming to consolidate the fundamental rights and guarantees advocated by the Federal Constitution with regard to *quilombola* communities, the Brasil *Quilombola* Program, in 2003, brings to light the Brazilian legal system basic guidelines for health promotion in these communities, sponsoring, by this bias, crucial points of the National Comprehensive Health Policy of the Black Population, which carries in its bulge determinations of integral health promotion to black populations, observing its specificities, with emphasis on *quilombola* communities.

The Saco da Várzea Community has the Martinho Mendes da Silva Health Center located not far from the residences, the organ has a good physical structure, having a reception room, outpatient clinic, nursing room, medicine room, pantry and bathroom. Structurally organized in a satisfactory way, the property that houses the services provided there was built in a land difficult to access the community, distancing primary health care to the community. However, the Alto da Boa Vista community does not provide its own Health Center, and the population, when they need care, should move about 2km, along a steep and bumpy road that leads to the car unit from Várzea community, to thus have access to health services, such as: medical consultation and nursing, prenatal care vaccination and childcare. The communities have only one community health agent to carry out home visits, about 180 per month in both communities, in addition, when requested home care, due to illness in bedridden patients, the team goes to the residence to perform the medical consultation. There is also the service provided by the Family Health Support Center, which is located in the city of São José do Piauí, in which, when necessary, the professionals of the family health strategy guide the need for specialized care and carry out the referral. When asked about the existence of a post or health center with an FHS team, close to their community, 46% know and often make use of the strategic service; 49% know, but use little and 5% know, but do not use this service. It was found that those who know but use little decrease with age (r= -0.89 and p< 0.01). Other studies found in the literature indicate that the *quilombola* population uses health services, as well as Vilanova, Ewerton& Pereira (2019) shows, in the same treadmill; Freitas *et al* (2018) attested that 90.77% of the interviewees in their work use primary care services. Inquiring at the portion that declined little or no use to the health center closest to their residence, the main causes of this attitude, according to which 53% stated that they did not suffer from health problems, while 13% prefer to apply traditional knowledge (Figure 3). According to Freitas*et al* (2018), 53.85% of the informants consider their health condition as normal and 40% when they get sick, they choose traditional methods. Vilanova, Ewerton& Pereira (2019) highlight the distance to the care unit as the main factor that hinders access to health services due to the difficulty in mobility and scarcity of the services provided.

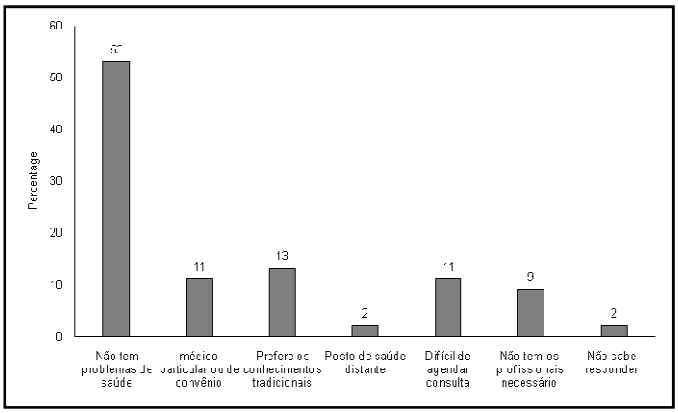

Figure 3. Main causes that lead them not to use or little use of the health center in the Communities Saco da Várzea and Alto da Boa Vista, 2019

In the *quilombola* communities analyzed, when there is a health emergency, 41% reported that they would call a public ambulance, 22% would go to the hospital and 15% would call a relative (Figure 4). According to Freitas *et al* (2018) in a similar study 38.46% revealed to seek the hospital when they are sick and 14.62% declined searching the Family Health Strategy. In the development of this study, the prevalence for the search of public care in emergenciesamong the communities object of this study was perceptive since they do not have private health care or economic conditions to opt for private care. According to Siqueira, Jesus & Camargo (2014), in a study developed in a *Quilombola* Community in the state of Bahia, there was a predominance in the search for public emergency care.

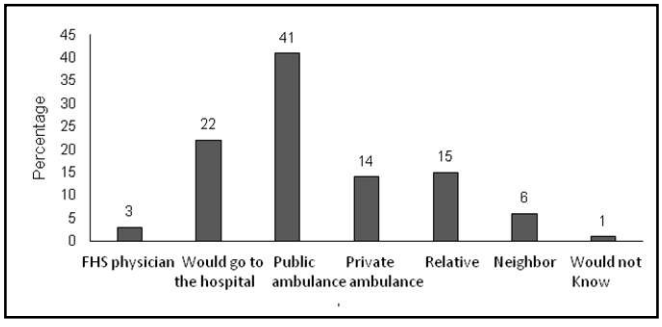

Figure 4. Actions carried out in the face of emergency in the Saco da Várzea and Alto da Boa Vista Communities, 2019

Regarding primary consultations in the face of illness, 48% of the sample seeks the pharmacy attendant, 19% uses relatives and 17% health professionals (Figure 8). A result similar to that obtained by Freitas *et al* (2018), according to which 44.62% of the informants reported preferring pharmaceutical care when they are sick. For Fernandes& Santos (2016) self-medication and the use of traditional methods used in communities and transmitted by relatives or neighbors, taken without resulting from the emergence of pathologies correspond significantly as the first treatment option. According to the data collected, 31% of the health agents interviewed said they value traditional knowledge as a viable means of treatment while 24% said no, and 21% did not know how to answer, because they stated that they never get sick. The community health worker that operates in these two communities resides in the Saco da Várzea community where she shares her knowledge, and guides, based on them, in realizing the use of medicinal plants so that mainly users of continuous medication will not make the substitution by homemade preparations without the consent of health professionals. Oliveira (2015) highlights the importance of promoting and valuing traditional knowledge found in the remaining *quilombola* communities, in the same sense as Zank, Avila & Hanazaki (2016). It is important to highlight that health professionals are not properly trained to prescribe and guide in relation to the use of integrative and complementary practices, since there are no disciplines in the undergraduate courses focused on the health area that addresses the theme of ICPs, or even focused on health in traditional communities. However, the National Policy of Integrative and Complementary Practices emerges as a way to initiate continuing education, seeking the qualification of professionals, focusing on Primary Care, and respecting the traditional and cultural knowledge of the Populations Brasil (2006).

Final Considerations

This study made it possible to identify the Integrative and Complementary practices present in the *quilombola* communities Saco da Várzea and Alto da Boa Vista. Which are transmitted orally for generations and comprise remarkable characteristics of the cultural richness and history of these communities. The data show that the use of medicinal plants in the form of teas, using mainly the leaves, correspond to the most used practices in these communities in a prophylactic way , or for the treatment of illnesses. The development of new research is fundamental to deepen knowledge about this theme in traditional *quilombola* communities; these studies provide subsidies for the formulation of health education actions on risks and benefits of these practices in communities.

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