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Socioeconomic and Demographic Characteristics of Living Conditions of Elderly Quilombolas from Maranhão, Northeast Region, Brazil

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Abstract

The elderly from Quilombola communities are groups socially vulnerable with specific needs. Quilombola communities are territories made up of descendants of escaped slaves, located in remote rural areas. This study aims to describe the socioeconomic, sanitary, and demographic characteristics of the living conditions of the elderly. A household survey was conducted with 208 older persons from 11 Quilombola communities in the Maranhão, Northeast, Brazil. Among the 208 elderly people interviewed, 54.3% were women, 48.6% were between 60 and 69 years old, 59.1% declared themselves black, 35.6% were married, and 54.3% did not know how to read and write. About 81% of the elderly are in the worst income stratum. Among 59.6% of households, the water supply comes from a well/spring on the property itself, and garbage was burned/buried in 89.4% of the houses. In overall, housing construction, 64.4% of the elderly had appropriate materials used on the walls, 89.9% in the construction of the roof, and only 30.7% in the construction of the floor. The majority of the elderly did not have adequate construction of ceiling, floor, and walls according to sex and age. It was observed that the elderly live in a situation of vulnerability and precarious living conditions.

Keywords: older persons, life conditions, groups of African descent, health surveys

1. Introduction

Brazil is a country known for its wide cultural variety, and although most of its inhabitants have black African descendants, the suppression of their ethnic and cultural values is present, preventing this group from exercising its right to full citizenship, including access to health services and good quality of life, even though it is legally insured. In this context, there are the remnants of Quilombola communities existing in several Brazilian regions [1].

The Brazilian black population's historical trajectory shows that these individuals have been seeking better living and health conditions through social struggles, which allowed them to achieve some social rights: the universal right to health and social participation. However, in order to address social inequalities, it is necessary to reduce the level of poverty, as well as to enable a more equitable distribution of goods and services that allow achieving the well-being and quality of life [2].

On February 7, 2007, the *Política Nacional de Desenvolvimento Sustentável dos Povos e Comunidades Tradicionais* was instituted, by Decree No. 6040. According to it, these people and communities are understood as culturally differentiated groups that recognize themselves as such, which have characteristic forms of social grouping, and that, through traditionally generated knowledge and practices, use territories and natural resources as a condition for reproducing their cultural framework [3].

Quilombola communities are examples of social groups that constitute traditional communities [4]. These represent approximately 5 million Brazilians. Due to their historical characteristics of fighting racial discrimination and specific conditions of poverty and inequality, they live in relative geographic isolation and have little access to governmental public policies, factors that make them more socioeconomically vulnerable [4].

According to the Brazilian legislation (Decree No. 4887, November 20, 2003), Quilombola communities are groups according to criteria of self-attribution, which have a historical trajectory, with a presumption of black ancestry related to the resistance to the historical oppression suffered. They are socially more vulnerable and have a predominantly rural geographical position [5]. The Palmares Cultural Foundation has been responsible for the recognition and certification of communities [6].

According to Law 7668, from Brazilian Government, the Palmares Cultural Foundation was created on August 22, 1988, linked to the Ministry of Culture in order to promote the preservation of cultural, social, and economic values arising from the black influence in the formation of Brazilian society [7].

There are almost 2 million people living in about 2997 Quilombola communities that are certified by the Palmares Foundation. Officially recognized Quilombola communities are found across all regions of Brazil. Their geographical distribution is related to the racial formation process and settlement policy implemented during the period of Portuguese colonization (from the discovery of the country in 1500 to independence in 1822) and the imperial governments (from independence in 1822 to the abolition of slavery in 1888 and subsequent emergence of the Republic in 1889). The majority of Quilombola communities are concentrated in the country's Northeast Region (63%) [8]. So, the distribution of these communities among the regions of Brazil reflects the structure of occupation and territorial exploitation made by the Portuguese crown during the colonization process. The great flow of enslaved black labor was concentrated in the Northeast Region of the country.

In the northeast of Brazil, there are 2061 Quilombos Remnant Communities (CRQ) certified by the Palmares Foundation (until May 2019) distributed among the federative units of this region: Bahia, 801 (38.8%) CRQs; Maranhão, 787 (38.2%) CRQs; Pernambuco, 161 (7.8%) CRQs; Piauí, 87 (4.2%) CRQs; Alagoas, 69 (3.3%); Ceará, 50 (2.4%) CRQs; Paraíba, 41 (1.9%) CRQs; Sergipe, 36 (1.7%) CRQs; and Rio Grande do Norte, 29 (1.4%) CRQs [9].

The *Baixada Maranhense* region has historically been home to a large number of Quilombola communities since the second half of the nineteenth century and

currently represents one of the state's regions with the largest number of remaining Quilombola communities [10].

2. Aging and Quilombola communities in Brazil

Population aging is a global phenomenon and is strongly linked to socioeconomic and health status, lifestyle, and social and health behaviors. In Brazil, several population surveys with the elderly have shown that there are important inequalities in this group in their quality of life and health, being inequalities in the living conditions and health status of older persons particularly more pronounced among vulnerable groups living in remote area, such as older persons living in Quilombola communities [8].

In Brazil, initiatives related to the well-being of the elderly population are still scarce. Although the concept of quality of life has an extensive field of variability between population groups, the promotion of good physical, mental, and emotional health should always be encouraged, as it is known that with advancing age, health problems in overall tend to increase [8, 11].

The aging of the Brazilian population, characterized by the increase of the average age of the individuals, is evidenced (comparing the data from the censuses of the year 2000 and the year 2010) by the decrease of the population growth (in the urban and rural areas) and by the increase of the proportion of people aged 60 and older. Maranhão showed the largest reduction in population growth in urban areas when comparing the two periods: in the 2000 census, the growth rate was 6.1% and in the 2010 census, 2.1%, which corresponds to a decrease of 67.5% [12, 13].

Regarding the increase in the proportion of the population over 60, comparing the census data from 2000 to 2010, there was an increase of 41.6%. Also, when comparing the data from these same periods, there was an increase of 30.6% in the individuals who declared themselves white, 57% for those who declared themselves as part of the black population, 124.6% for yellow population, 60.8% for brown-skinned population, and 6.8% for those classified as indigenous [12–14].

Over the years, Quilombola communities face obstacles and struggles for ethnic-cultural and historical recognition. Among the problems faced are racial prejudice, territorial losses to irregular occupations, insufficient family income, extreme poverty, and ineffective health services [1].

The literature on the quality of life and living conditions of the Quilombola population in the country is scarce, and the existing data are mostly directed to those located mainly in Bahia, whose results show that this population group lives in a vulnerable situation and has less access to goods and services [15].

The interest in this research is due to the identification of the reality faced and the sociodemographic and epidemiological problems in the studied communities and how it can possibly contribute to the planning and development of policies and actions that take into account the social, political, and environmental context of these communities.

This research is perceived as fundamental because it allows the population and the public power to develop strategies that effectively meet the many needs of the Quilombos Remnant Communities recognized by the Palmares Foundation and located in the municipality of Bequimão.

As it is a historically abated population and for generations it has suffered the absence of social investments to improve their living and health conditions,

it is expected that the results of this study point to the health reality of the Quilombola elderly and that this is marked by a set of vulnerabilities and socio-economic needs.

Thus, this study aims to describe the socioeconomic, sanitary, and demographic characteristics of living conditions of the elderly in Quilombola communities in a city of Baixada Maranhense region.

3. Methodology

3.1 Study area and population

This study is part of the project *Population Survey on Living and Health Conditions of the Quilombola Elderly from a City of Baixada Maranhense* (IQUIBEQ Project). This is a cross-sectional, home-based study conducted in 11 CRQs in the municipality of Bequimão, MA. All 11 Quilombola communities are officially recognized as remnants of blacks who escaped slavery by the Palmares Cultural Foundation and the Ministry of Culture (**Figure 1**).

The municipality of Bequimão is inserted in the northern mesoregion and microregion of Maranhense Western Baixada. Geographically, it is located by the edge of the MA-211 road, at a point equidistant from the São Luís capital and the Federal University of Maranhão Campus located in the city of Pinheiro, MA. In 2010, the total area of the municipality of Bequimão was 761.49 km², and the census population was 20,344 inhabitants (67.5% in the rural area and 12.3% elderly). The Human Development Index (HDI)¹ was 0.601, and the gross domestic product per capita was R\$ 2754.37 [17]. The Palmares Foundation recognizes and certifies 11 CRQs: Rio Grande, Ramal de Quindiuá, Conceição, Mafra, Santa Rita, Juraraitá, Marajá, Pericumã, Siberia, Sassuy, and Ariquepá [9].

The study population consisted of elderly people ≥ 60 years old living in the communities. These were selected from the articulation with the Municipal Secretary of Social Assistance and the Community Health Agents (*Agentes Comunitários de Saúde*, ACS) of the respective communities. The ACS conducted a previous survey and built a nominal list with information on gender and date of birth, accounting for 220 elderly. All of these were invited to participate in the research, but after refusals and difficulties to find the elderly in the community in two attempts on different dates, the final population consisted of 208 elderly.

The data collection was carried out on weekdays during commercial hours between July and October 2018. A pilot study was performed to adjust the instruments and train the interviewers. During the collection, the interviewees could consult a manual to clarify doubts, besides being accompanied by the researchers responsible for the research.

¹ The HDI is a social index. It is composed of the agglutination of three previous simple indicators (longevity, income, and education). The use of this indicator in the analysis of living and health conditions is justified due to the simplicity and capacity of these indices to synthesize situations in which whether you need to have a general comparative assessment of well-being, quality of life, or level of socioeconomic status of human collectivities, while allowing them to orient themselves more objectively, and the prioritization of resources and actions of social and health policies for different places [16]. This indicator can take any value between 0 (zero) and 1 (one). The HDI measures the level of human development. Cities can be classified into below HDI (<0.5), medium HDI (0.5 and 0.8), or high HDI (>0.8) [16].

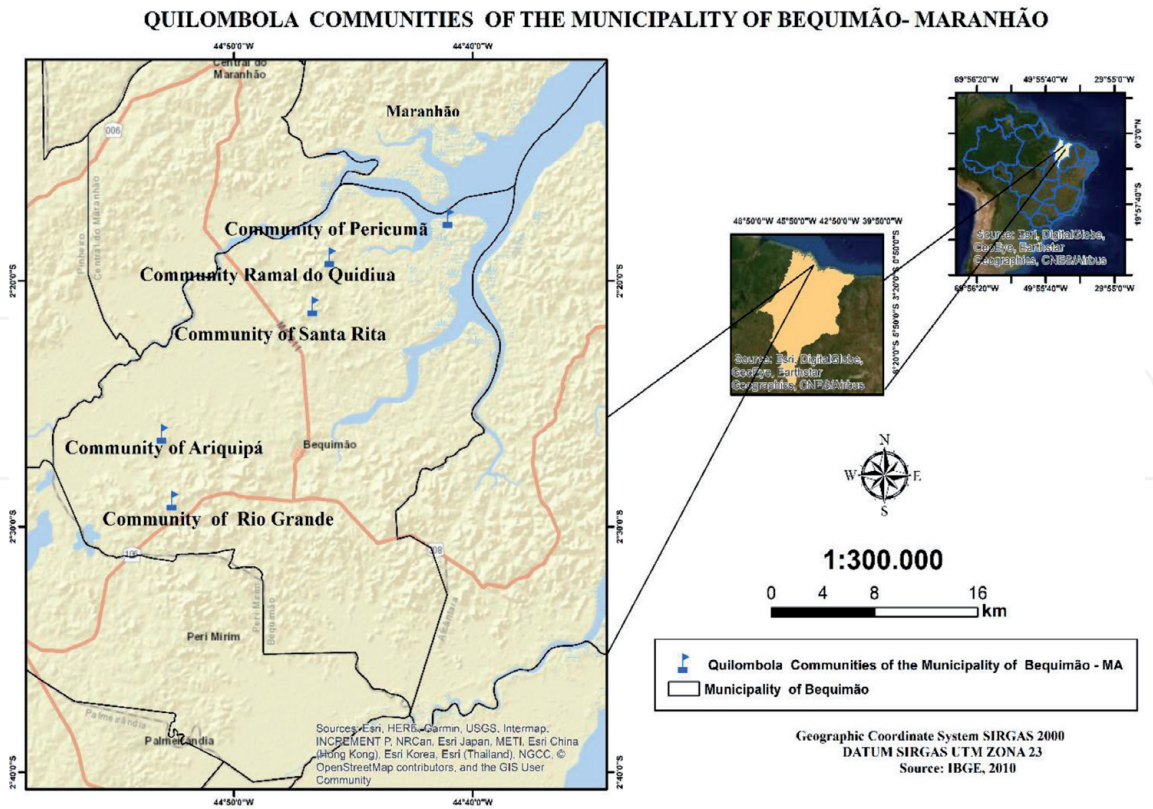


Figure 1.
Geographic localization of Quilombola communities in Bequimão, Maranhão, Brazil, 2018.

3.2 Data collection and research instruments

Four questionnaires were applied: a socioeconomic one; one on the population's health conditions, access to and use of health services, and surveillance for noncommunicable chronic diseases and the associated risk factors; a questionnaire on dietary patterns and anthropometry; and the Mini-Mental State Examination (MMSE). The first two were adapted from the 2013 National Health Survey (*Pesquisa Nacional de Saúde*, PNS) questionnaire.

For this study, only the data obtained from the first questionnaire were used, using the following variables: gender; age; race/skin color; marital status; number of residents per household; ability to read and write; family income in reais (R\$); economic stratum according to social class by the New Criteria Brazil (ABEP) of the year 2018 [18]; receipt of retirement/pension benefit; *bolsa família* benefit; appropriate material used in the construction of the wall (masonry with or without coating), roof (tile, slab), and floor (ceramic, cement); number of rooms; water supply; drinking water treatment; and sewage.

3.3 Inclusion and exclusion criteria

The study included individuals ≥ 60 years old of both sexes and resident in the communities certified by the Palmares Foundation in the municipality of Bequimão and who were able to communicate with the interviewer. Those who are < 60 years of age, with inability to communicate with the interviewer, and those with impaired cognitive function were excluded from the study.

3.4 Data analysis

After collection, data were entered into an Epi Info version 7[®] statistical program with double data entry technique. Data were then analyzed using the Stata[®]

version 14 program (StataCorp LP, College Station, Texas, United States). The absolute and relative frequencies of the variables considered in the study were estimated.

3.5 Ethical considerations

The research was approved by the Research Ethics Committee of the University Hospital of UFMA (favorable opinion: 2,476,488 of January 28, 2018), and all participants signed the informed consent form prior to collection.

4. Results

Among 11 CRQs, 208 seniors were interviewed. **Table 1** shows this data. Among these, 54.3% were women, 48.6% were between 60 and 69 years old, and 19.2% were ≥ 80 years old. Regarding race/skin color, 59.1% declared themselves to be black and 28.9% brown, and 12.0% were classified in other racial groups. The data on marital status indicated that 35.6% are married or have a stable union; 13.5% said they were separated, unmarried, or divorced; and 25% were widowed.

Regarding education 54.3% could not read and write. Most (57.7%) lived with ≥ 3 people at home and 15.4% lived alone. About 36.0% had family income of less than 1 minimum wage, and 63.9% had income between 1 and 2 minimum wages. Regarding the socioeconomic strata, no elderly were classified in social strata A and B. Most of the elderly were in stratum E (81.3%), 91.8% reported receiving retirement or pension benefits, and 6.7% received *bolsa família*.

Water was supplied by a well or river on the property (59.6%), and only 68.7% had proper water treatment at home. Regarding household toilets, 56.7% have access to a septic tank to dispose dejects, and 14.9% have to do it in the open. Most of the elderly burned household waste (89.4%).

Most resided in four- to seven-room households (68.3%), with 64.4% of the elderly having appropriate material used in the construction of their home walls, 89.9% being constructed of appropriate roofing materials, and only 30.7% had appropriate floor construction material.

Figure 2 presents the housing conditions and suitability, considering simultaneously the quality of the material used in the construction of the ceiling, walls, and floor of the houses according to the gender and age of the Quilombola elderly.

The proportion of elderly people residing in households considered inappropriate in relation to the material used in the construction of houses was higher at the extremes of age, reaching the highest prevalence among men aged 60–69 years (88.5%) and ≥ 80 years (92.9%) and women 67.3% and 65.4% at their respective ages, suggesting a growing gradient of worsening material living conditions.

The highest percentages of houses with roofs, walls, and floors built with appropriate material were in the age group of 70–79 years, for both sexes—36.8% of the houses belonging to women and 44.8% of those belonging to men were inadequate.

Most of the elderly live in households with low amount of appliances. The number of electronic equipment in homes is an important indicator of the infrastructure for the quality of home life. Around 53.0% of the elderly lived in homes with up to two appliances, 75.0% with up to three, and 95.7% with up to five. Only 0.5% lived in households with 10 appliances (**Figure 3**).

Variáveis	(N = 208)	%
<i>Sex</i>		
Male	95	45.7
Female	113	54.3
<i>Age bracket (years)</i>		
60–69	101	48.6
70–79	67	32.2
≥80	40	19.2
<i>Skin color/race</i>		
Blacks	123	59.1
Browns	60	28.9
Others	25	12.0
<i>Marital situation</i>		
Married	74	35.6
Separate/divorced	28	13.5
Widower	52	25.0
Single	54	25.9
<i>Can read and write</i>		
Yes	95	45.7
No	113	54.3
<i>Number of residents per household</i>		
Only	32	15.4
Two	56	26.9
Three or more	120	57.7
<i>Household income at minimum wage 954.00 (in reais)</i>		
<1 minimum wage	75	36.1
1 and 2 minimum wage	133	63.9
<i>Stratum socioeconomic*</i>		
C	4	1.9
D	35	16.8
E	169	81.3
<i>Receive benefits from</i>		
Retirement/pensions	191	91.8
Bolsa família	14	6.7
<i>Number of rooms per household</i>		
≤3	4	1.9
4–7	142	68.3
≥8	62	29.8
<i>Suitable material used in the construction of</i>		
Walls	134	64.4
Roof	187	89.9

Variáveis	(N = 208)	%
Floor	64	30.7
<i>Water supply</i>		
General network	37	17.8
Well or river on the property	124	59.6
Well or river outside the property	45	21.6
Other ways	2	1.0
<i>Home water treatment</i>		
Appropriate	143	68.7
Not appropriate	65	31.3
<i>Destination of sewage from bathrooms/toilets at home</i>		
Septic tank to dispose dejects	118	56.7
Rudimentary septic tank	59	28.4
Sewer dumped on public road	31	14.9
<i>Waste collection forms</i>		
Dumped on public roads	22	10.6
Burnt/buried	186	89.4

**There were no elderly in social strata A and B.*

Table 1.
Socioeconomic, demographic, and health characteristics of Quilombola elderly people ≥60 years old, Bequimão (IQUIBEQ Project), Maranhão, Brazil, 2018.

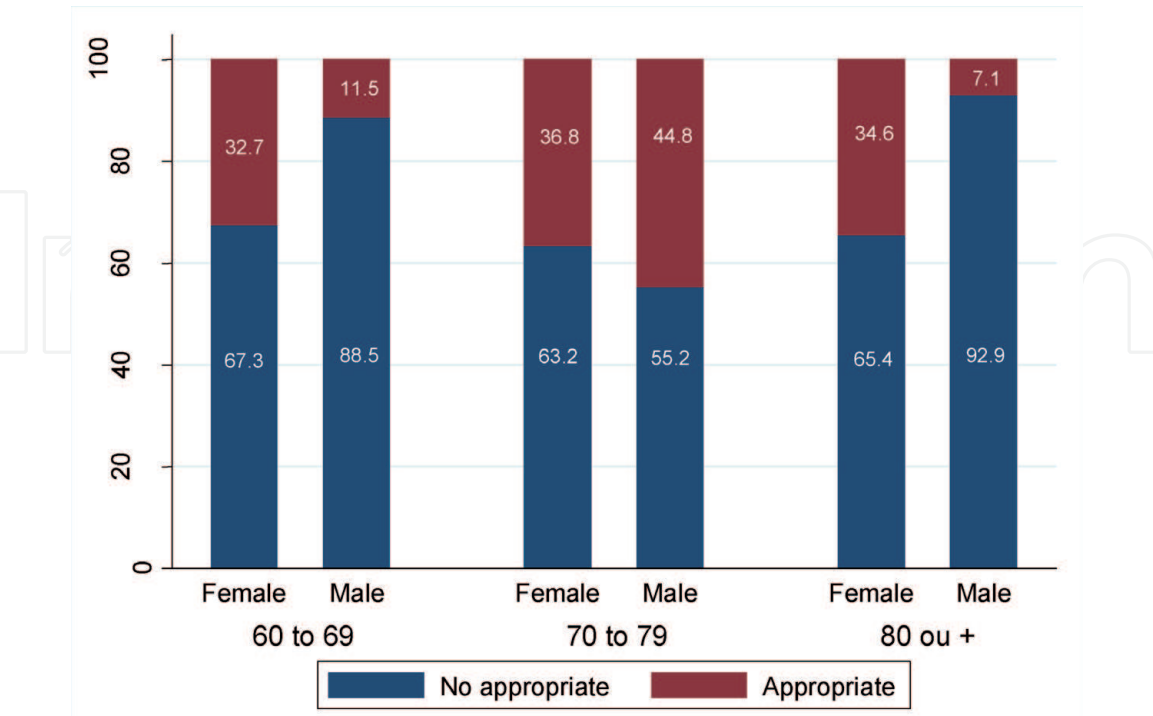


Figure 2.
Adequate housing condition of ceiling, floor, and walls simultaneously according to gender and age of Quilombola elderly ≥60 years, Bequimão (IQUIBEQ Project), Maranhão, Brazil, 2018.

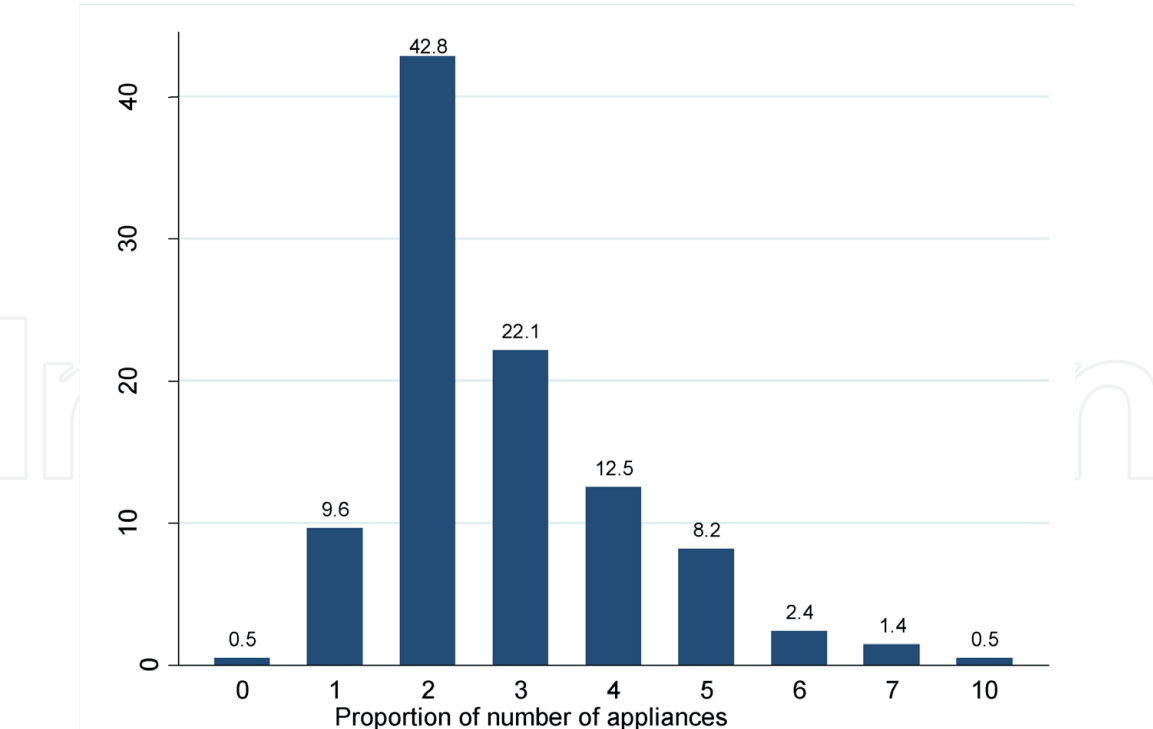


Figure 3.
Proportion of the number of appliances in homes of Quilombola elderly people ≥60 years old, Bequimão (IQUIBEQ Project), Maranhão, Brazil, 2018.

5. Discussion

The results of this study show that older Quilombolas experience significant overlapping inequalities and vulnerabilities, characterized by poor socioeconomic status and inadequate household and community sanitation facilities.

Previous studies have shown that older brown and black people in Brazil are disadvantaged in terms of socioeconomic and demographic indicators too [11, 19]. This picture tends to be worse for older black persons living in rural areas. These stark inequalities are deeply woven into the fabric of society. Ever since the period of slavery to the present day, the material conditions of life and health of black people have been worse than those of white people. Typically located in rural areas, Quilombola communities tend to be isolated, increasing their level of exposure inequalities. Historical processes of racial segregation and discrimination have meant that these communities have accumulated disadvantages across life cycles and generations [8].

The aging of the Brazilian population is marked by different rhythms and flows, constituting heterogeneous processes. According to the projections of the Brazilian Institute of Geography and Statistics (IBGE) (2013), by 2042 in Brazil, the number of deaths will have exceeded the number of live births, thus stopping the growth of the Brazilian population. By 2060, estimates indicate that the cohort aged 65 and over is expected to be 26.7% (58.4 million) and life expectancy will approach 81 years [20].

Following this panorama and the gradual prolongation of longevity, the topics and themes related to old age in communities located in remote areas such as Quilombola communities have become privileged objects of investigation in different areas of knowledge, bringing paradoxes, challenges, and dilemmas about public policy to emerge. In the general elderly population, according to the data from the 2000

Population Census, for example, there were gender differences in the aging process, as more than 55% of the population aged 60 and over were women, and this number increases proportionally to the age cohort. This phenomenon was called the “feminization of aging” and brings up discussions about gender experiences to gerontology [21].

Other aspects that exacerbate the differences in the aging process of the Brazilian population are the inequalities between rural and urban areas. Similar to other studies, our results indicate that the indicators present a rural reality in which poverty, geographic isolation, low educational levels, precarious residences, transportation limitations, chronic health problems, and distance from social and health resources in urban centers predominate. This reality is the result of a historical process of inequalities associated with the social and regional development project in the country, which is rooted in the process of discrimination, stigma, and enslavement of the black and brown population, often poorer and poorly educated [22].

In this way, studies reveal that the variable *race/ethnicity* corroborates profound differences regarding the composition of sociodemographic indicators, health conditions, and use and access to health services in the Brazilian elderly population [23]. Black and brown elderly compared to white elderly predominate in the younger age groups (60–69 years), with high dependence exclusively on public health services, less education, and lower income quintile, and live in areas with worse social and health indicators in the country [11].

Quilombola communities are expressions of resistance to the history of social exclusion suffered by black people in Brazil. They are made up of descendants of people who were enslaved and organized into quilombos, spaces that allow the expression of traditional values and practices, based on African ancestry. In these communities, racial inequities translate into vulnerabilities that contribute to the maintenance of material misery, restriction of political participation, and spatial and social isolation.

6. Conclusions

With this research it was possible to identify the sociodemographic, health, and demographic characteristics of the elderly being interviewed. They represent a social group whose majority are self-declared black; are unable to read and write; have a family income of 1–2 minimum wages, most receive retirement and pension; and are characterized as part of the E socioeconomic stratum. Sanitary and housing conditions are inadequate, lacking a general water supply, adequate garbage collection, and better household and community material conditions.

The findings of this study suggest that the living conditions and health status of this population group are poor and worse than those experienced by the general older population in Brazil, revealing the need for effective actions to reduce the inequalities and weaknesses that jeopardize the well-being and quality of life of this group. Major efforts are urgently needed to promote the health and well-being of older Quilombolas in order to meet the needs and reduce the health inequalities identified by this study.

Then, the problems identified may guide the planning of actions consistent with the reality experienced by this population and the implementation of measures that may improve the socioeconomic conditions of Quilombolas.

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