Relationship between territory and health residence: a possible decolonial experience?

Relação entre território e residência em saúde: uma possibilidade de experiência decolonial?

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ABSTRACT Can the presence of health residency in the territory be a way to decolonize the academy? This article addresses the possibility of decolonizing the academy through a multiprofessional family health residency program focused on rural health in the region. This is an experiential report whose epistemological basis is postcolonial and decolonial theories, especially the pedagogy of the territory, and includes elements of interdisciplinary and multidisciplinary training, the territory and health, the relationship between the territory and the health of the rural population in the Quilombola community of Estivas, in the rural region of Garanhuns, Pernambuco. The conclusion is that the multiprofessional residency, as an institute of collective spaces, allows a new look at the territory, the community and health professionals to develop their actions based on interdisciplinarity, popular education and continuous training as a practice to understand other ways of producing health and stimulate change not only in the community and health professionals, but especially in society, making an important contribution to the decolonization of the academy.

KEYWORDS Epistemologies. Rural population. Territory. Residence. Health.

RESUMO *A presença da residência em saúde no território pode contribuir para decolonizar a Academia? Este artigo visa refletir sobre a possibilidade de decolonização dos processos de construção do conhecimento nas instituições de ensino, pesquisa e extensão por meio da presença de um Programa de Residência Multiprofissional em Saúde da Família com ênfase em Saúde da População do Campo no território. Trata-se de um relato de experiência, com base epistemológica das teorias pós-coloniais e decoloniais, em especial, a Pedagogia do Território. O estudo refere-se à intersecção da formação interdisciplinar e multiprofissional na ótica da relação território e saúde a partir da realidade da comunidade quilombola de Estivas, localizada na zona rural do município de Garanhuns, região agreste de Pernambuco. Conclui-se que a residência multiprofissional como instituidora de espaços coletivos possibilita um novo olhar para o território, a comunidade e o profissional da saúde, a fim de desenvolver suas ações pautadas na interdisciplinaridade e na educação popular como uma práxis. Permite ainda compreender outros modos de produzir saúde, estimulando não só a transformação na comunidade e do profissional de saúde, mas sobretudo da sociedade, sendo, portanto, um espaço potente no contributo para a decolonização da Academia.*

PALAVRAS-CHAVE *Epistemologias. População rural. Território. Residência. Saúde.*

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Introduction

Rural education, whether in the form of undergraduate, licensure, or graduate education, with emphasis on Multiprofessional Residencies in Rural Health, is the result of a process of epistemological and social struggles to defend an education that envisions a political-pedagogical plan, coherent with the specifics of the subjects of the field. As recommended by the Pedagogy of the Territory[1], this comprehensive and engaged approach to collective health education includes the possibility of decolonizing educational practices and promoting the uprooting of identities and territories.

The pedagogy of territory idealized by Núcleo Tramas aims at a more pluralistic academic methodology inspired by Feminist Epistemologies[2], Southern Epistemologies[3], Political Ecology[4], the proposal of a 'science guided by activism'[5], the 'knowledge of experiences made'[6,7] and decolonial theories[8], among others. According to the Núcleo Tramas, this academic practice arises from the need to break with the hegemonic forms of the relationship between the academy – understood as an educational system and intellectual environment as a whole – and the territory, which leads to reflections on a production of knowledge in line with the processes of struggle in defense of rights. This rupture makes it possible to deconstruct the power-knowledge relations between the academy and the territory and to enter into dialogue with cultures that have been historically silenced, as is often the case with rural, forest, and water populations. Thus:

> it represents an intercultural and pluriepistemic practice that establishes dialogue between the issues, knowledge, expertise, and actions of the university, the militancy of social movements, and the experiences of residents of communities affected by environmental injustices[1(369)].

In turn, it is worth reflecting on the reason for the need to decolonize the relationship between academy, health, and territory. Perhaps because, as Krenak[9(3)] points out:

> It would be interesting for us to think about what we call care and health, and not be prisoners of these already established characteristics of health, disease and well-being; these crystallized ideas about the body, a body that is not constituted, a body that is given.

In this way, this and other counter-hegemonic epistemologies emerge as counterpoints to the constant attempts to deny traditional knowledge, especially in relation to fields, forests, and waters. This denial, in turn, is a legacy of the Eurocentric perspective and a consequence of the colonization process that, according to the Modernity/Coloniality group, persists through new readings, guiding views, knowledge, and existences that form the triad: Power, Knowledge, Being[8].

The concept of colonial power, originally developed by sociologist Aníbal Quijano[10], refers to a symbolic and material power structure that maintains a system of subalterns. Based on the extension of the concept of power, Mignolo[11] coined the concepts of coloniality of Being and Knowledge, assuming that 'colonized being' occurs when power and thought become mechanisms of exclusion. Maldonado-Torres[12] (following Quijano, Levinas, Fanon, and others) deepened the theory of Being by noting that the coloniality of power takes on an ontological dimension when it takes into account the gradients of being human according to race.

For Santos[13], these forms of violence through knowledge, power, and being are tools to form and deepen an abysmal line marked by the polarity – epistemic, geographic, social, and political – between the visible (on this side of the line) and the invisible (beyond the line); or, as the author says, between the global North and South. This border, in turn, is the result of a colonial process that goes beyond the legal-administrative structure between territories and involves various forms of domination,

appropriation, and violence of collective and individual bodies. This abysmalness consists in the denial of bodies and knowledge, as they are produced as invisible and therefore subject to domination, exploitation, and/or elimination.

Health education has such concepts as its epistemological basis, since it is anchored in a (biomedical) science that not only appropriates popular knowledge, but also denies it. In the monolithic view of biomedicine, traditional knowledge is therefore an inferior reality that contributes little or nothing to health care. However, unlike Western medicine, which focuses mainly on disease and the dismemberment of the body, traditional medicine constitutes itself simultaneously as a therapeutic, legal, political, and spiritual entity[14]. For this reason, there is an urgent need for the institutions responsible for health education to change their own actions and their view of the individual, as they need to break with the Eurocentric hegemonic perspective of the individual as part of a collectivity, and not as a unique being, in order to break with the different forms of control imposed by power, including knowledge and being, that is, the faces of coloniality.

In this last perspective, and considering the context of the field, in a supposed attempt to broaden the reflection-action on health, stand out in the context of health education and the Unified Health System (SUS): the National Policy for the Holistic Health of Black Populations (PNSIPN)[15]; the National Policy for the Comprehensive Health of Rural, Forest, and Water Populations (PNSIPCFA)[16]; the National Policy for Popular Health Education (PNEPS-SUS)[17]; and Multiprofessional Residency in Family Health with a Focus on Rural Population Health (RMSFC)[18]. These strategies demonstrate the importance and necessity of breaking with the medical-centered, uniprofessional, fragmented, and hierarchical model of education and health care. They aim to increase problem-solving capacity through interdisciplinary action and the possibility of holistic care for individuals and communities by valuing diverse knowledge, ancestry, dialogue, and territory.

Despite these more equitable political-institutional perspectives, these strategies are embedded in a context underpinned by capitalist and colonial concepts of health focused on the control of the biological and social body, dichotomized between subject-object, universal knowledge-partial knowledge, neutral knowledge-implicit knowledge, i.e., anchored in the biomedical colonial paradigm of education[19]. So, as Krenak[9(4)] asks:

> [...] at what moment is it possible to cross the idea of integrality and equality, when the whole complex itself has no equality, and even when it strives for integrality, it does so in a manipulated way and with the aim of control? The Western health care system is control.

This brings us to the following concern: can the presence of health residency in the region be a way to decolonize the academy? This article reports, in the form of a field report, the possibility of decolonizing the academy through an RMSFC program in the Quilombola community of Estivas, in the rural area of Garanhuns, in the rural region of Pernambuco.

Family Health Multiprofessional Residency with emphasis on the Health of the Rural Population: a path to be followed

The RMSFC program is one of the strategies to internalize health and overcome the historical invisibility of health care for rural, forest, and water populations. In addition, the Organic Health Law[20] and the Federal Constitution of 1988[21] give SUS the authority to organize human resources training in health. Based on these institutional political frameworks, a

movement of construction of new paradigms begins, affecting the organization of health services and especially the model of training of interdisciplinary health professionals.

Although health residencies have existed since the late 1970s, our study addresses the RMSFC coordinated by the University of Pernambuco in collaboration with the Movement of Landless Rural Workers (MST), the Quilombola communities of Garanhuns, the Escola Nacional Florestan Fernandes, and the 2015 Collective for Health in the Field. The experience took place in a settlement in Caruaru and in a quilombola community in Garanhuns, both in Pernambuco. In these six years, the program has been expanded to other places such as the Federal District and built through joint management involving the territory, the academy, the health department (state and municipal), and the Ministry of Health.

The guiding principles of the program are education through and for work and the Pedagogy of Alternation. The Pedagogy that emerged in Brazil in 1969

> [...] is a methodology that favors the access and retention in school processes of rural youth and adults, previously hindered by their characteristic of not being articulate with reality and rural lifestyles[22](120).

Residencies in rural health seek support in the references of the pedagogy of alternation and have popular education (in health) as guiding principles, based on the principles of: know how to listen; transform naivety into political action; learn from each other; know how to dialogue; live patiently impatient; take risks; realize that no one is alone in the world; know how to be loving, etc.[23-25] and active and participatory methods. The goal is to train health workers whose profile is more in line with local realities and consistent with the principles of SUS and popular health education. In this way, professionals will be trained not only to fight against inequalities in health, but also to have the technical capacity to consider not only the individual, but above all the territory in which they work, its way of life, its production, and its social reproduction, and to develop a decolonial perspective.

Due to the specificity of the context, there's also a need to update and train preceptors and tutors with permanent qualifications. However, there's a lack of political-methodological framework for in-service training, aimed mainly at rural, forest, and water populations. Therefore, it is not only a basic strategy for residents, but also contributes to the professional performance of preceptors (professionals associated with the service) and tutors (professionals associated with the educational institution).

These strategies are essential to identify and in some way fill the existing gaps in public health policies and bring about a solution in the context of health services through a different way of learning and teaching that understands that the process of health and disease integrates values and beliefs and therefore requires a different way of doing health. In view of the above, and despite the advances in residency training, rural residency training represents a milestone in the education and health care of the rural population, contributing to a specific theoretical, practical, critical, and reflective approach that still focuses very much on the urban population, with little consideration and appreciation of the knowledge of the rural population, taking into account the location of educational institutions.

Rural Health Multiprofessional Residency: experience report in the Remnant Community of Quilombo do Sítio Estivas

Since the promulgation of the 1988 Constitution, the concept of 'Traditional Peoples' has evolved greatly, increasingly

legitimizing the character of collective identities and territoriality. This concept is now a legal category and a subject of public policy, consolidating a wide range of social groups and highlighting their own characteristics in terms of their way of life and their cultural and historical specificities[26]. Decree No. 6040/2007, which establishes the National Policy for the Sustainable Development of Traditional Peoples and Communities, defines in Art. 3:

> Traditional peoples and communities: culturally differentiated groups recognized as having their own forms of social organization, occupying and using territories and natural resources as a prerequisite for their cultural, social, religious, ancestral, and economic reproduction, using knowledge, innovations, and practices that have emerged and are passed on through traditions[27].

Currently, this theme is reinforced by the quilombos or the Remnant Communities of Quilombos. They are one of the oldest forms of social organization in the country and can be seen as forms of resistance to the colonial project, then when they opposed the slave system, and today when they oppose neocolonialism and fight for access to land that they, as well as other peoples, have historically been denied or forcibly deprived of. For Rail[28(61)],

> The current landscape of quilombos actualizes, however, the struggle of blacks in Brazilian society, in this historical period of the territory in which the forces of capital alienate the territory in an increasingly globalized economy.

In 2004, the Ministry of Health created Decree No. 1.434[29] to engage the quilombola population by establishing the Family Health Strategy Teams for quilombola communities. In 2009, Executive Order No. 992 established the National Policy for the Comprehensive Health of the Black Population, which established goals to improve health, with special attention to the quilombola population[30].

The Remnant Community of the Quilombos do Sítio Estivas is located in the countryside of Pernambuco. Originally, their land was inhabited by the indigenous people of the Cariris branch, when around the 17th century, whites and blacks fleeing from the Dutch subjugation occupied the swamplands and settled there in scattered villages.

The experience reported in this article is part of a course on 'Decoloniality and Knowledge Dialogues in Territories' promoted by Fiocruz-Recife in collaboration with the Universidade Federal Rural de Pernambuco. At the end of the course, it was proposed to the students to organize a seminar related to the decolonial theories from the text 'The Pedagogy of Territory: Epistemic Disobedience and Academic Insurgencies in the Practice of the Núcleo Tramas'[1]. This reflection allowed the group to problematize the relationship between territory and residence through the following question: Can the academy be decolonial?

The relevance of the discussion allowed seminar participants, in the face of a rural black community, to try to look at ethnic-racial and cultural issues in a geographic approach and to understand the relationships between labor, lifestyle, and human connectedness to the earth. To understand these dynamics, it was necessary to explore the concept of territory and territoriality to understand how the remaining community of Quilombos do Sítio Estivas builds relationships with its surroundings through the use of territory and affirms the search for Afro-descendant identity.

The dialogue of this seminar was constructed from the speeches of three guests: a community leader, a resident of RMSFC R1 (first year), and a resident of RMSFC R2 (second year). Beforehand, the following reflective questions were asked: 1. Who are you and what is your relationship with the area? 2. What do you see as the social and political function of the academy in the

territories? 3. Do you think the territory has changed since you have been there? If so, what are the main positive and/or negative impacts you can cite? 4. Do you believe in combining popular knowledge and academic knowledge for social change?

The speeches of the residents made it clear that it is necessary to know the peculiarities of the territory, understand how the community behaves and how it deals with the different aspects that make up health and disease, so that the health interventions aren't the same as those that are usually carried out in an urban environment. For this, it is necessary to enter into a dialogue, to listen, and to recognize the incompleteness of academic knowledge, that is, it is necessary to experience the autonomy and the power of creation in the care process based on reality. The importance of the territorialization process is highlighted, not only as a geographical process, but as a recognition of the relationships between the environment, the living conditions, the health situation, and the health network[31]. These aspects represent a challenge for the training for a SUS worker, since the initial health training of residents is oriented towards a biomedical model of care that, among other things, ignores the context and the subject, which is different from the way in which rural living is traditionally organized through a process of daily and collective learning.

The historical '(de)territorialization' of knowledge and identities through various forms of power needs to be reconsidered in order to establish a dialogue with decolonial thought, affirming that it is possible to connect the systems of scientific knowledge with the knowledge that comes from people's daily experience with nature.

The dialogue, an easy and complex tool, was highlighted by the inhabitants as a way to unite the world of science with the universe of wisdom of the traditional peoples, respecting the existence of the other. In this sense are the words of Cotta et al.[32](282) when they point out that,

> One cares only for what one knows correctly, otherwise one's actions are nothing more than diagrams learned in the academy and reproduced completely uncritically and detached from the needs of the people.

Another major contribution of residency to the education of residents and highlighted as essential to changing their perspective was the need for interdisciplinary collaboration and teamwork between residents and the community. Interdisciplinarity must be understood not only as an amalgamation of knowledge but also as a practice, that is, a process of constructing knowledge and action that takes shape through consensus and disagreement[33]. It seems indisputable that it's only possible to build stronger bonds and determined health actions if the work is truly collective and collaborative, from the planning to the execution of activities. Collaboration is challenging, however, because it requires all participants to give up their perceived certainties to some degree, which requires constant negotiation.

The speech of the community leader pointed out two key points: the first refers to his relationship with the territory, which is about ancestry, since he understood himself as Quilombola through his family history and belonging to the Remnant Community of Quilombo de Estivas. In this sense, he stressed the importance of considering aspects that go beyond the physical body in health care, considering ancestry and lifestyle as health practices. As pointed out by Farias et al.[34](634)

> From this perspective, the promotion, prevention, and restoration of the health of this segment of the population must be understood from the African worldview and Afrocentric forms of knowledge. The prerequisite for this understanding lies in contextualizing the Black African civilization paradigm and the African cosmovision.

Another important point was the positive evaluation of the residency in the Quilombo. For the leader, the combination of traditional and academic knowledge, with mutual respect, enriches the territory and everyone's learning, as residents bring innovation and different perspectives, including new political and social provocations that take the Quilombo out of its comfort zone and lead to an internal organization that also welcomes residents. In addition, the residency has helped the quilombolas face the pandemic and develop activities to address immediate needs arising from the pandemic scenario, such as hunger, as we'll see below.

In the early months of COVID-19, residents were removed from the quilombo to reflect on what their contribution would be in light of the anticipated risks. After the initial understanding of the situation, it was necessary to understand what the words 'stay home; wear mask; keep distance; wash hands' meant to a community that had multiple family members at home who depended on rural labor. In addition to cuts in social support and rising food prices, another challenge was added: hunger. Therefore, the 'Worker Health' residency module included discussion of agroecological science and expanded the concept of health in the RMSFC.

Faced with the difficulty of working in people's homes, and triggered by the real need of hunger, immediate and urgent proposals arose for the construction of community vegetable mandals, a biopurification plant, and a community kitchen. The challenge, however, was to unite people under health surveillance and to comply with safety measures to prevent spreading COVID-19.

> *The leaders were asked to talk to the residents and bring up their current difficulties. They were also asked to think about how residents can work together to take care of the health of the community, and to write down anything that can be done to reduce the problems that have arisen as a result of the pandemic.* (Leader).

To facilitate communication, residents formed groups via cell phone apps (with those who had access to cell phones) and collaboratively created a schedule based on whether the community had the opportunity to meet to build gardens and bio-power plants together. Each person had a task, and there were always guidelines for social distance, wearing a mask, and hand washing.

Having water to wash hands isn't so easy in the semi-arid northeastern region, so one of the first measures considered was to find a way to provide water to the population. According to Almeida et al.,[35] an alternative technology with plastic bottles, pipes, and a tap placed at strategic points in the community was used to promote hand washing and make it easier for those who wanted to wash but had no place to do so. This technology has opened new possibilities of collective action for the community of Sítio Estivas.

After analyzing all the possibilities that minimize the risks, the second step was to invite the community leadership to consult directly with the residents of the area, so that the ideas could be adapted to the real needs of the moment, "*and so the vegetable mandalas and the biodigestor were born*" (Leadership).

It is clear from the community leader's report that this pandemic scenario helped to clarify the collective construction from local hardship and strengthen the residents' commitment to experiencing the reality into which they were placed. Based on the popular theoretical-methodological health education, understood as a political and transformative action in which theory and practice are inseparable[36], residents were able to think about solutions together with the community, in a collective and interdisciplinary way, taking into account the factors of social determinacy, holism of care, and social participation – and, moreover, understanding the role of residents in the territory and the possibility of implementing the principles of SUS. Thus, "science brings its intersection in the real space of the training of the SUS residents and staff"[36(17)].

Final considerations

The Pedagogy of the Territory is expressed in this experience through shared construction, attentive and creative listening, but above all through the refusal to deny and silence beings and knowledge that have been and are historically silenced as a legacy of Eurocentrism, through ethno-structural epistemic racism. Given this pedagogy, the RMSFC represents an important strategy for thinking about and producing health with a different lens on specific populations, leading to changes in professional practice, contributing to the effectiveness of health equity interventions, and most importantly, making these communities visible.

Given the brief accounts, the reported experiences suggest some ways in which this visibility may be possible. They contextually present ways of thinking and acting from a post-abyssal perspective, both in terms of living in the territory and acting in health. It seems, then, that this training space represents an effective way for the decolonization of knowledge, being, and power of the academy and SUS in their ways of knowing, caring, learning, and experiencing the territory.

Despite these powers, however, it is useful to point out some limits of residency in the health area under the quilombola context. First, we're dealing with an area and a people marked by historical processes of violence and persecution that translate into poorer living and health conditions. Second, the vast majority of resident professionals (despite curricular change in some universities) haven't received in-depth training or consistent historical conceptual reflection on the health of the black population, certainly not in specific contexts, nor on aspects such as racism, equity, and otherness. This can make dialogue with these communities difficult and gives residency the character of initial training. In addition, the health sector's creative and active view of quilombos is to some extent limited to territories that receive residents, as even basic services are sometimes absent, decontextualized, unprepared, incomplete, and/or not prioritized by local and federal administrations in these and other traditional communities. This limitation risks limiting the strategies of multiprofessional health centers to an isolated experience and to the academic field, which doesn't have continuity or represent sustainable changes for the territory.

Collaborators

Araújo JM (0000-0001-6205-0116)*, Costa KAO (0000-0001-5585-5768)* and Silva FCCM (0000-0003-1695-0740)* contributed to the idealization of the study design, collection, analysis and interpretation of data, manuscript writing, and final review and approval of the manuscript for submission. Gervais AMD (0000-0002-1393-529X)* contributed to the final review and approval of the manuscript for submission. ■

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