

Health service utilization by Quilombola and non-Quilombola adolescents living in a rural area in the semi-arid region of the state of Bahia, Brazil

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Abstract *This article describes health service utilization by Quilombola and non-Quilombola adolescents living in a rural area in the semi-arid region of Bahia. Quantitative and qualitative methods were used to gain a more in-depth understanding of the object of study. A cross-sectional household survey was conducted with 390 adolescents. Health service utilization was described using frequency distribution and 95% confidence intervals. Discussions were held with four focus groups, which were transcribed and analyzed using content analysis. The most commonly reported usual place of care was the local family care center (70,0%) and 15,1% of the adolescents had sought health care in the last 15 days. The main reason for seeking care was illness (37,3%). The findings of the qualitative component of the study reveal multiple factors influencing access to services, including long waiting times, lack of prioritization of adolescent care and geographical barriers. Health services should attempt to get closer adolescents and provide care tailored to the specific needs of this group.*

Key words *Adolescent, Rural health, Ethnicity and health, Access to health services*

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Introduction

Adolescence is defined as the stage of life between 10 and 19 years and is characterized as the period of transition between childhood and adulthood¹. In accordance with international instruments, the Brazilian Constitution confirms that adolescents are subjects of rights and have specific developmental needs and rights, while the Child and Adolescent Statute regulates and ensures the right of children and adolescents to health through the country's public health care system, the *Sistema Único de Saúde* (SUS)².

Brazil is a socially diverse country of continental proportions, meaning that Brazilian adolescents should not be treated as a singular homogeneous group. It is therefore important to recognize the range of factors that influence adolescent health care, such as social class, gender, race, place of residence, etc^{2,3}.

Studies show that health care-seeking behavior among adolescents differs from that of the rest of the population. For example, they tend not to give due attention to milder symptoms and experience difficulties seeking preventive care^{4,5}. Studies have also shown gender differences in health care-seeking behavior among adolescents, with girls seeking services for needs related to pregnancy and delivery and generally showing greater concern with their health^{6,7}.

Adolescents living in rural areas face difficulties related to access and quality of health services, especially those in remote areas⁸. The unique characteristics of these areas should therefore be taken into account in the organization of health care for this group³. Quilombola communities fall within this context. Distinguished by their ethnic identity, unique way of living, habits, social and historical aspects, and marked by oppression and resistance to structural violence, these communities are characterized by a high prevalence of basic health problems and difficulty in accessing goods and services^{1,9-12}.

Contextualized information about health care in a specific territory is vital for society and the state in the process of transformative management. It is in the territory that we are able to understand processes and trends to help diagnose situations of social risk and monitor actions developed to reduce inequalities and assist in incorporating intersectoral strategies¹³.

The utilization of health services is the central element of the *day-to-day functioning* of health systems and is influenced by individuals' needs and characteristics, service availability, ease of

access, funding and staffing¹⁴. Information in the literature on the utilization of health services by adolescents is limited, especially when it comes to ethnic minority populations, particularly Quilombola people³.

Therefore, the aim of this study was to describe the utilization of health services by Quilombola and non-Quilombola adolescents living in a rural area in the semi-arid region of the state of Bahia.

Methods

This study is part of a larger research project entitled "Being adolescent: Adolescent Health in Rural Areas and Conditioning Factors", conducted in 2015 with adolescents living in rural Quilombola communities recognized by the Palmares Cultural Foundation¹⁵ and non-Quilombola communities in Vitória da Conquista, Bahia. The study was approved by the Research Ethics Committee at the Multidisciplinary Institute of Health, Federal University of Bahia and all participants signed an informed consent or assent forms. A combination of quantitative and qualitative methods were employed to gain a more in-depth understanding of the object of study.

Quantitative Component

We conducted a cross-sectional household survey of adolescents aged between 10 and 19 years living in 21 rural communities (including nine Quilombola communities) using a semi-structured questionnaire. The questionnaire was adapted from National Student Health Survey (PeNSE)¹⁶ and National Health Survey (PNS)¹⁷ to tailor the data collection instrument to the local context. The final version of the instrument was defined after pretesting and a pilot study.

Sample size was estimated using data from the Form A of the Primary Care Information System, filled out by community health workers (CHW) during home visits and confirmed afterwards during a mapping exercise. The sample universe consisted of 811 adolescents (350 from Quilombola communities and 461 from non-Quilombola communities). To ensure a representative sample and study viability, we calculated two samples (Quilombola adolescents and non-Quilombola adolescents).

The sample size was calculated based on an estimated prevalence rate of 50% (in view of the heterogeneity of the measured events), precision of 5%, a 95% confidence level and design effect of 1.0. We also added 15.0% to the calculated sample to account for possible losses. However, since only one adolescent was interviewed per household and the number of households in the Quilombola communities was less than the sample number, we added only 7.1% in the Quilombola group.

Sampling in the non-Quilombola communities was carried out in two stages: 1) random selection of households with adolescents based on the proportion adolescents in each community; 2) random selection of one adolescent in each household. In the Quilombola communities, all the households were selected and one adolescent was randomly selected from each household.

The pilot study was undertaken in December 2014 in a rural community that was not part of the main study. The proposal was presented in meetings of the local health council, Quilombola territorial council and family health teams to help publicize the study in the communities. Since the study was conducted in a rural area, we mapped the households and community facilities. The households were informed about the project during the mapping process with the help of CHWs.

The questionnaire was organized into thematic blocks covering sociodemographic characteristics, risk behavior and health protection and including questions about health service utilization. The data were collected between January and May 2015 by a team of previously trained undergraduate students using pocket PCs (HP Pocket Rx5710). Five percent of the sample were reinterviewed to ensure data quality.

The following variables were used to describe health service utilization: always use the same place, doctor or health service (no/yes); usual place of care (pharmacy; health center/family health center; urgent care center/public hospital accident and emergency; public hospital/outpatient clinic; other); last medical consultation (last 12 months; between one and two years; two years or more/never seen a doctor); has sought health care in the last 15 days (no/yes); reason for not seeking health care in the last 15 days (there was no need; the health facility was far away or difficult to get to; inconvenient times; long waiting times; other); seen on the first visit to the health service (no/yes); place of first contact (care center/family care center; urgent care center/public

hospital accident and emergency; public hospital/outpatient clinic; other); main reason for seeking health care (accident or injury; illness; dental problem; continuation of treatment; vaccination; other); medication prescribed at the last appointment (no/yes); got the prescribed medication (all; part; none); how did the respondent get the medication (health insurance; the medicine access program *Programa Farmácia Popular*; public health service; a mix of the former; none of the former); bought the medication (no/yes); admitted to hospital for 24 hours or more in the last 12 months (no/yes); main type of treatment during admission (normal delivery; clinical treatment; psychiatric treatment; surgery; complementary diagnostic tests; other); admitted under the SUS (no/yes); admission covered by health insurance (no/yes); paid for admission (no/yes).

The data were described using frequency distribution and 95% confidence intervals. Data analysis was performed using Stata version 15.0.

Qualitative Component

Four focus groups (Quilombola boys, Quilombola girls, non-Quilombola girls, Quilombola girls) were formed to understand the adolescents' perceptions of the condition, access to and utilization of health services.

The focus group discussions were held in November 2015 in a local school. One discussion a day was held with an average of 10 participants and lasting an average of 40 minutes. Focus group participants were randomly selected using the following inclusion criteria: adolescents aged between 12 and 18 years studying in the administrative center of the district who had used health services in the last 12 months. During the awareness raising stage, each randomly selected adolescent was visited to explain the study and invite them to participate.

The group discussions were recorded and transcribed. To ensure data confidentiality, fictitious names were used for the adolescents. The study topics were addressed using pre-formulated questions from a semi-structured guide.

The data were analyzed using the content analysis technique proposed by Bardin¹⁸, which analyzes what is said and observed in the interviews, classifying the data into themes or categories that help understand the content. Data analysis was conducted in three stages: pre-analysis, *analytic description* and inferential interpretation.

In the first stage, we organized the collected data by conducting a detailed reading and

re-reading of the transcriptions to obtain a first impression of the information. In the second stage, the data were classified and categorized, considering relevant extracts of the transcripts. Finally, the findings were processed and interpreted considering the frequency of each respective interpretation in the dataset.

Results

Quantitative Component

Of the 390 adolescents interviewed, 200 (51.3%) were girls and 167 (42.8%) were Quilombolas. Losses amounted to 15.2% and 7.9% of the Quilombola and non-Quilombola groups, respectively. The proportion of losses varied according to group and sex, being highest among non-Quilombola boys (p-value 0.038). The main reasons for losses were: home closed after three visits, adolescent not found at home after three visits and refusal.

Most of the adolescents (70.0%) always use the same place, doctor or health service when they need health care, with the majority (70.0%) usually going to the health center/family care center. More than half of the respondents (54.4%) had seen a doctor in the 12 months prior to the interview and 15.5% reported seeking health care in the last 15 days. The main reason for not seeking health care in the last 15 days (92.2%) was because there was no need (Table 1).

Among the adolescents who had sought health care, 96.6% were seen on the first visit to the health service and 66.1% of these appointments were in a care center/family care center. The main reason for seeking health care was illness (37.3%). Among those who had an appointment, 59.7% were prescribed medication and 79.4% got all the medications that were prescribed (12.5% from a public health service, 15.6% from the *Programa Farmácia Popular*, and 54.6% bought some or all of the medications) (Table 2).

With regard to hospitalization, 7.2% of the adolescents had been admitted to hospital for 24 hours or more in the last 12 months. The most common types of treatment during admission were clinical treatment (39.3%) and surgery (14.3%). Most of the adolescents (82.1%) were admitted under the SUS (Table 3).

Qualitative Component

In the focus group discussions, most of the adolescents made positive comments about their health and generally regarded themselves as healthy. The groups reported that they seek care at the family care center in the district's administrative center or family health center outposts in the communities, either directly or via the CHW. The adolescents considered that the family care center is important, because it helps people solve their health problems, and necessary, especially for those with limited financial resources. However, the findings show that when adolescents were unable to get an appointment at the family health center, health care-seeking behavior differed between Quilombola and non-Quilombola adolescents, with the former being more likely to go to public hospitals and the latter to private clinics.

Most of the visits to health services were for unscheduled care, mainly vaccination, weight and height measurement, medical consultations and dental care. The adolescents also mentioned that they had access to health actions developed by family health teams in the school, such as education activities, vaccination card checks and updates and anthropometric measurements. The findings also show that the girls appeared to show greater concern for their health than the boys, seeking services to schedule examinations, routine consultations/preventive care and diagnosis of health problems, while the boys tended to seek services as a result of an accident or injury.

With regard to the adolescents' perceptions of the public health service, all the groups associated long waiting times – both for consultations and scheduling examinations, especially in specialist services – with “lack of priority” for adolescent care: “they only see pregnant women”, “older people” and “children for vaccination and weighing”. This finding shows that the adolescents experience difficulty in accessing health services. The groups also mentioned physical infrastructure, the condition of equipment and hygiene in the family care center and health outposts, highlighting poor facilities, poorly maintained equipment and the need for more stringent hygiene standards.

Other questions – raised only by the adolescents from non-Quilombola communities – were the distance between the community and the town, poor evening transport services and limited opening hours at the family care center. These factors hampered access, particularly to urgent

Table 1. Utilization of health services by Quilombola and non-Quilombola adolescents living in a rural area in the semi-arid region of Bahia, Bahia, 2015 (n=390).

Variables	n	%	95%CI
Always use the same place, doctor or health service			
No	117	30.0	25.6 – 34.7
Yes	273	70.0	65.2 – 74.4
Usual place of care			
Pharmacy	27	6.9	4.8 – 9.9
Health center/family health center	273	70.0	65.4 – 74.5
Urgent care center/public hospital accident and emergency	31	8.0	5.6 – 11.1
Public hospital/outpatient clinic	20	5.1	3.3 – 7.8
Other	38	9.7	7.2 – 13.1
Last medical consultation			
Last 12 months	212	54.4	49.5 – 59.4
Between 1 and 2 years	114	29.3	24.9 – 34.0
Two years or more/never been to the doctor	63	16.2	12.8 – 20.2
Sought care in the last 15 days			
No	331	84.9	80.9 – 88.1
Yes	59	15.1	11.9 – 19.0
Reason for not seeking care in the last 15 days [‡]			
No need	305	92.2	88.7 – 94.6
Health facility far away or difficult to get to	9	2.7	1.4 – 5.1
Inconvenient times	4	1.2	0.4 – 3.2
Long waiting time	5	1.5	0.6 – 3.6
Other	8	2.4	1.2 – 4.8

P-value calculated using chi-squared; †P-value calculated using Fisher's exact test; ‡n=331.

Source: Author's elaboration.

and emergency care. The Quilombola adolescents highlighted the irregularity of care provided in community health outposts, reporting that the services only open "every month or so", thus restricting access to health care.

Discussion

The most commonly reported usual place of care was the family care center. The adolescents

Table 2. Utilization of health services in the last 15 days by Quilombola and non-Quilombola adolescents living in a rural area in the semi-arid region of Bahia, Bahia, 2015 (n=59).

Variables	n	%	95%CI
Seen on the first visit to the health service			
No	2	3.4	0.8 – 13.0
Yes	57	96.6	87.0 – 99.2
Place of first contact			
Health center/family health center	39	66.1	52.8 – 77.2
Urgent care center or public hospital accident and emergency	6	10.2	4.5 – 21.3
Public hospital/outpatient clinic	5	8.5	3.5 – 19.2
Other	9	15.3	8.0 – 27.2
Main reason for seeking health services			
Accident or injury	3	5.1	1.6 – 15.0
Illness	22	37.3	25.7 – 50.6
Dental problem	5	8.5	3.5 – 19.2
Continuation of treatment	4	6.8	2.5 – 17.1
Vaccination	3	5.1	1.6 – 15.0
Other	22	37.2	25.7 – 50.6
Medication prescribed at the last appointment			
No	23	40.4	28.2 – 53.9
Yes	34	59.7	46.1 – 71.8
Got the prescribed medication			
All	27	79.4	61.6 – 90.2
Some	6	17.7	7.8 – 35.2
None	1	2.9	0.4 – 19.8
How did the respondent get the medication			
Health insurance	3	9.3	2.9 – 26.6
Programa Farmácia Popular	5	15.6	6.3 – 33.6
Public health services	4	12.5	4.5 – 30.2
A mix of the above	12	37.5	22.0 – 56.1
None of the above	8	25.0	12.5 – 43.7
Bought the medication			
No	15	45.4	28.8 – 63.2
Yes	18	54.6	36.8 – 71.2

Source: Author's elaboration.

reported that they used mainly public services, highlighting the following difficulties: long wait-

Table 3. Hospital admissions in the last 12 months among Quilombola and non-Quilombola adolescents living in a rural area in the semi-arid region of Bahia, Bahia, 2015 (n=28).

Variables	n	%	95%CI
Admitted to hospital for 24 hours or more in the last 12 months (n=390)			
No	362	92.8	89.8 – 95.0
Yes	28	7.2	5.0 – 10.2
Main type of treatment during admission			
Normal delivery	2	7.1	1.6 – 26.2
Clinical treatment	11	39.3	22.4 – 59.2
Psychiatric treatment	2	7.1	1.6 – 26.2
Surgery	4	14.3	5.1 – 33.9
Complementary diagnostic tests	2	7.1	16.3 – 26.2
Other	7	25.0	11.8 – 45.3
Admitted under the SUS			
No	5	17.9	7.2 – 37.9
Yes	23	82.1	62.1 – 92.8
Admission covered by health insurance			
No	26	92.9	73.7 – 98.4
Yes	2	7.1	1.6 – 26.3
Paid for admission			
No	24	85.7	66.0 – 94.9
Yes	4	14.3	5.1 – 34.0

Source: Author's elaboration.

ing times, lack of priority specific to adolescents, poor facilities and health center maintenance, and irregular service provision in the community. The Quilombola and non-Quilombola adolescents reported different care-seeking strategies when they were unable to get an appointment at the family health center, with the former tending to go to public hospitals and the latter to private clinics. Only a small percentage of the adolescents reported seeking health care in the last 15 days before the interview.

Almost all the adolescents who needed health care (96.6%) were seen on the first visit to the health service. These findings are consistent with the data for the general population (95.3%)¹⁹. These experiences can directly influence the service user's decision to use the same place, doctor or health service in the future. In this regard, studies have shown that having a usual health

professional or health service is related to better access to services and is considered an important element of care quality, continuity and health professional-adolescent relations⁴.

In this sense, the Family Health Strategy (FHS) needs guidelines that support different activities, strengthening welcoming practices and community affiliation, providing adolescents with a sense of security and reference point, and promoting positive changes in relation to health care. In this regard, adolescents demonstrate knowledge of the services provided in the community and the dynamics of the places and subjects (both individual and collective), which helps guarantee the continuity, longitudinality and effectiveness of care.

To take care of people's health. Take care of the health of people in need. To schedule a test. (Banguça – non-Quilombola)

To donate medicines. (Marrentinha – non-Quilombola)

To help people with their problems. (Estrela – Quilombola)

The SUS aims to ensure the provision of universal and equitable comprehensive care. The findings show that most of the adolescents (70.0%) usually go to the family care center or health outposts when they need care. This data is consistent with the findings of national health surveys^{19,20} (56.9% and 47.9%, respectively) and other studies in rural communities (87.4% in Jequitinhonha, Minas Gerais)²¹.

For most things, whenever an illness occurs it's straight to the outpost. (Narizinho - Quilombola)

(What do you do when you need health care?) I go to the doctor (...) in the outpost. (Caxixe - Quilombola)

(What do you do when you need health care?) I ask the community health worker to schedule an appointment [in the outpost]. (Patrick – non-Quilombola)

The fact that the most commonly cited usual place of care was health centers reinforces the importance of primary care as the point of entry to the health system, especially in rural areas, where other types of services are scarcer than in urban areas²¹. In addition, the fact that the adolescents had a service of choice may be related to positive experiences with care delivery and bonds of trust with professionals, many of whom are already known in the community²².

Despite advances in health care access and utilization in Brazil, mainly due to the expansion of coverage in the primary care system, studies show that there are inequalities in health between

geographic areas and socioeconomic groups, especially among minority ethnic groups^{6,23}. In this regard, it is important to bear in mind that 7.8% of the adolescents did not seek services despite needing health care.

Health care-seeking behavior may be related to both cultural factors and difficulties accessing services. The adolescents reported that the main reason for not seeking care was because there was no need. However, some also confirmed that they did not seek services due to distance – a typical feature of rural areas – inconvenient appointment times, and waiting times.

... there was this case of a friend of mine who came home without being seen ... there were a lot of people, and she was one of the first to arrive, and it took ages for her to be seen. (Rosa - Quilombola)

Sometimes it's good, but ... you have to wait a long time sometimes, when it's a test. (Capacete – non-Quilombola)

It's good, just that it's really bad because it takes ages. Because, like, when we ask to do a test, it takes a long time to get the results. So it's better to go to Vitória da Conquista. Because I used to come here and it would take a long time. For our neighbor it took six months [to get the results], before you know it she had died; it was only after [she died] that the results arrived. (Unidentified - Quilombola)

One of the barriers to health service access and utilization reported by the adolescents was excessive waiting times. In addition, according to the adolescents, health centers do not provide equal coverage for all audiences, with adolescents not being considered a priority group in the FHS. This situation was also observed in another study with adolescents in Bahia²⁴.

... they only see pregnant women"... "and older people" (Majin Boo - Quilombola)

Children for vaccination and weighing. (Kel - Quilombola)

And sick people who use crutches. (Caxixe - Quilombola)

Sometimes the problem is we need to go to school, so the day is scheduled for us in the morning, so we go, right? When we get there, we arrive first, but children are seen before us, pregnant women, the elderly, and we end up being last. So sometimes we are not seen, because we have to go back, to go to school, so we leave without being seen. (Estrela-Quilombola)

The adolescents also highlighted the lack of resources in public health services, referring to the poor physical infrastructure and condition of equipment in the family care center and health outposts.

You have to come here, there are outposts there that open every month or so, they're all dirty. (Caxixe - Quilombola)

Ah, some outposts, the rust is eating away the cabinets, that sort of thing (...). (Batoré – non-Quilombola)

The Quilombola and non-Quilombola adolescents who were unable to get an appointment at the family health center showed different health care-seeking behavior, with the former being more likely to go to public hospitals and the latter mostly using private clinics.

It was supposed to be through the SUS, but it took a long time, so I had to pay (Bin Laden – non-Quilombola).

So I felt a strong stabbing in the chest, and it just got worse, and I went to hospital twice [...]. yeah, yeah in Conquista! Public service. (Princesinha- Quilombola)

I generally go private. (Unidentified – non-Quilombola)

I also went to the gynecologist. When I went there [to a private service] it took six months here [in the outpost]. (Menorzinha – non-Quilombola)

It depends on the financial situation of the person, doesn't it? Sometimes you go to the SUS or go private. (Bolachão – non-Quilombola)

Other studies with adolescents show that socioeconomic factors influence access to health services^{4,25}. Our findings show that the proportion of adolescents from families with lower socioeconomic status was higher among the Quilombola group (76.1% compared to 50.2%)²⁶. Claro et al.²⁵ reported that students from public schools are almost five times more likely to seek services at a public health center than students from private schools, with the latter having easier access to private health insurance and/or services. In a study investigating health inequities, Nunes et al.⁴ showed that the prevalence of use of health services was lower among adolescents from lower socioeconomic groups, those who worked and did not study and those who were black.

Other barriers to access highlighted by the non-Quilombola adolescents were the distance between the community and the town, poor evening transport services and family care center opening hours. These factors hamper access to services especially in situations requiring urgent and emergency care.

It's because there [in the urban area] everything is closer, here everything is further away. (Bin Laden – non-Quilombola)

So, like, because there is no night service, unless you go to the hospital [...] and I couldn't find any

transport, because the bus was not running, it was two and a bit in the morning, so either I went on foot or I died. (Estrela – non-Quilombola)

Unlike the non-Quilombola adolescents, the Quilombola group did not mention distance or poor transport. This may suggest that these factors are irrelevant to this group, that Quilombola adolescents have a higher level of resilience, being able to adapt to adverse situations, or that they are accustomed to daily hardship.

To promote equity in health service access and utilization, services should be organized in order to minimize barriers to access²⁷. In this regard, family care team visits to the community are a form of reducing geographical barriers to access, facilitating the use of health services. On the other hand, providing services with the same regularity to closer and more distant locations with different racial and socioeconomic characteristics can produce inequities in health service access and utilization. The remarks below about barriers to access in Quilombola communities illustrate this:

It's only open now and again, not all the time. (Madinbu – Quilombola)

[It opens] every month or so. (Caxixe – Quilombola)

When we have a problem like you said, we have to come [here], because there at the outpost it's only sometimes, every month or so. (Estrela – Quilombola)

In this regard, Travassos and Castro²⁷ emphasize that social injustice is characterized by inequalities in health between social groups and in health service access and utilization resulting from the existence of unequal opportunities for different social positions. In this regard, it is important to highlight that both the national guidelines for comprehensive adolescent health care¹ and the National Policy for Comprehensive Healthcare for the Black Population⁹ highlight the need for strategic actions to expand the coverage of health care for the Quilombola population with the aim of reducing ethnic and racial inequality.

The findings show that only a small proportion of the adolescents use preventive care services. This finding is corroborated by the literature, which shows that the main reasons for seeking health care are aspects related to illness^{20,28}.

I only go when I'm ill. (Lua - Quilombola)

Diniz suggests that adolescents' resistance to seeking preventive health care is associated with factors such as not giving due attention to non-severe and non-physical symptoms⁵.

I had tooth ache, so I went. (Obama – non-Quilombola)

I had stomach ache and my legs an back were aching... I went to the doctor. (Safadão – non-Quilombola)

However, some of the accounts show that services were also used for prevention purposes, particularly when the adolescent had a relative or family member with the condition in question.

I just did a check-up there one day. (...) Because my dad has it [the health problem] and so I could have it, you know!?" (Bin Laden – non-Quilombola)

More than half of the appointments the adolescents had (59.7%) resulted in a prescription, which is consistent with the data for the general population (64.8%)¹⁹. This may be related to the growing tendency to medicalize, whereby the majority of consultations end with a prescription, since the public tend to value and prefer curative practices²⁹.

The prevalence of access to all prescribed medications (79.4%) was consistent with the national average (75.8%)¹⁹. It is important to highlight that, although the *Programa Farmácia Popular* was the main source of medication (15.6%), followed by public health services (12.5%), a large proportion of the sample (54.6%) bought the medications. It is important to note that rural areas do not have public sector pharmacies, except for those in family care centers. Unless the patient can afford prescription medications and/or the trip to the nearest public sector pharmacy, the lack of medicines in rural areas makes it impossible to continue the treatment. This problem can lead to the worsening of symptoms, which in turn can result in additional demands on health services, a reduction in the likelihood of seeking the same health services in the future due to the negative experience, and use of alternative cures²⁵.

Our findings show that 7.2% of the adolescents were admitted to hospital in the 12 months prior to the interview. Vieira²¹ suggests that high prevalence of hospital admissions may be related to problems in accessing primary care or non-adherence to treatment. In the present study, most of the admissions were for clinical treatment (39.3%), which is generally the result of complications and deterioration in patients with chronic illnesses, reinforcing the need for better access to primary care to avoid the need for acute care.

Our study has some limitations. The sample size for the quantitative component was not designed to test differences related to gender and

place of residence, meaning that it was not possible to estimate differences between the groups.

Final considerations

*Adolescence is a life stage in which individuals begin to develop their health habits. This means that health services should attempt to get closer to this group, developing health education and promotion actions centered on their specific self-perceived health needs in different cultural settings. A range of strategies can be adopted from this perspective, for example: intersectoral actions tailored to the local context, peer education, and actions aimed at improving the public perception of health services, which are often seen by adolescents as unwelcoming*³⁰.

Ensuring the comprehensiveness of primary care could have an important impact on the health of Brazilian adolescents, especially those living in rural areas and/or Quilombola communities. To this end, strengthening primary care, and in particular the Family Health Strategy, is vital to improving the performance of adolescent care services.

Access to health services is a right protected by the SUS, meaning that barriers to access are a violation of this right, *compromising* the delivery of adequate timely care. The findings of this study provide valuable insights that can contribute to the definition of effective adolescent health care strategies.

Collaborations

KC Santana, EKP Silva, RB Rodriguez, R Souza and DS Medeiros contributed to study conception and implementation, data analysis and interpretation, and to writing this article. VM Bezerra contributed to study conception and data interpretation, and critically revised the article for important intellectual content. All authors read and approved the final version to be published.

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