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ORIGINALES

Assessment of the level of implementation of primary health care attributes as an indicator of the quality of care provided to quilombola communities in the state of Rio Grande do Norte

Avaliação do grau de implantação dos atributos da atenção primária à saúde como indicador da qualidade da assistência prestadas às comunidades quilombolas no estado do Rio Grande do Norte

Evaluación del grado de implantación de los atributos de la atención primaria a la salud como indicador de la calidad de la asistencia prestada a las comunidades quilombolas en el estado de Rio Grande del Norte

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ABSTRACT:

Objective: To evaluate the degree of implementation of the attributes of primary health care as an indicator of the quality of care provided to quilombola communities in the state of Rio Grande do Norte**.**

Methodology: This is an evaluative study carried out in 33 quilombola communities certified in the state by Palmares Cultural Foundation. Fifty-one professionals, physicians, nurses and nursing technicians, who work in primary health care, participated in the study using the Primary Care Assessment-Brazil version. The essential attributes, capacity, performance, and the derived attributes were considered: accessibility, logitudinality, coordination - information systems, coordination - care integration, integrality, family orientation and community orientation. The percentage of identified answers was distributed in four classifications: not implemented (from 0 to 25%); incipiently implemented (from 26% to 50%); partially implemented (from 51% to 75%); totally implemented (from 76% to 100%).

Results: From the analysis, it was found that the PHC actions in quilombola communities in Rio Grande do Norte were classified as fully implemented (82.2%), considering the dimensions capacity (77.92%) and performance (85.56%). When observing the derived attributes: longitudinality (92.94%), coordination - information systems (80.88%), integrality - available services (85.91%), family orientation (87.45%), and community orientation (92.16%), it is noted that these dimensions were also fully

implemented. Only the dimensions accessibility (74.51%) and coordination - integration of care (56.86%) were considered as partially implemented.
Conclusion: It was possible to carry out a situational diagnosis of PHC actions in quilombola communities, identifying the weaknesses and potentialities in the provision of health care to these communities.

Keywords: Health Evaluation; Black Population Health; Primary Health Care.

RESUMO:

Objetivo: Avaliar o grau de implantação dos atributos da atenção primária à saúde como indicador da qualidade da assistência prestadas às comunidades quilombolas no Estado do Rio Grande do Norte**.**
Metodologia: Estudo avaliativo realizado nas 33 comunidades quilombolas certificas no estado pela Fundação Cultural Palmares. Participaram 51 profissionais, médicos, enfermeiros e técnicos de enfermagem, que atuam na atenção primária à saúde por meio do instrumento de avaliação *Primary Care Assessment*-versão Brasil. Foram considerados os atributos essenciais, capacidade, desempenho, e os atributos derivados: acessibilidade, logitudinalidade, coordenação – sistemas de informações, coordenação – integração de cuidados, integralidade, orientação familiar e orientação comunitária. O percentual de respostas identificadas foi distribuído em quatro classificações: não implantado (de 0 a 25%); implantado incipiente (de 26% a 50%); parcialmente implantado (de 51% a 75%); totalmente implantado (de 76% a 100%).
Resultados: A partir das análises realizadas, verificou-se que as ações da APS em comunidades quilombolas do Rio Grande do Norte, foram classificadas como totalmente implantadas (82,2%), considerado-se as dimensões capacidade (77,92%) e desempenho (85,56%). Ao observar os atributos derivados: longitudinalidade (92,94%), coordenação – sistemas de informações (80,88%), integralidade – serviços disponíveis (85,91%), orientação familiar (87,45%), e orientação comunitária (92,16%), nota-se que essas dimensões também foram totalmente implantadas. Apenas as dimensões acessibilidade (74,51%) e coordenação – integração dos cuidados (56,86%) foram consideradas como parcialmente implantadas.
Conclusão: Foi possível realizar um diagnóstico situacional das ações da APS nas comunidades quilombola, sendo identificado as fragilidades e potencialidades na prestação do cuidado em saúde a essas comunidades.

Palavras-chaves: Avaliação em Saúde; Saúde da População Negra; Atenção Primária à Saúde.

RESUMEN:

Objetivo: Evaluar el grado de implantación de los atributos de la atención primaria de salud como indicador de la calidad de la atención prestada a las comunidades quilombolas del Estado de Rio Grande do Norte.
Metodología: Estudio evaluativo realizado en las 33 comunidades quilombolas certificadas en el estado por la Fundación Cultural Palmares. Participaron 51 profesionales, médicos, enfermeros y técnicos de enfermería, que actúan en la atención primaria de salud a través del Evaluación de la Atención Primaria-versión Brasil. Se consideraron atributos esenciales, capacidad, desempeño y atributos derivados: accesibilidad, logitudinalidad, coordinación – sistemas de información, coordinación – integración asistencial, integralidad, orientación familiar y orientación comunitaria. El porcentaje de respuestas identificadas se distribuyó en cuatro clasificaciones: no implementado (de 0 a 25%); incipiente implantado (del 26% al 50%); parcialmente implantado (del 51% al 75%); completamente implementado (del 76% al 100%).
Resultados: A partir de los análisis realizados, se constató que las acciones de APS en comunidades quilombolas de Rio Grande do Norte fueron clasificadas como totalmente implementadas (82,2%), considerando las dimensiones capacidad (77,92%) y desempeño (85,56%). Al observar los atributos derivados: longitudinalidad (92,94%), coordinación - sistemas de información (80,88%), integralidad - servicios disponibles (85,91%), orientación familiar (87,45%) y orientación comunitaria (92,16%), se observa que esas dimensiones también se implementaron completamente. Solo las dimensiones accesibilidad (74,51%) y coordinación – integración del cuidado (56,86%) fueron consideradas parcialmente implementadas.
Conclusión: Fue posible realizar un diagnóstico situacional de las acciones de APS en comunidades quilombolas, identificando debilidades y fortalezas en la prestación de servicios de salud a estas comunidades.

Palabras clave: Evaluación de la Salud; Salud de la Población Negra; Primeros auxilios.

INTRODUCTION

The enslavement of people of African descent that lasted about 380 years in Brazil was characterized by a period of extreme violence and genocide of these people [1]. Even 133 years after Law No. 3353 of May 13, 1888, abolished slavery, there has been no effective social reparation or mitigation of racial hierarchy [1], which contributed to the process of stigmatization, a result of the socio-historical racism that shapes the construction of the country, still remains today.

As a resistance to the exploitation suffered during the years of slavery, the quilombola territories arose. Such territorial structures, grouped mostly African peoples and their enslaved descendants who rebelled against the prevailing system, indigenous peoples and some white Europeans excluded from the system [2].

Currently, Fundação Cultural Palmares records [3], indicate that 61% of the quilombola communities are located in the Northeast Region of Brazil, 33 of them in Rio Grande do Norte. These quilombola communities are vulnerable to various social impacts, with high levels of poverty, illiteracy, unemployment, lack of sanitation, electricity, and access to health services, contributing to the permanence of high rates of social and collective vulnerability [3]

In this way, the policies to promote equity in health are configured as a set of actions and health services that aim to ensure resolute access, in a timely manner and with quality [4]. Among these policies, the National Policy for the Integral Health of the Black Population (NPIHBP), as well as the National Policy for the Integral Health of the Rural and Forest Populations (NPIHRFP) highlight the need to attend to the specific health needs of the remaining quilombo population, since they express living conditions marked by the process of exclusion of the black Brazilian population and, especially, are present in rural areas [4,5].

However, research has shown weaknesses in the execution of interventions that allow access to public policies by this population [6]. Among them, access to Primary Health Care is not only due to the geographical barriers in rural areas, but also to the shortage of professionals willing to experience the rural context, the lack of knowledge about the reality and specificities, as well as the racial discrimination stigmatization that surrounds vulnerable populations [7].

It is observed that the investments made in PHC, easily evidenced by the expansion of Family Health Strategies (FHS) and Basic Health Units (BHU), are far from this population, which goes against what is established in the National Policy of Primary Care (NPPC) and in the NPIHRFP, which advocate universal care without distinction of gender, race/color, ethnicity, and sexual orientation [5,8,9]

For Bárbara Stafield[10], the assistance in the context of PHC should be guided by observing the attributes of access to the first contact with the service, longitudinality, integrality and coordination of care, following three attributes. Considering the attributes pre-established by PHC in the context of quilombola communities, the normative evaluation in health is characterized as an important tool for analysis of the social complexity of this population group, and can show what NPPC and NPIHRFP recommend about the actions performed in quilombola communities [11].

Given the above, it is considered relevant studies that expand the discussion about the assistance provided by PHC in quilombola communities from the precepts established by the Unified Health System (UHS). The use of normative assessments applied to professionals who experience this reality is configured as a powerful ally in the construction of actions, which strengthen from a value judgment, the measures that ensure the performance and capacity of health care offered to this community.

In this sense, the objective of the present study is to evaluate the degree of implementation of the attributes of primary health care (PHC) as an indicator of the quality of care provided to quilombola communities in the state of Rio Grande do Norte.

METHOD

This is a study to evaluate the quality of primary health care attributes with a focus on the assistance provided to quilombola communities, which is characterized as an initial tool for the recognition of a certain reality that results in future interventions.

The scenario of this study was 33 quilombola communities distributed in 24 municipalities of the state of Rio Grande do Norte that are registered and recognized by the Palmares Cultural Foundation [(3)].

The target sample of this study was composed of doctors, nurses and nursing technicians or assistants who work in the Family Health Strategies (FHS) and Primary Care Teams (PCT) working in quilombola communities. In this sense, all 99 professionals responsible (doctors and nursing staff) for care in quilombola communities that are registered and recognized by the Palmares Cultural Foundation, distributed in 24 municipalities in the state of Rio Grande do Norte (RN), were invited to participate in the study. However, with the absence of responses from some professionals, the study had the participation of 51 professionals, 10 doctors, 25 nurses, and 16 nursing technicians.

The research sample was approximately 52% representative. Furthermore, it was possible to observe that in the municipalities of Bom Jesus, Ielmo Marinho, Ipanguaçu, Parelhas, Patu and Touros (Baixa do Quinquim) 100% of responses from registered professionals were obtained, on the other hand, the municipalities of Bom Jesus (Sítio Pavilhão), Portalegre (Sitio Arrojado/Engenho Novo and Sitio Pega) and São Tomé did not obtain any response from registered professionals.

For data collection, an instrument called Primary Care Assessment (PCATool/2020) version Brazil [(10)], was used, adapted to the reality of Primary Health Care in quilombola communities. The PCATool aims to measure the degree of implementation of PHC attributes in health care services [(10,11)].

Data collection occurred between September and October 2021. To carry it out, the professionals were previously contacted by email or phone that were requested to the PHC coordination of each municipality in order to present information about the research. After that, the evaluative questionnaire was sent via Google Forms.

The overall score was calculated by adding the scores of all the components that form

the essential attributes and the derived attributes (first contact access - accessibility, longitudinality, coordination - integration of care, coordination - information system, completeness - services available, completeness - services provided, family orientation, and community orientation), divided by the total number of components[10].

According to the score achieved, the actions were judged as to their implementation through the criteria recommended by Ferreira and Silva (2014)[12], which was adapted for this study, as follows: not implemented (from 0 to 25%); incipiently implemented (from 26% to 50%); partially implemented (from 51% to 75%); fully implemented (from 76% to 100%).

Since this is a research involving human beings, the requirements proposed by the National Health Council were met, through Resolution No. 510/2016 [13]. It is important to reiterate that the research was only conducted after approval by the Research Ethics Committee (CEP/CENTRAL) of the Federal University of Rio Grande do Norte, according to opinion 4.895.214.

RESULTS

Table 1 shows the characterization of the professional respondents. Regarding gender, 74.51% (n=38) are women and 25.49% (n=13) are men. Regarding the time they have been working in the quilombola community, it was possible to observe that 49.02% (n=25) have worked for one year, followed by 35.29% (n=18) who have worked from 2 to 5 years, and 3.92% who have worked more than 11 years in the community. It was also found that the professionals working with this 49.02% (n=25) are nurses, 31.37% (n=16) are nursing technicians and 19.61% (n=10) are doctors.

Table 1 Characteristics of primary health care professionals responsible for assistance in quilombola communities, Rio Grande do Norte, Brazil, 2021. (n=51)

Variable	N	%
Sex		
Female	38	74.51
Male	13	25.49
Time working in the community		
Up to 1 year	25	49.02
2 to 5 years	18	35.29
6 to 10 years	06	11.76
More than 11 years	02	3.92
Category		
Nurse	25	49.02
Nursing technician	16	31.37
Doctor	10	19.61

Source: Research data.

From the data analysis performed, it was identified that the PHC actions in quilombola communities in Rio Grande do Norte were classified as fully implemented (82.2%), considering the dimensions Capacity (77.92%) and Performance (85.56%). When observing the derived attributes: longitudinality (92.94%), coordination - information systems (80.88%), integrality - available services (85.91%), family orientation (87.45%), and community orientation (92.16%), it is noted that these dimensions were also fully implemented. Only the dimensions accessibility (74.51%) and coordination -

integration of care (56.86%), were considered as partially implemented, as can be seen in Table 2.

However, it is worth noting that although most attributes have been fully implemented when considering the overall assessment, some items are still only partially implemented or implemented in an incipient way.

Table 2 - Degree of PHC attributes in quilombola communities in Rio Grande do Norte, Brazil, 2021

Variables	Expected	Obtained	Final score (%)	Degree classification
Total	93.18	76.43	82.02	Fully implemented
1. CAPACITY	43.18	33.65	77.92	Fully implemented
Acessibility	15.91	11.85	74.51	Partially Implemented
A1 - When your health service is closed and someone from the quilombola community gets sick, there is a phone number or virtual communication tool contact (which they can contact	2.27	1.87	82.35	Fully implemented
A2 - It is easy for a user from the quilombola community to schedule a review appointment (routine consultation, checkup) at your health center	2.27	2.18	96.08	Fully implemented
A3 - Its service has its own physical structure for the quilombola community	2.27	1.52	66.67	Partially Implemented
A4 - The physical structure of its service allows the doctor, nurse, and nursing technician to perform their functions simultaneously without difficulty in the quilombola community	2.27	1.65	72.55	Partially Implemented
A5 - Your team has adequate transportation for the transfer of the professionals to the quilombola community	2.27	2.18	96.08	Fully implemented
A6 - Does your service have internet in the quilombola community?	2.27	1.47	64.71	Partially Implemented
A7 - On the way to the quilombola community do you encounter any access barriers	2.27	0.98	43.14	Incipient
Longitudinality	11.36	10.56	92.94	Fully implemented
B1 - In your health service, are the quilombolas always seen by the same doctor or nurse?	2.27	2.18	96.08	Fully implemented
B2 - Do you give the quilombola users enough time to talk (discuss) about their concerns or problems	2.27	2.18	96.08	Fully implemented
B3 - Do you believe that your quilombola users feel comfortable telling you about their concerns or problems	2.27	2.18	96.08	Fully implemented
B4 - Do you know which issues are most important for your quilombola users	2.27	2.01	88.24	Fully implemented
B5 - Would you know if your quilombola users had problems obtaining or paying for prescription drugs	2.27	2.01	88.24	Fully implemented
Coordination - Care Integration	6.82	3.88	56.86	Partially Implemented
C1 - When your quilombola users need referrals, you discuss the different services where they can be seen	2.27	2.14	94.12	Fully implemented
C2 - After the consultation with the specialist or in the specialized service, you talk to your quilombola user about the results of this consultation	2.27	1.52	66.67	Partially Implemented
C3 - The quilombola users, when they go to the specialized service, are provided with accessible transportation	2.27	0.22	9.80	Not implemented

Coordination - Information Systems	9.09	7.35	80.88	Fully implemented
D1 - You ask the quilombola users to bring their medical records received in previous visits (e.g. emergency care records, vaccination cards, lab test results)	2.27	2.14	94.12	Fully implemented
D2 - The medical records of the quilombola users are always available when you see them	2.27	2.27	100.00	Fully implemented
D3 - Your service already has an electronic medical record in the quilombola community	2.27	0.89	39.22	Incipient
D4 - Do you perform the compulsory and non-compulsory notifications rigorously in the quilombola community	2.27	2.05	90.20	Fully implemented
2, PERFORMANCE	50.00	42.78	85.56	Fully implemented
Integrality - Services Available	38.64	32.84	85.01	Fully implemented
E1 - Advice on nutrition or diet in the quilombola community	2.27	2.14	94.12	Fully implemented
E2 - Vaccinations in the Quilombola Community (immunizations)	2.27	2.27	100.00	Fully implemented
E3 - Verify if the quilombola family can participate in any social assistance program or social benefits (ex: Bolsa Família Program, Social Tariff)	2.27	0.89	39.22	Incipient
E4 - Evaluation of oral health in the quilombola community (dental exam)	2.27	2.05	90.20	Fully implemented
E5 - Family planning or contraceptive methods in the quilombola community	2.27	2.23	98.04	Fully implemented
E6 - Counseling or treatment for the harmful use of licit or illicit drugs in the quilombola community (ex: alcohol, cocaine, sleeping pills)	2.27	1.87	82.35	Fully implemented
E7 - Counseling for mental health problems in the quilombola community (e.g. anxiety, depression)	2.27	2.05	90.20	Fully implemented
E8 - Identification (some kind of evaluation) of hearing problems (for listening) in the quilombola community	2.27	1.29	56.86	Partially Implemented
E9 - Identification (some kind of assessment) of visual (to see) problems in the quilombola community	2.27	1.38	60.78	Partially Implemented
E10 - Preventive exam for cervical cancer (PC, Pap smear test) in the quilombola community	2.27	2.23	98.04	Fully implemented
E11 - Smoking counseling (e.g. how to quit smoking) in the quilombola community	2.27	1.92	84.31	Fully implemented
E12 - Women's Health Care in the Quilombola Community	2.27	2.23	98.04	Fully implemented
E13 - Screening for diseases common in this population (e.g. sickle cell anemia, chagas' disease, and heart disease) in the quilombola community	2.27	2.05	90.20	Fully implemented
E14 - In the quilombola community you develop actions directed to adult health	2.27	2.05	90.20	Fully implemented
E15 - In the quilombola community you develop actions directed to the health of the child	2.27	2.05	90.20	Fully implemented
E16 - In the quilombola community you develop actions directed to the health of the elderly	2.27	2.09	92.16	Fully implemented
E17 - In the quilombola community you develop actions directed to adolescent health	2.27	2.05	90.20	Fully implemented
Family Orientation	**11.36**	**9.94**	**87.45**	**Fully implemented**
F1 - You ask the quilombola users what their ideas and opinions are when planning the treatment and care of the user or someone in their family	2.27	1.96	86.27	Fully implemented

F2 - You ask about diseases or health problems that can occur in the family of the quilombola users	2.27	2.09	92.16	Fully implemented
F3 - Discussion of familial risk factors (e.g., genetic)	2.27	2.05	90.20	Fully implemented
F4 - Discussion about economic resources of the Quilombola users' family	2.27	1.74	76.47	Fully implemented
F5 - Discussion of social risk factors (e.g. job loss)	2.27	2.09	92.16	Fully implemented
Community Orientation	**6.82**	**6.28**	**92.16**	**Fully implemented**
G1 - Do you or someone from your health service make home visits in the quilombola community	2.27	2.27	100.00	Fully implemented
G2 - Do you believe that your health service has adequate knowledge of the health problems of the quilombola community you serve	2.27	2.01	88.24	Fully implemented
G3 - In your health service you get opinions and ideas from the quilombola community on how to improve health services	2.27	2.01	88.24	Fully implemented

Souce: Research data.

Finally, Table 3 presented the number of items per level of implementation (Not implemented, Incipient, Partially implemented and Fully implemented) according to the dimensions Capacity (Accessibility, Longitudinality, Coordination - Integration of Care and Coordination - Information Systems) and Performance (Completeness - Services Available, Family and Community Orientation). It was possible to observe that of the 19 items evaluated in the Capacity dimension 5.26% (n=01) were not implemented, 10.53% (n=02) were implemented in an incipient way, 21.05% (n=04) were partially implemented and 63.16% (n=12) were totally implemented, while of the 22 items evaluated in the Performance dimension it was noted that 4.55% (n=01) were implemented incipiently and 95.45% (n=24) were totally implemented. Overall, 2.44% (n=01) of the items were not implemented, 6.81% (n=03) were implemented incipiently, 9.09% (n=04) were partially implemented, and 81.82% (n=36) were fully implemented.

Table 3 - Distribution of items and degrees of implementation of PHC attributes in quilombola communities in Rio Grande do Norte, Brazil, 2021

Dimension and Criteria	Items evaluated N	Degree of implementation			
		Not implemented	Incipient implementation	Partially implemented	Totally implemented
		n (%)	n (%)	n (%)	n (%)
1. CAPACITY	19	01 (5.26)	02 (10.53)	04 (21.05)	12 (63.16)
Acessibility	07	-	01 (14.29)	03 (42.86)	03 (42.86)
Longitudinality	05	-	-	-	05 (100.0)
Coordination - Care Integration	03	01 (33.33)	-	01 (33.33)	01 (33.33)
Coordination - Information Systems	04		01 (25.00)		03 (75.00)
2. PERFORMANCE	22	-	01 (4.55)	-	24 (95.45)
Integrality - Services Available	17	-	01 (5.88)	-	16 (94.12)
Family Orientation	05	-	-	-	05 (100.0)
Community orientation	03	-	-	-	03 (100.0)
Total	44	01 (2.44)	03 (6.81)	04 (9.09)	36 (81.82)

Source: Research data.

DISCUSSION

From this evaluation study, it was possible to carry out a situational diagnosis of PHC actions in quilombola communities in Rio Grande do Norte, identifying the weaknesses and potentialities in the provision of health care to these communities.

With regard to the accessibility dimension, it can be seen that it was classified as partially implemented (74.51%). Similarly, items A3, A4 and A6 in this dimension were also classified as partially implemented, while item A7 was classified as implemented in an incipient way. These items deal, respectively, with the structure of the service, the presence of internet and the barriers that are encountered by professionals on their way to the quilombola communities, which shows that these aspects still need more attention for the effectiveness of the care provided to these communities.

Although the terms access and accessibility are often used synonymously, these concepts have different meanings. Accessibility refers to the supply-side characteristics that enable people to reach services, while access is the way people perceive accessibility [(9)]. Thus, it is understood that accessibility is characterized by the supply of services and the ability to meet the health needs of a given population, whenever they are needed in an easy and convenient manner.

These aspects demonstrate the variety of conditions that still need more attention for PHC to work effectively as the first contact service for the quilombola communities.

Regarding the longitudinality attribute, it was observed that it was classified as fully implemented (92.94%), as well as all items that compose it. Longitudinality is characterized by the continuity of care and the professional-patient relationship throughout the user's life, regardless of the absence or presence of disease. Thus, it is noted that this attribute is closely related to the bond.

The way in which a link is established with the community is a determining factor in the quality of the service provided by PHC. The relationships established between professionals and users are configured as a strong mechanism capable of making health services a satisfactory and usual source of attention to the population's needs. This relationship generates a feeling of trust on the part of users and accountability on the part of professionals who are part of this process [(14)].

When the coordination - care integration dimension is considered, it is noted that, like the accessibility dimension, this attribute was only partially implemented (56.86%). It is worth remembering that the dimension in question is characterized by the guarantee of continuity of care within a network of services, i.e., it is through this dimension that responses to the set of health needs presented by the population are organized [(15)]. As discussed by Madureira (2015) [(15)], This attribute is essential for PHC to occupy a fundamental role in the health system. However, the Brazilian Unified Health System (UHS) still faces the great challenge of qualifying the PHC to perform this function of care coordination and thus provide users of the UHS with adequate responses to their needs [(9)].

Regarding each of the items that make up this dimension, it is noted that only one was classified as fully implemented (Item CI - 94.12%). This item refers specifically to

discussions about the referral of the user to other services in the health network, which indicates that the teams seem to inform users about the specialized services that make up the network and their purpose. However, the results also show that although there is an initial communication between professionals and users, this dialogue seems to lack continuity, considering that item C2, which concerns the discussions that are held with the user after the consultation with the specialist, was classified as partially implemented (66.67%).

The difficulty in accessing other services in the health network is not a problem restricted to the quilombola communities in the state of Rio Grande do Norte. Previous studies have already shown that there is underutilization of health services by this population, and this occurs, in large part, due to the remoteness of quilombola communities from urban centers [16].

In addition, in order for care coordination to exist, it is also necessary to transfer information about users' health problems, which demands the existence of a longitudinal follow-up chart and an effective system of reference and counter-reference. This statement made by Madureira[15] leads to another attribute investigated in this research, coordination - information systems, through which we sought to investigate the use of medical records, access to medical records, and whether there is a record of useful information for the continuity of health care. This attribute was rated as fully implemented (80.88%), which indicates that the professionals who participated in the study seem to make proper use of this work tool.

The importance of the use of the medical record by health teams is emphasized, given that an essential part of coordination is the availability of information covering health problems and access to health services. According to Starfield [11], Coordination challenges can arise when, within the primary care setting, users are seen by different team members and information about them is generated in different places. Thus, the medical record is the main document for recording information about the user and the care provided to him or her [17].

However, despite the full implementation of this dimension, we cannot fail to highlight the fact that item D3 (Your service already has an electronic medical record in the quilombola community) had an incipient implementation (39.22%). This indicates that a large part of the teams still do not use the digital health record, bringing up again one of the limitations that are experienced in the quilombola communities: lack of internet access.

Far from being trivial, the use of electronic medical records can have significant impacts on the care of the quilombola community. An investigation conducted in the municipalities of Aracaju, Belo Horizonte, Florianópolis, and Vitória on the implementation of the FHS with a focus on integration with the care network found that among the facilitating conditions for the integration of services were the implementation of the computerized system for scheduling and regulation of medical appointments and specialized exams (SISREG), and the existence of electronic medical records with online access [9].

One can see, in view of the above, that the investment in Information and Communication Technology - ICT, such as the computerization of medical records, is an important initiative that can be considered pro-coordination. However, if it is already

a challenge to implement these systems in urban centers, the difficulties become even more evident when it comes to quilombola communities, due to the lack of internet access in these places. A recent survey conducted with quilombola communities in the Northeast of Brazil showed that 29% of the homes do not have Internet access. Among the families that do have internet at home, a large part of them have difficulties to pay the monthly expenses with the service. In addition, only 11% of families living in quilombola communities have a computer, the others use cell phones with limited data plans to access information, study, work, access religious and cultural content, and connect to the community [18].

With regard to the attribute comprehensiveness - available services, it was observed that this was classified as fully implemented (85.01%). This result is similar to that found in the research conducted by Sala et al. (2011), which assessed the level of implementation of comprehensiveness from the perspective of users of health units in the city of São Paulo [18].

As stated by Silva, Miranda and Andrade[19], Different meanings can be attributed to the term integrality that are not necessarily mutually exclusive. Among them, integrality can be understood as a practice of considering the whole in the knowledge about diseases, so as to enable the treatments given to subjects to be guided by a comprehensive view of their needs. Moreover, the aforementioned authors point out that another interpretation of the term considers integrality as a way to organize professional practices and services, considering that they should be able to perform a broad understanding of the needs of the population they serve.

These definitions are aligned with the notion of integrality adopted in this research, which considers this attribute as the recognition of the broad spectrum of needs of an individual, which implies offering preventive and curative services and ensuring access to all types of services for all age groups through referral, when necessary. In integrality, promotion, prevention, and treatment are integrated in the professional practice, which assumes an approach focused on the individual, his family, and his context, being essential the interdisciplinary work of the health teams. Thus, one can understand that in the day to day of health services, integrality is expressed through the ability of professionals to respond to the suffering of users and, in a coordinated way, identify and offer, for each unique situation, preventive actions [18].

However, despite the full implementation of this attribute, some items are still incipiently implemented (E3), and partially implemented (E8 and E9). Regarding item E3 (Verify if the quilombola family can participate in any social assistance program or social benefits - e.g. Bolsa Família Program, Social Tariff), it is possible that its implementation was incipient because the sample of this study was mostly made up of doctors, nurses, and nursing technicians and, in general, issues related to ensuring the rights of users end up being the responsibility of the social service professional. Items 8 (Identification of hearing problems in the quilombola community) and 9 (Identification of visual problems in the quilombola community) may have been partially implemented due to the absence of means and/or professionals that can assess these dimensions of health in the quilombola communities, which demonstrates the need to expand the services offered in the PHC.

In turn, the attribute family orientation was classified as fully implemented (87.45%). This attribute consists in considering the family as the subject of health care, assuming

the importance of the diagnosis, the family needs and characteristics according to the physical, economic, cultural and social situation in which they live and are inserted. In short, family orientation is the consideration of the family and the family environment in the care provided.

Family orientation is an attribute that is materialized from the comprehensiveness of the integrality principle that offers support for the consideration of the person within his/her environments [11]. The bond with the family at home allows PHC workers to identify opportunities for new care, guiding their actions by the social health indicators of the population. Through qualified listening, professionals can plan strategies to respond to the particular characteristics and needs of families, not restricting themselves to technical knowledge only [20].

Given the results found, it is inferred that the professionals participating in this study seem to take into account the particular characteristics of the families assisted in the provision of health care. These data go against what was observed in a previous study conducted with users of a health service, which found that the attribute family orientation received very low percentages of positive responses in most of the items that make up the dimension [20]

It is considered that one of the primary points for the effectiveness of family counseling are home visits, which are important and indispensable for the consolidation of horizontal relations between PHC professionals and families in the dynamics of care. In the home context, professionals get to know the family reality, employment, housing, and sanitation conditions, facilitating the planning of the work that will be developed for health prevention and promotion [21].

In this sense, it is considered that one of the possibilities of PHC action with regard to family counseling is to favor family counseling spaces in order to promote important information about genetic aspects that are directly associated with the health conditions of the black population [16].

Finally, the attribute community orientation, similar to what was observed for family orientation, was classified as fully implemented (92.16%), as well as all items that make up this dimension. Community orientation refers to the understanding that the health needs of the population are directly related to their social context and that the recognition of these needs presupposes that health teams know the area where they work.

It is considered a positive finding of this study that the family and community orientation dimensions were classified as fully implemented, considering that in previous studies these dimensions were negatively evaluated by users of different health services [21].

In this context, it is crucial the training of health professionals, who must be aware of the health and social specificities that are experienced by the black population, specifically quilombola communities living in rural contexts. Professional training, when disconnected from the reality of living and health conditions of the population, results in a lack of preparation to deal with patients with different sociocultural characteristics, which is an obstacle to the full implementation of PHC attributes in quilombola communities.

Given the above, this study reaffirms its relevance, because by recognizing the health conditions that are imposed on quilombola communities in Rio Grande do Norte, it is possible to improve the health care provided to this population, considering the positive aspects in order to strengthen them, and identifying what still needs to be transformed. It is understood that the search for change in the reality of quilombola communities is necessary, and this can occur through engagement in struggles that aim to comply with the laws and social policies that ensure comprehensive health care for this population.

Entretanto, apesar das contribuições do presente estudo, o mesmo não é isento de limitações.

The low number of responses from professionals is considered a limitation of this research, which may, in some way, have impacted the results. We initially estimated a sample of 99 professionals, 33 from each area (physicians, nurses and nursing technicians), however, in the end, only 51 participants responded to the study, most of whom were nursing professionals. This is an important fact to be highlighted, as it makes the results predominate the perspective of a single category, being relevant that future studies seek to balance the number of participants per professional category, in order to have a broader view of the problem investigated.

CONCLUSION

From the results of the data of this study it was possible to infer that most of the attributes of PHC are classified as fully implemented in quilombola communities in Rio Grande do Norte, however, it could also be observed that some points still need to be improved, specifically those related to the physical structure of services, access to the Internet and the conditions of locomotion and transportation of both users and professionals.

It is worth noting that almost all attributes and items that were classified as partially implemented or implemented in an incipient way, point to problems that do not depend only on the multiprofessional team to be solved. For the attributes of PHC to be fully implemented in the investigated quilombola communities it is necessary, first of all, to count on government investment in order to solve the difficulties that were identified.

To deal with issues related to quilombola communities in Brazil is to bring to the center of the debate problems that range from vulnerabilities to ethnic, cultural, and historical resistance of a people marked by conflicts and dilemmas. History has not infrequently relegated the black population to a trajectory of prejudice, discrimination, injustice, inequality, and inequity, which has reinforced processes of social exclusion, depriving the black population of better opportunities and living conditions. In this sense, studies focused on the health of this population should be increasingly present in the academic and scientific sphere, in order to ensure the promotion of equality aimed at the development and strengthening of specific public policies, as well as highlighting the process of inequality of this population, historically neglected.

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