Use of health services by quilombola elderly people

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ABSTRACT

Objective: To analyze the use of health services by quilombola elderly people. **Methods:** This is a cross-sectional and household-based study conducted in 11 quilombola communities, with 236 elderly people ≥60 years old. Statistical differences were found in the estimates of indicators of the use of health services according to gender and age group. Pearson's Chi-square or Fisher's Exact tests were performed. Differences were considered statistically significant when $p<0.05$. **Results:** Most of the elderly people did not have a health insurance plan, seeking mainly public hospital/outpatient unit. The last medical consultation for 80.3% of the participants was performed in the 12 months prior to the interviews, with fewer consultations for men $(p= 0.027)$. There was a low hospitalization rate in the last year and a low demand for health services in the last two weeks. **Conclusion:** Quilombola women and long-lived elderly people use health services more and, in general, the elderly citizens depend on SUS to exercise their right to health. The public hospital/outpatient unit was the most used service, and PHCU was little sought.

Descriptors: Elderly, African Continental ancestry group, Health services, Health services Accessibility.

INTRODUCTION

The use of health services in the country has been growing gradually, mainly after the establishment of the Brazilian Unified Health System (SUS, as per its Portuguese acronym), which expanded access to health care for a large part of the population [1–3]. Nonetheless, the literature demonstrates that, in addition to the availability of health services, there are other factors that determine the use of these services, such as demographic, socioeconomic, organizational, informational, cultural, geographic and health characteristics [4].

Inequalities between urban and rural areas in the use of health services still occur in Brazil, resulting from the greater social vulnerability of residents of rural areas, which interfere with access to these services [5]. The quilombola population, being mostly rural, suffers from difficulties in terms of accessing and using health services, which is reflected in the emergence and worsening of chronic non-communicable diseases, functional disability, nutritional imbalances and cardiovascular risk, especially among older quilombola citizens [6–8].

Although distinct, the terms "access" and "use of health services" are related. Access can be defined as responsible for intermediating the relationship between demand and entry into the health service, that is, it concerns the characteristics of the provision of these services, and, consequently, it may end up facilitating or preventing the use of health services, which, in turn, is demonstrated by the contact established between the individual and the health professional [4,9].

Some studies point to determining factors for greater use of health services by the population, such as age (elderly aged 60 years or older), female gender, higher education and residents of urban areas in the South and Southeast regions of the country. Conversely, elderly people with lower income and education use less health services[3,10,11].

When contextualizing the use of health services by quilombola citizens, the consequences of the unfavorable conditions experienced by this population can be observed. It is noticed that there is low use of health services by this population group, and most need public services to exercise the right to health. In addition, diseases were presented as the main reason for seeking

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and using health services [10], thus demonstrating the precariousness of prevention and health promotion actions for this population.

The inequalities experienced by the black population are the result of the historical process of enslavement, which hinders access to opportunities and rights, including the right to health. In the Maranhão State, where it is estimated that it ranks second in number of quilombola locations in the Northeast region, inequalities in the general situation of life and health are even worse than those found in other parts of the country or even this region, especially for the elderly population [12–15].

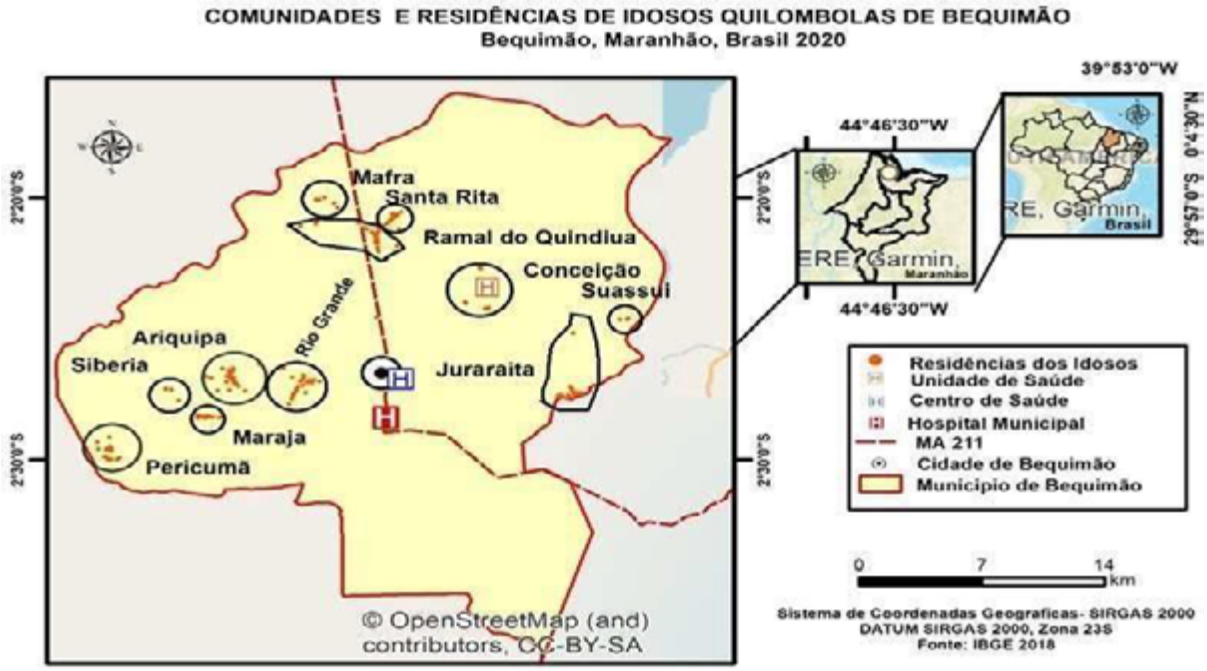
Despite knowledge about the aging of the elderly citizens in Brazil, available studies about the use of health services by the quilombola elderly population in the country are still scarce and their health conditions are little explored. Nevertheless, available studies demonstrate that these elderly people still live in precarious sanitary and health conditions [7,8], thus exposing existing inequalities, which seem to be determining factors for greater difficulty in using health services by quilombola citizens.

Therefore, this study sought to analyze the use of health services by quilombola elderly people in a municipality in the Baixada of the Maranhão State.

METHODOLOGY

This is a cross-sectional and household-based study conducted in 11 remaining quilombola communities in the municipality of Bequimão, Maranhão, Brazil. All communities are officially recognized as remnants by the Palmares Cultural Foundation linked to the Brazilian Ministry of Culture. This study is part of the project entitled "*Population Survey about the Living and Health Conditions of Quilombola Elderly People in a City in the Baixada of the Maranhão State*" (IQUIBEQ Project).

The study population consisted of elderly people aged 60 or older, males and females, and residents of the 11 quilombola communities: Ariquipá, Conceição, Juraraitá, Mafra, Marajá, Pericumã, Santa Rita, Sibéria, Suassuí, Ramal do Quindíua and Rio Grande (Map 1). The elderly



Map 1: Geographic location of the 11 quilombola communities in Bequimão (IQUIBEQ Project), Maranhão, Brazil, 2020.

Source: Authors.

citizens were invited through articulation with the Department of Social Welfare of the municipality and the Community Health Workers (CHW) of the respective communities. CHW conducted a previous survey and prepared a nominal list with information on gender and birth date, accounting for 245 elderly people in the 11 communities. All these elderly people were invited to participate in the research, but, after refusals and difficulties in terms of finding them in the communities in two attempts on different dates, the final evaluated population was 236 elderly people.

The defined inclusion criteria were age (≥60 years), males and females, living in a certified community and being able to communicate with the interviewer. Those individuals aged <60 years, with altered cognitive function that compromised the understanding of questions and communication were excluded.

Data collection took place throughout the week, during business hours, between July 2018 and April 2019. Previously, a pilot study was carried out to adjust the instruments and train the interviewers. During data collection, interviewers could consult the instruction manual to clarify doubts, in addition to being accompanied by the researchers responsible for the survey.

In this research, data collected through a form adapted from the 2013 National Health Survey (NHS) related to the socioeconomic and demographic situation, health conditions and access to and use of health services by the elderly respondents were used. *The socioeconomic and demographic characteristics were*: gender, age, color/race, marital status, can read and write, socioeconomic status according to Social Class according to *Critério Brasil* [16], receipt of retirement/pension benefit or *Bolsa Família* benefit, number of residents per household, material used in the construction of walls, roof and floor, number of rooms, form of water supply and sewage destination. *The variables related to health conditions were*: self-evaluation of general health status (good and not good) and number of chronic diseases. Finally, *those regarding the use of health services* were defined by having a health insurance plan, type of care or health care location you usually seek when you need it, when you last consulted a doctor, number of medical consultations in the last year, when you last consulted the dentist, had been hospitalized in the last 12 months; in the last two weeks; if you sought a health service or professional; and if you have ever had a prostate examination, cytopathological exam of the cervix or mammogram.

All data were entered into the statistical program EpiInfo, version 7®, with the double data entry technique and analyzed in the Stata® program, version 14 (StataCorp LP, College Station, Texas, United States). Absolute and relative frequencies were calculated for the set of all evaluated characteristics. It was sought to verify statistical differences in the estimates of indicators of the use of health services according to gender and age group (60 to 69, 70 to 79 and ≥80 years). Pearson's Chi-square or Fisher's Exact tests were performed to compare proportions. In all analyses carried out, differences were considered statistically significant when $p<0.05$.

The research was approved by the Ethics Committee for Research with Human Beings (CAAE: 73307317.8.0000.5086), in addition to being conducted in accordance with the ethical aspects for research involving human beings set out in Resolution nº 466/2012. All participants signed the Free and Informed Consent Form (FICF).

RESULTS

Most of the participants were females (55.9%), aged between 60 and 69 years (50.4%), belonging to the black color/race (56.8%), without a spouse (63.1%), living with three or more people (58.1%), in homes with 4 to 7 rooms (68.2%), constructed with inadequate materials for the walls, roof and floor (71.8%), with water supply through from a well or spring on the property (59.8%) and sewage from bathrooms stored in septic tanks (56.0%); illiterate (54.7%), retired (92.3%) and in the worst socioeconomic status (group E), with 82.1% of the participants. As for health conditions, it was observed that 57.7% evaluated the general state of health negatively and more than 80% of the participants had at least one chronic disease (Table 1).

It was found that most of the elderly citizens are dependent on the Brazilian Unified Health

Table 1

Socioeconomic, demographic, sanitary and health characteristics of quilombola elderly people aged ≥60 years (n= 236), Bequimão (IQUIBEQ Project), MA, Brazil, 2018.

Variables	(N=236)	%
Gender		
Female	132	55.9
Male	104	44.1
Age group (years)		
60 to 69	119	50.4
70 to 79	75	31.8
≥80	42	17.8
Color/race*		
Black	133	56.8
Brown	74	31.6
Others	27	11.6
Number of residents per household		
Living alone	34	14.4
Two	65	27.5
Three or more	137	58.1
Marital status		
With spouse	87	36.9
Without spouse	149	63.1
Can read and write*		
Yes	106	45.3
No	128	54.7
Socioeconomic status**		
C	4	1.7
D	38	16.2
E	192	82.1
Social benefits received***		
Retirement/pensions	216	92.3
Bolsa Família	16	6.9
Number of rooms per household		
≤ 3	4	1.7
4 to 7	161	68.2
≥ 8	71	30.1
Predominant material used in the construction of walls, roof and floor is simultaneously adequate*		
Adequate	66	28.2
Not adequate	168	71.8
Water supply*		
General Network	42	17.9
Well or spring on the property	140	59.8
Well or spring outside the property	50	21.4
Other forms	2	0.9
Disposal of sewage from household bathrooms/toilets *		
Septic tank	131	56.0
Rudimentary septic tank	67	28.6
Open-air	36	15.4
Self-evaluation of general health status*		
Good	99	42.3
Not good	135	57.7
Number of chronic diseases		
None	45	19.1
One	69	29.2
Two	58	24.6
Three or more	64	27.1

Notes: *Total: 234 elderly people; **Total: 234 elderly people and there were no elderly people in social statuses A and B; ***Total: 232 elderly people.

System (SUS, as per its Portuguese acronym), since 97.9% do not have a health insurance plan. When analyzing the main health service that the elderly people tend to seek, it is also observed that 37.3% seek the public hospital/outpatient unit, both males (39.4%) and females (35.6 %), and only 4.2% of the elderly people seek private medical offices. It is also noticed that the elderly do not usually go to the Primary Health Care Unit (PHCU) (1.7%). Some elderly people (33.5%) reported commonly using more than one type of health service, especially women (37.1%) (Table 2).

Table 2

Indicators of the use of health services by quilombola elderly people aged ≥60 years according to gender, (n= 236), Bequimão (IQUIBEQ Project), MA, Brazil, 2018.

Variables	Total (N=236)		Male (N=104)		Female (N=132)		p-value
	N	%	N	%	N	%	
Ownership of a health insurance plan*							
Yes	5	2.1	3	2.9	2	1.5	0.454
No	229	97.9	99	97.1	130	98.5	
Type of service you usually seek							
Pharmacy	8	3.4	5	4.8	3	2.3	
PHCU	4	1.7	2	1.9	2	1.5	
Emergency care**	34	14.4	12	11.5	22	16.7	
Public hospital/outpatient unit	88	37.3	41	39,4	47	35.6	0.375
Private medical office***	10	4,2	6	5,8	4	3.0	
At home with a professional****	10	4,2	7	6,7	3	2,3	
Shaman, healer	3	1,3	1	1,1	2	1.5	
More than one service	79	33,5	30	28,8	49	37.1	
Last medical consultation*							
Less than 1 year	188	80.3	78	76.5	110	83.3	
From 1 year to < 2 years	21	9.0	8	7.8	13	9.8	0.071
From 2 years to < 3 years	9	3.9	4	3.9	5	3.8	
3 years or more	16	6.8	12	11.8	4	3.1	
Number of medical consultations in the last year							
None	34	14.4	22	21.2	12	9.1	
One	57	24.2	26	25.0	31	23.5	0.027
Two	43	18.2	20	19.2	23	17.4	
Three or more	102	43.2	36	34.6	66	50.0	
Last time you had a consultation with the dentist*							
Less than 1 year	40	17.1	20	19.6	20	15.2	
From 1 year to < 2 years	24	10.3	9	8.8	15	11.4	
From 2 years to < 3 years	14	5.9	5	4.9	9	6.8	0.117
3 years or more	112	47.9	42	41.2	70	53.0	
Never	44	18.8	26	25.5	18	13.6	
Hospitalization in the last 12 months*							
Yes	30	12.8	11	10.8	19	14.4	0.413
No	204	87.2	91	89.2	113	85.6	
Sought a health service in the last two weeks *							
Yes	48	20.5	19	18.6	29	22.0	0.530
No	186	79.5	83	81.4	103	78.0	
Undergone prostate examination (rectal examination)							
Has undergone			71	68.3			
Never undergone			33	31.7			

(Continuation)

Table 2

Indicators of the use of health services by quilombola elderly people aged ≥60 years according to gender, (n= 236), Bequimão (IQUIBEQ Project), MA, Brazil, 2018.

Variables	Total (N=236)		Male (N=104)		Female (N=132)		p-value
	N	%	N	%	N	%	
Undergone cytopathological exam of the cervix							
Has undergone					114	86.4	
Never undergone					18	13.6	
Undergone mammogram							
Has undergone					46	34.8	
Never undergone					86	65.2	

Notes: *Total: 234 elderly people (Males: 102, Females: 132); **Emergency Care Unit, Emergency Room or Emergency of public or private hospital; ***Private medical office or clinic, outpatient clinic or office of a company or union; ****At home, with a Family Health Team or a private doctor.

The last medical consultation of 80.3% of the elderly people had been in the 12 months prior to the interviews. Among men, this percentage reached 76.5%, while it was 83.3% for women. In addition, 11.8% of men had their last consultation 3 years or more ago. The number of consultations in the last year was lower for men, as 21.2% said they had not gone to any consultations. Conversely, 50.0% of women had three or more medical consultations in the same period, where it was demonstrated a statistically significant difference (p=0.027). Regarding the period of the last consultation with the dentist, 47.9% claim to have consulted for 3 years or more, mainly women (53.0%). Moreover, 18.8% of the elderly never went to a dentist appointment, mainly men (25.5%) (Table 2).

Most of the elderly people were not hospitalized in the last year (87.2%) and did not seek health services in the two weeks prior to the survey (79.5%). Nonetheless, of those who were hospitalized and sought a health service, the majority consisted of women (14.4% and 22.0%, respectively). When evaluating the accomplishment of a prostate examination by men, 68.3% claim to have already undergone this examination in their lives, as well as 86.4% of women have also undergone some cytopathological examination, but 65.2% have never undergone a mammogram (Table 2).

Considering the indicators of use of health services according to age groups, it was observed that all younger elderly people (60 to 69 years old) did not have a health insurance plan. The public hospital/outpatient unit and emergency care were the main health services sought by all age groups, but the emergency care was more used by elderly people aged 60 to 69 years (17.6%), and the public hospital/outpatient unit mainly by elderly aged 80 years or older (40.5%). In the last year, the number of medical consultations was high, as most of all age groups sought the service three or more times, with 42.0% of the elderly aged 60 to 69 years, followed by 44.0% of those aged 70 aged 79 and 45.2% of those aged 80 or older (Table 3).

Table 3:

Indicators of use of health services by quilombola elderly people aged ≥60 years according to age group, (n= 236), Bequimão (IQUIBEQ Project), MA, Brazil, 2018.

Variables	60-69 years (N=119)		70-79 years (N=75)		80 years or older (N=42)		p-value
	N	%	N	%	N	%	
Ownership of a health insurance plan*							
Yes	0	0.0	3	4.1	2	4.8	0.069
No	119	100.0	70	95.9	40	95.2	

(Continuation)

Table 3

Indicators of use of health services by quilombola elderly people aged ≥60 years according to age group, (n= 236), Bequimão (IQUIBEQ Project), MA, Brazil, 2018.

Variables	60-69 years (N=119)		70-79 years (N=75)		80 years or older (N=42)		p-value
	N	%	N	%	N	%	
Type of service you usually seek							
Pharmacy	6	5.0	1	1.3	1	2.4	0.771
PHCU	3	2.5	0	0.0	1	2.4	
Emergency care**	21	17.6	8	10.7	5	11.9	
Public hospital/outpatient unit	41	34.5	30	40.0	17	40.5	
Private medical office***	4	3.4	3	4.0	3	7.1	
At home with a professional****	5	4.2	4	5.3	1	2.4	
Shaman, healer	1	0.9	2	2.7	0	0.0	
More than one service	38	31.9	27	36.0	14	33.3	
Last medical consultation*							
Less than 1 year	95	79.8	59	80.8	34	81.0	0.997
From 1 year to < 2 years	10	8.4	7	9.6	4	9.5	
From 2 years to < 3 years	5	4.2	3	4.1	1	2.4	
3 years or more	9	7.6	4	5.5	3	7.1	
Number of medical consultations in the last year							
None	17	14.3	12	16.0	5	11.9	0.997
One	30	25.2	17	22.7	10	23.8	
Two	22	18.5	13	17.3	8	19.1	
Three or more	50	42.0	33	44.0	19	45.2	
Last time you had a consultation with the dentist*							
Less than 1 year	21	17.6	13	17.8	6	14.3	0.981
From 1 year to < 2 years	12	10.1	8	11.0	4	9.5	
From 2 years to < 3 years	6	5.1	6	8.2	2	4.8	
3 years or more	58	48.7	34	46.6	20	47.6	
Never	22	18.5	12	16.4	10	23.8	
Hospitalization in the last 12 months*							
Yes	12	10.1	7	9.6	11	26.2	0.017
No	107	89.9	66	90.4	31	73.8	
Sought a health service in the last two weeks *							
Yes	24	20.2	13	17.8	11	26.2	0.558
No	95	79.8	60	82.2	31	73.8	
Undergone prostate examination (rectal examination)*****							
Has undergone	35	60.3	27	84.4	9	64.3	0.060
Never undergone	23	39.7	5	15.6	5	35.7	
Undergone cytopathological exam of the cervix******							
Has undergone	55	90.2	39	90.7	20	71.4	0.034
Never undergone	6	9.8	4	9.3	8	28.6	
Undergone mammogram******							
Has undergone	21	34.4	18	41.9	7	25.0	0.344
Never undergone	40	65.6	25	58.1	21	75.0	

Notes: * Total: 234 elderly people (60 to 69 years old: 119 elderly people, 70 to 79 years old: 73 elderly people, 80 years old or older: 42 elderly people); **Emergency Care Unit, Emergency Room or emergency of a public or private hospital; ***Private office or clinic, Outpatient clinic or office of a company or union; ****At home, with a Family Health Team or a private doctor, *****Total: 104 men (60 to 69 years old: 58 elderly people, 70 to 79 years: 32 elderly people, 80 years old or older: 14 elderly people; ******Total: 132 women (60 to 69 years old: 61 elderly people, 70 to 79 years old: 43 elderly people, 80 years old or older: 28 elderly people).

Regarding the period of the last consultation with a dentist, the group with the highest percentage of elderly people who never consulted was those aged 80 years or older (23.8%). This same group also had the highest hospitalization rate in the last 12 months (26.2%), unlike those aged 70 to 79 years, where this percentage went to 9.6%, and those aged 60 to 69 years (10.1 %), with a statistically significant difference (p=0.017) (Table 3).

An important part of the elderly people in all age groups had never had a prostate examination, especially the elderly aged 60 to 69 years (39.7%) and 80 years or older (35.7%). In turn, regarding the cytopathological examination of the cervix, 90.2% of the evaluated women aged 60 to 69 years have already undergone the examination in their lives, as well as 90.7% of the elderly women aged 70 to 79 years have also undergone it. Nevertheless, this percentage decreases (71.4%) when women aged 80 or older are observed (p=0,034). Moreover, the percentage of elderly women who have never had a mammogram is high at all ages (65.6%, 58.1% and 75.0%, respectively, by age group) (Table 3).

When observing the prevalence of the number of consultations by gender and age, there was a lower number of visits to the doctor among men of all ages, especially when observing the lack of consultations in the last year, being 22.4% of those aged 60 to 69 years, 21.9% of those aged 70 to 79 years and 14.3% of those aged 80 years or older. Among men and women, the difference between having or not going to at least three consultations was greater among the elderly aged 60 to 69 years (54.1% of women and 29.3% of men) (Figure 1).

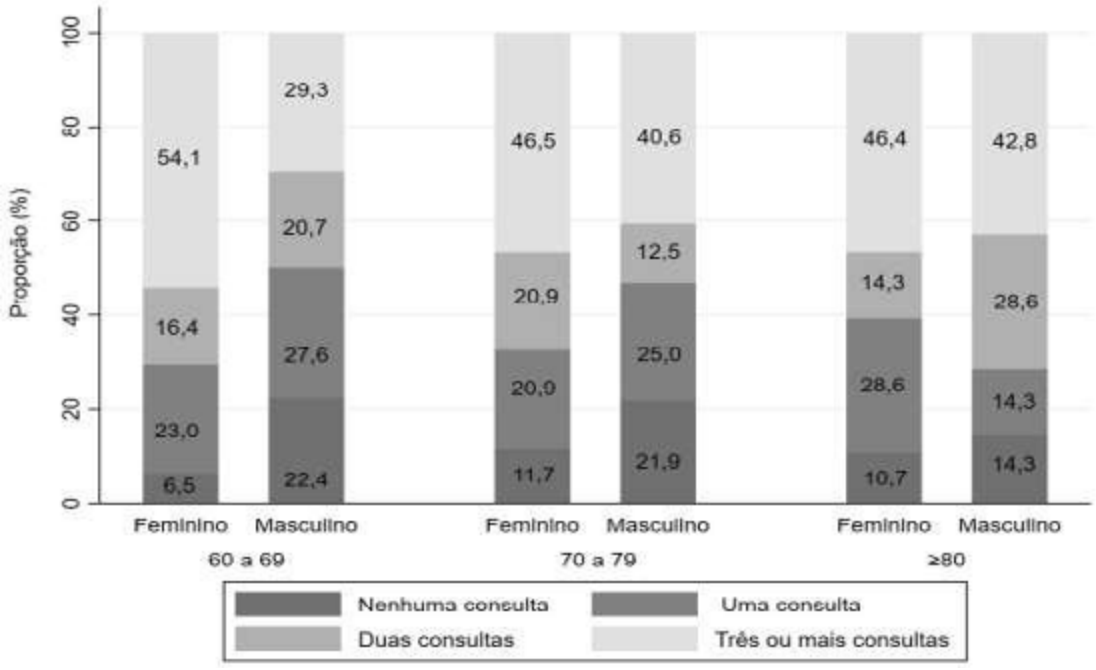


Figure 1: Prevalence of the number of consultations according to gender and age of quilombola elderly people aged ≥60 years, Bequimão (IQUIBEQ Project), Maranhão, Brazil, 2018.

DISCUSSION

The results of this study showed that quilombola elderly people are aging under precarious socioeconomic, demographic and health conditions. The use of health services was mainly guaranteed by SUS, since most of them do not have a health insurance plan and mainly use the public

hospital/outpatient unit, with PHCU being little sought. It was noted that there were low rates of examinations to screen for cellular alterations in both men and women.

The profile found in this study corroborates most of the data found in other studies[10,15,17–19]. The feminization of old age is a phenomenon that may explain the higher number of elderly women, due to women seeking more preventive health services and men being the population most affected by accidents due to external causes [20–22]. This fact is reflected in a scenario of elderly women without spouses, also observed in our study, and who often feel alone, which can trigger a mental disorder [15,18].

It is also worth underlining that most elderly people are retired and survive on their retirement income, often being the breadwinner for the family. Accordingly, due to the fact that the elderly citizens in this study are in the worst socioeconomic status, it is essential to evaluate whether this source of income is being sufficient for food, hygiene, medicines and essential housing costs, in addition, the way in which this income influences access to health services [14,17,18].

It is necessary to carry out a situational diagnosis whenever actions are planned, given that the strategies will be effective in terms of meeting the health demands of that population. In this case, when evaluating the housing conditions of the participants, it was found that the residences were constructed with inadequate materials and there is no basic sanitation, corroborating the study carried out with the quilombola population of Vitória da Conquista [10].

Concerning the health conditions of the quilombola elderly people, it was observed that more than half did not classify their health as good and more than 80% of the elderly citizens had at least one chronic disease, as observed in previous studies [10,17–19]. The aging process in Brazil is characterized as a phase of frailty, where the elderly person presents alterations that lead to a decrease in independence, the onset of cognitive decline, an increase in the level of frailty and the appearance of chronic diseases, which together reflect on a health condition classified as poor and with a lower quality of life for this public [23].

It was identified in the study that the quilombola elderly people do not have a health insurance plan, using the services offered by SUS, coinciding with other surveys [21,24]. Nonetheless, it was found that the use of the public service among the elderly citizens in this study was focused on care in situations where the pathologies were already installed, mainly in hospitals and emergency care units/emergency room units, not seeking PHCU for actions related to health promotion and disease prevention. Moreover, PHCU was one of the services least sought by the elderly people to resolve their health demands, diverging from other studies [10,21].

Primary Health Care (PHC), considered the care coordinator and organizer of the Health Care Network, is characterized by actions related to health promotion, disease prevention, diagnosis, treatment and rehabilitation. Therefore, PHCU, as the main axis of implementation of PHC, is the gateway to SUS and a service that presents resolution of 80% of the health needs of the population, but it still has some barriers to be faced in relation to the access of the population and attendance to the entire community that seeks for its services. Geographic barriers, opening hours and repeated changes of higher-level professionals in rural health units may be reasons for low use of PHCU [10,21,25]. In this sense, one of the conducts carried out by the PHCU team is the active search for groups that require more actions related to health care, such as the elderly population, strengthening this bond and facilitating the use of these services [17,21].

When understanding the changes that occur in the aging process, it is imperative that the elderly people are aware that these factors, in some cases, can be modifiable and preventable, provided that they carry out continuous monitoring with health professionals and that they provide support in terms of planning strategies that contribute to a greater stimulation of these elderly people, according to their limitations [17,19,23].

Regarding continuous health monitoring, the women in the study had a higher percentage of having had at least one medical consultation in the last 12 months, while the men had their last consultation 3 years or more ago [10,19]. The greater use of health services favors the early diagnosis of diseases and also enables early intervention, in order to minimize harms and prevent new complications or pathologies from arising because of that installed disease [26].

In addition, statistical significance was observed in the association of the variables "number of medical consultations in the last year" and the "gender of the interviewees", indicating that 21.2% of the men did not attend any consultation and 50.0% of the women had three or more consultations. Currently, a taboo of the strength that exists in masculinity is still experienced, where men are stronger and do not get sick, which is why they seek health services less [22]. Nonetheless, when men seek services, they already have established and often advanced diseases, and it is not possible to reverse the situation and minimize the consequences [27].

This is still an aspect to be worked on by health professionals, since, even though there are public policies aimed at men, as well as campaigns that encourage their approach to health services, this is still a scenario that requires greater attention on the part of managers and professionals [28]. Prostate cancer is one of the problems that affect the male population and has a high lethality, and should be investigated following the recommendations of the Brazilian Ministry of Health [29]. In our study, most men have already undergone the examination at least once in their lives, but the need for monitoring with health professionals should be highlighted.

Regarding the consultation with the dentist, it was identified that many elderly citizens had been for 3 years or more, while 25.5% of men and 23.8% of long-lived elderly people had never been, which was also identified in a quilombola community in Minas Gerais [30] and among community elderly citizens [17]. Oral health care must exist in all cycles of life, and it is no different for the elderly population, since dental care prevents the onset of infections and oral diseases, as well as interferes with the self-esteem and well-being of the elderly person when smiling [30]. Nonetheless, in the study by Viacava and Bellido (2016) [31], it is observed that the Northeast region has one of the lowest percentages of dental consultations.

With respect to hospitalization, most elderly people were not hospitalized in the last year and did not seek the health service in the two weeks prior to the survey, contributing to a decline in hospitalization rates in the Northeast region and representing one of the lowest rates of recent use of health services [31]. However, among those who were hospitalized and sought services, women and long-lived elderly people predominated. With advancing age, chronic problems tend to arise in the elderly person and often have consequences that lead to hospitalization [32,33]. As much as aging is a natural process, this stage will also reflect the life that this individual has developed, considering his/her lifestyle habits [34].

Regarding women's health, it was observed in our study that 65.2% of women had never had a mammogram, especially those aged 80 years or older, diverging from part of the study by Schäfer et al. (2021) [35], which shows that more than 90% of women of eligible age to undergo a mammogram had already accomplished it, but with a lower percentage for those residing in the Northeast region, with low education and without health insurance, in this case, which is the same profile found in our study.

Considering having had a cytopathological examination of the cervix ever in their lives, there was a statistically significant difference between the age groups, where the number of women who had ever undergone the examination decreased with age. Nonetheless, Schäfer et al. (2021) [35] demonstrated the decrease in relation to the accomplishment of this examination at the other end of the age group, among younger women, where they also reported that the frequency of accomplishment in relation to the test was lower for women of black race/color, compared to white women. It is important to highlight that, in addition to persistent social and racial inequalities, the cytopathological examination of the cervix still carries with it several taboos, where many women refuse to undergo due to shame and insecurity, and it is necessary to develop strategies to facilitate this adherence [35,36].

STUDY LIMITATIONS

As limitations of this study, those related to the cross-sectional study and those arising from information and memory bias stand out, since data about the use of health services were collected from the reports made by the elderly patients. Another issue is that the reasons that led to the demand and use of health services were

not investigated. In this study, no association was found between socioeconomic characteristics and indicators of the use of health services. Nevertheless, it must be considered that the characterization carried out through socioeconomic data shows the precarious conditions in which the elderly quilombola people live.

CONTRIBUTIONS FOR PRACTICE

Despite the limitations, this study contributes to strengthening the literature related to studies about the sociodemographic and health profile of elderly quilombola people, as well as the use of health services by this group. It can encourage actions to improve access, opening of services and attention directed to the needs of the quilombola people, guaranteeing the implementation of strategies focused on health promotion and disease prevention among these individuals.

CONCLUSION

The results of this study pointed out that women and long-lived elderly people use health services more and, in general, quilombola elderly people depend on SUS to exercise their right to health. The most used type of service was the public hospital/outpatient clinic, and PHCU was little sought. The last medical consultation was mainly in the 12 months prior to the interviews, but, conversely, most did not usually consult a dentist. There is a proportion of men and women who have never had a screening test for prostate, breast and cervical cancer, thus suggesting little attention to the health of this population. In addition, this population group lives in a situation of socioeconomic, domestic, sanitary and health vulnerability.

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