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RESEARCH

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MANAGEMENT OF HEALTH CARE PROVIDED TO QUILOMBOLA MEN

Gestão do cuidado em saúde no contexto do homem quilombola

Administración en la atención a la salud en el contexto del hombre quilombola

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ABSTRACT

Objective: The study's main purpose has been to discuss the management of health care provided to quilombola men. **Methods:** this descriptive study with a qualitative approach was performed with two Family Health Strategy (FHS) teams delivering care for quilombola people in the municipalities of *Ananindeua* and *Santa Izabel do Pará*. Individual interviews were carried out with 17 participants, including team members and municipal managers, over the period from July to September 2017. **Results:** the use of content analysis allowed the emergence of two thematic categories: "Knowledge and practices of professionals and managers on the public policies targeting quilombola men" and "Intervening factors in the implementation of the measures established in health policies targeting quilombola men". **Conclusion:** it is necessary to speed up the acquisition of knowledge and implementation of practices in health facilities. All social actors should participate in this process to provide the best possible care for quilombola men because enhancing care management according to the quilombola population's needs is a well-known challenge and can contribute to the delivery of integrated care in these municipalities.

Descriptors: Primary health care, Rural health, Men's health, Health management.

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RESUMO

Objetivo: Discutir a gestão do cuidado na dimensão da saúde do homem quilombola. **Método:** estudo qualitativo, descritivo, desenvolvido em duas equipes da Estratégia Saúde da Família em comunidades quilombolas nos municípios de Ananindeua e Santa Izabel do Pará. Realizou-se entrevistas individuais com 17 participantes, entre profissionais das equipes e gestores municipais, no período de julho a setembro de 2017. **Resultados:** utilizou-se a técnica de análise de conteúdo e organizou-se duas categorias temáticas: "Saberes e práticas de profissionais e gestores sobre as políticas públicas direcionadas ao homem quilombola" e "Fatores intervenientes para implementação das ações previstas nas políticas de saúde direcionadas ao homem quilombola". **Conclusão:** concluiu-se que é necessário avançar no desenvolvimento da díade "saberes-práticas" nos serviços de saúde, com os atores sociais envolvidos para prestar atendimento com qualidade, pois construir gestão compatível com os quilombolas é um desafio reconhecido por todos e pode contribuir para um cuidado integral nesses municípios.

Descritores: Atenção primária à saúde, Saúde da população rural, Saúde do homem, Gestão em saúde.

RESUMEN

Objetivo: Discutir la administración de la atención a la dimensión de la salud del hombre quilombola. **Método:** estudio cualitativo, descriptivo, desarrollado en dos equipos de la Estrategia de Salud Familiar, realizadas en comunidades quilombolas localizadas en los ayuntamientos de Ananindeua y Santa Isabel del Pará. Se realizaron entrevistas individuales con 17 participantes, entre profesionales de los equipos y administradores municipales, en el periodo de julio a setiembre de 2017. **Resultados:** se utilizó la técnica de análisis de contenido, organizada en dos categorías temáticas: "Conocimientos y prácticas de profesionales y administradores sobre las políticas públicas dirigidas al hombre quilombola" y "Factores que intervinieron para apoyar la implantación de las acciones previstas en las políticas de salud dirigidas al hombre quilombola". **Conclusión:** es necesario avanzar en el desarrollo de la dupla "conocimientos y prácticas" en los servicios de salud, con todos los actores sociales envueltos para prestar una atención con máxima calidad, ya que construir una administración compatible con los quilombolas es un desafío reconocido por todos y contribuye a una atención integral en esos ayuntamientos.

Descriptores: Atención primaria de salud, Salud rural, Salud del hombre, Gestión em salud.

INTRODUCTION

In order for care management to result in comprehensive care, it is necessary that all aspects involving the health and illness process are taken into account throughout the service planning. The user and his/her needs are the starting point to accomplish this.[1]

The analysis of socio-cultural environments contributes to the understanding of local health contexts, which allows the creation of tools that contribute to the reorientation of care practices in accordance with the reality of the population. Thus, due to the importance of guiding people through self-care or instituting and implementing care measures, care management emerges as a technology that contemplates and considers the *Determinantes Sociais em Saúde* (DSS) [Social Determinants for Health] since they interfere with population health.[2]

The reality in the Amazonian region is very diverse in terms of geography, society, and culture compared with the rest of Brazil. It is in this context that traditional populations such as the quilombola communities that survive amid various difficulties. Their life and work relationships are closely linked to the natural and cultural environment in which they live.[3]

The Brazilian Health Ministry, considering these populations' unfavorable health conditions, aiming to reduce health inequities and morbidity and mortality rates, instituted the *Política Nacional de Saúde Integral das Populações do Campo e da Floresta* (PNSIPCF) [Brazilian Policy on Integral Health of the Population living in Rural Areas and Forests], which, together with the *Política Nacional de Saúde Integral da População Negra* (PNSIPN) [National Policy on Integral Health of the Black Population], provides actions to serve them in an integral manner.[4]

The quilombola men's vulnerability is part of a context in which self-care is not assumed as a practice pertinent to gender identity and is not part of the male attributes that were historically constructed. Additionally, the fact that the health services do not recognize men's uniqueness may cause difficulties in incorporating them as protagonists of care.[5]

The *Política Nacional de Atenção Integral à Saúde do Homem* (PNAISH) [Brazilian Policy on the Integral Care for Men] was formulated in 2009 and provides a set of principles and guidelines to promote health actions that contribute significantly to the understanding of the unique male reality in various socio-cultural and political-economic contexts. The policy reflects a great yearning for recognizing that male illnesses constitute real public health problem.[5]

In order to minimize inequities in relation to the health of black quilombola men living in rural areas, new strategies for care management must be taken into account in order to truly understand the reality of this vulnerable group in order to promote health in an integral and equitable manner.[4] Bearing the aforementioned in mind, this work ment to discuss the management of health care provided to quilombola men.

METHODS

This descriptive study with a qualitative approach was carried out in quilombola communities located in the municipalities of *Ananindeua* and *Santa Izabel do Pará*, *Pará* State, Brazil.

In the municipality of *Ananindeua*, the research setting was the quilombola community of *Abacatal/Aurá*. Approximately 139 families were living in this community, which is located approximately 8 km from the center of the municipality of *Ananindeua* and had approximately 573,5463 hectares demarcated by the *Instituto de Terras do Pará* (ITERPA) [Land Institute of *Pará* State] in 1999 and 2008. This community is covered by the Family Health Unit

(FHU) of *Aurá*, which has one health care team from the Family Health Strategy (FHS) of *Aurá* and one from the FHS of *Jardim Japonês*. The purpose of these teams is to provide care for the quilombola community of *Abacatal/Aurá*.

In the municipality of *Santa Izabel do Pará*, the research scenario was the quilombola community of *Macapazinho*, which is located approximately 15 kilometers from the municipality's capital. In this community, the FHU of *Conceição do Itá* is responsible for the health care, which has one health care team from the FHS of *Macapazinho*.

All of the health care teams delivering care for quilombola communities and representatives of municipal administration participated in this study.

During data collection, the health care team from the FHS of *Jardim Japonês* was incomplete with three health agents and one nurse technician. The health care team from the FHS of *Macapazinho* was composed of four community health agents, one oral health agent, one nurse, one physician, and three nurse technicians, totaling 14 workers. One primary care technical manager was a representative of the municipal administration of *Ananindeua*. Furthermore, two representatives of the municipal administration of *Santa Izabel do Pará* participated in this study. So, there was a total of 17 participants.

Permanent or temporary public employees from municipal FHS units, working in the health care sector, and caring for quilombola people for at least six months were included in this study. Managers having at least six months of service time were also included.

During the first contact, managers and health care teams were visited at the municipal health departments of *Ananindeua* and *Santa Izabel do Pará*. Then, information about this study, its objectives, and the data collection tool were presented. After that, the managers and health care teams were invited to participate in this study and the interviews were scheduled. Data collection took place from July to September 2017 at the participants' workplace, preserving their privacy and respecting their limits and professional performance.

Collected data were submitted to content analysis.[6] The content of the interviews was organized according to the questions of the instrument and rigorously analyzed to identify the predominant themes and categories that could meet the study objectives.

Ethical guidelines addressed by the Resolution No. 466/2012 from the Brazilian Health Council were respected. This study was authorized by the municipal health departments of *Ananindeua* and *Santa Izabel do Pará* and approved by the Research Ethics Committee under the *Certificado de Apresentação para Apreciação Ética* (CAAE) [Certificate of Presentation for Ethical Appraisal] No. 70155917.0.0000.5170.

The participants provided written consent prior to starting the study. To preserve their anonymity, they were identified with a reference code beginning with the letters P (Professional) and M (manager) followed by a number representing the order in which they were interviewed.

RESULTS AND DISCUSSION

Participants' characteristics

The participants were within the age group from 26 and 55 years old, with a predominance of 32-38 years old (11/64.70%). Most of the participants were women (13/76.47%). Concerning the marital status, most of the participants were married (11/64.70%). Observing the education level, all of the community health agents had completed high school. Among the participants with higher education, 35.29% obtained a Specialist's Degree or were specializing. Considering those numbers, 66.66% obtained a Specialist's Degree in Public Health. Regarding the length of service, most of the participants working in the community of *Abacatal/Aurá* (3/75%) had completed 10 months of service, while most of the participants working in the community of *Macapazinho* (8/80%) had completed 9 months of service. It is worth noting that the management of the municipality of *Santa Izabel do Pará* was changed in January 2017, which resulted in changes in almost their entire health care team.

Data analysis allowed the emergence of two thematic categories: "Knowledge and practices of professionals and managers on the public policies targeting quilombola men" and "Intervening factors in the implementation of the measures established in health policies targeting quilombola men".

Knowledge and practices of professionals and managers on the public policies targeting quilombola men

Herein, the knowledge and practices of professionals and managers on the public policies targeting quilombola men were discussed.

When questioned about their knowledge about public health policies, the participants unanimously pointed out a set of laws and guidelines aimed at population health. It can be seen that the opinions of the professionals and managers converged with the use of expressions such as "set of laws", "actions and strategies", and "laws and guidelines". Such legislation was approved to promote population health:

> *"I believe that a political group in association with some sectors of the population, including workers, users, and managers, performs actions and implements strategies aimed at population health. The Brazilian Unified Health System absolutely needs these policies, which must be constantly rethought to always meet the needs of the population". (P4)*

> *"I understand that health is regulated by state legislation [...]. There are laws, guidelines, actions, strategies, plans,*

and goals. This legislation is proposed and planned by managers and governors for the sake of the community and according to the demands of people using the Brazilian Unified Health System". (P5)

"Throughout undergraduate education, we study that public health policies are laws and strategies for health promotion and prevention and treatment of diseases. It may sound like something distant from our reality, like something that is only the responsibility of the State. Nevertheless, here I learned that health policies are designed daily with the help of managers, professionals, and users". (M2)

"I understand that they are a set of laws and guidelines that guarantee the population's access to the Brazilian Unified Health System. It is the State's duty to give health to all people in an equitable and universal way. Health policies are designed to systematize health services in Brazil". (M1)

The participants' ideas were coherent in terms of health policies and public policies as they can be understood as a set of provisions, measures, and procedures that reflect state policy and regulate government activities related to tasks of public interest. They are the responsibility of the State through a decision-making process that is constructed by different public agencies and agents.[7]

As far as public health policies are concerned, the *Sistema Único de Saúde* (SUS) [Brazilian Unified Health System] is the formalization of the conquest of the right to health and the only source of care available to more than 140 million Brazilians. Establishing public health actions and services, the SUS is a public policy defined in the Brazilian Constitution, a network, and a unified system. Despite the difficulties faced during the implementation of the SUS, this unified system represents a victory of the Brazilian people through a movement that became known as *Reforma Sanitária* [Health Reform] or *Movimento Sanitarista* [Sanitary Movement].[8] This understanding was evidenced in some of the participants' statements:

"Public policies are a political construction by the State for the population. Within the context of health, it's to make the SUS work because the conquest of this right was very important for all of us: professionals and users. Laws and health policies guide us to serve the community and organize services". (M1)

"Health policies were achieved by society through many struggles and popular pressure. The SUS is the best health insurance plan a person can have even with all the difficulties". (P12)

"The SUS is the best health insurance plan a person can have [...] It's the best and most complete health policy I know. It serves everyone without distinction and many people have fought to make it work!". (P8)

"The policies were a milestone in the history of the emergence of the SUS. They were conquered by the population and it's our responsibility to always manage and review the laws and strategies to better provide free, care for all people in a dignified manner". (M3)

The study participants demonstrated that the SUS is important public health policy in Brazil. Being a victory achieved by social movements, it is the result of a long process of collective construction and not a product created only by the State.

When asked about which health policies could be adopted in health services for quilombola men, the participants unanimously pointed out policies on integral care for certain population groups:

"The main policies we have are the Brazilian Policy on Primary Care and some others like the Brazilian Policy on Integral Care for Men and the Brazilian Policy on Integral Actions for Populations". (P1)

"The Brazilian Policy for the Rural Population [...] and the Policy on Men's Health. These are the main ones because they are formulated to specifically assist the population. There are others as well, but I believe these are the most important ones". (P3)

"I believe policies complement each other. Many guidelines complete the policies. We have the Brazilian Policy on Primary Care and the Policy for Rural and Forest Populations. Furthermore, we are now discussing how to encourage the implementation of the Policy on Men's Health here in our services". (M1)

"The Health Policy for Rural and Forest Populations and the Health Policy for the Black Population is discussed in some meetings so that we can serve our community in the best way possible, guaranteeing that all people (men or women) can access health services". (M3)

Understanding which health policies and actions for quilombola men are being implemented is essential to ensure that they receive integrated care so that their needs can be satisfied.

The Brazilian Federal Government plans to implement some initiatives stated in the Program for Accelerating the Growth of the Quilombola Population and are almost completely focused on sanitation and infrastructure works. According to the Brazilian Health Ministry, the actions targeting the quilombola population are, in general,

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marked by the idea of encouraging equity by extending the coverage of already existing actions, such as the Housing and Sanitation Program, food and nutritional security actions and the Family Health Strategy.[9]

Knowing the policies and programs targeting traditional communities is still a challenge. There are few initiatives capable of promoting concrete research on these specific groups in order to support the implementation of more specific measures, especially those aimed at quilombola men's health.[10] The study participants did not have full knowledge about the health policies targeting quilombola men in an integral manner. This little knowledge may suggest a deficiency in the quality of health services since health care teams cannot be guided by the planning of the policies and goals.

In order to understand these policies, it is necessary to understand people's reality and the factors interfering with their health. This context is part of the concept of the DSS, which expresses the idea that the living and working conditions of individuals and populations are related to their health situation.[9]

In 2007, the *Comissão Nacional sobre os Determinantes Sociais da Saúde* (CNDSS) [Brazilian Commission on Social Determinants for Health] defined that the DSS are the social, economic, cultural, ethnic/racial, psychological and behavioral factors that influence the occurrence of health problems and their risk factors among people.[9]

This concept provides the basis for all epidemiological and social studies that pointed out the vulnerability of quilombolas, especially males, which is a situation covered in health policies. Nonetheless, it is noted that health care workers have limited access to important patient data, such as gender, age, and work relationships. Thus, the care delivered can be compromised, putting their quality of life at risk.

Given the aforesaid framework, the majority of the professionals reported knowing about the cultural situation of users seeking health facilities, recognizing some of the specific DSS of the quilombola population.

All of the study participants reported having knowledge of the specific policy on men's health. Nevertheless, some of them (7/41.17%) pointed out actions that are part of this policy:

"I know that the Policy on Men's Health is a new policy that deals with the specific characteristics of men within the context of health. It's important to consider that caring for men is different from caring for women". (P3)

"I know that the policy exists, but I don't know its details. I only know what we see in the November campaigns. I know that men should receive special care, but I still don't have a deep knowledge of how to do it". (P4)

"I know that the policy is new and is still being implemented in the services. [...] Addressing men's health is the same as reducing the rate of contracting diseases, such as prostate and penile cancer. Moreover, it's the same as preventing chronic diseases, such as hypertension and diabetes, which are more prevalent among men". (P7)

"The health policy for men has recently begun to intensify because it's important to reduce male morbidity and mortality in our municipality [...] We have to take action not only during the Blue November, but also throughout the whole year trying to bring men to health units so that, for example, they can participate in prenatal care as a companion and receive guidance on prevention of prostate cancer". (P9)

According to the study participants, addressing men's health is a still recent practice in health services. Although the PNAISH was established in 2009, its implementation in the municipalities studied has been progressing slowly. Furthermore, even though they are aware of the existence of this policy, the health care workers still do not follow it. According to the PNAISH, the concept of being a man involves personal and collective aspects. As a result, it is possible to redeem values and break gender paradigms that can hinder men's access to health services.

This issue involves intense work in health education in partnership with various social and government agents sharing the same responsibilities as health is a prerogative of citizenship.[11]

In regard to the care actions targeting quilombola men, all the interviewees pointed out a list of activities carried out in the units to satisfy their needs. However, these actions were limited, as can be seen in the statements below:

"We always try to find the causes of the diseases affecting men. We consider the environment in which they live and how they relate to it. [...] Some chronic diseases, such as diabetes and hypertension, predominate. Not to mention sickle cell anemia, which is quite prevalent here. In the case of children, we focus on preventing parasitic and skin diseases". (P1)

"Besides encouraging the prevention of prostate cancer through educational actions, it's common to organize campaigns for the care of wounds and injuries that generally occur at work. The reason is that most of them have diabetes and sickle cell anemia, so the healing process takes a very long time and the risk of infection is high". (P7)

"We are trying to expand the health services for them. In addition to providing men with reproductive care, we are trying to think of new strategies aimed at providing

> *mental health care for them since depression rates are increasing among them. Another reason is the constant growth of dependence on alcohol and other drugs due to social factors". (M1)*

> *"We are conducting activities designed to bring men to the units. The proportion of men receiving care here is still very small. They usually seek the services when they have some chronic illness or suffered an occupational accident and some complications happened due to care negligence". (M2)*

The vision of social vulnerability is usually present in epidemiological studies relating health and disease to quilombola communities. Morbidity and mortality in the communities are caused by infectious and chronic degenerative pathologies. The importance of ethnic/racial factors for disease treatment and living conditions among black people allows the identification of population groups more susceptible to certain health conditions, such as hypertension and sickle cell anemia.[9]

As was evident in the participants' statements, even though they did not follow the PNAISH in terms of coverage, there was a joint effort of professional teams and managers to meet the specific needs of quilombola men taking into account their DSS. By caring for patients with the most prevalent diseases, the professionals can use strategies such as health education, distribution of information leaflets by the community, and events in partnership with schools and universities to raise awareness about self-care.

Most of the participants (13/76.47%) pointed out the prevalence of chronic-degenerative diseases, such as diabetes mellitus, hypertension, and sickle cell anemia; infectious diseases, such as worm infestations (helminthiasis), parasitic protozoan infections (protozoan diseases) and mycoses; and infestation of parasites such as lice and fleas, which cause an increase of the occurrence of dermatological diseases. To change this reality, health care teams try to invest in material inputs to make medicines available to the population. Nevertheless, this is not always feasible since there is a shortage of these inputs in health units.

Some health care team members (5/35.71%) mentioned that there were cases of sickle cell disease in the community. According to them, many adult men do not know about their health condition and only discover it while seeking care due to other reasons, such as injuries caused by occupational accidents. Moreover, they reported that nutritional and food education was being offered to young children in schools to prevent further worsening of sickle cell disease.

It is important to note that one manager mentioned men's mental health and the need to recognize it as an important factor in psychosomatic illness. Despite needing more attention, these issues have been little discussed in primary care units serving quilombola communities. The study participant reported being informed by some professionals that men have been increasingly consuming alcohol and taking other drugs. Establishing strategies to understand the reasons why quilombola men become addicted and/or mentally ill is important and may be the first step to address this issue.

The lack of certainty regarding the future and personal growth, difficult housing conditions, and the lack of policies aimed at valuing rural men have often been pointed out as the cause of the high rate of alcoholism and smoking among the quilombola people. Diseases resulting from these harmful habits and the exacerbation of other established conditions demonstrate the need for a special strategy targeting these population groups.[12]

To face this problem, the manager reported seeking to strengthen the partnership with services such as the *Centros de Referência de Assistência Social* (CRAS) [Referral Centers for Social Assistance], *Centros de Referência Especializado de Assistência Social* (CREAS) [Specialized Referral Centers for Social Assistance], and the *Centros de Atenção Psicossocial* (CAPS) [Referral Centers for Psychosocial Care], and meeting with other managers and professionals so that this situation in the community can be reversed.

Intervening factors in the implementation of the measures established in health policies targeting quilombola men

Here, the intervening factors in the implementation of the measures established in health policies targeting quilombola men were discussed. When questioned about the facilitating and/or hindering factors in the health services, the study participants pointed out that the care delivered was according to the health policies and regarded care management as a strategic tool:

> *"I find it more difficult to approach the patients to provide care and build relationships of trust with them. Many feel a little intimidated in front of us and it takes a lot of talking to know how to establish a good bond with them and make them trust our work. The community health agents' work is fundamental and helps us a lot". (P3)*

> *"In my opinion, it is a victory to bring users to the health unit by using some strategies [...] or approach them when they're with their wives or when they bring their children to get some medication. [...] We can easily schedule them for a consultation to check their general health". (P8)*

> *"Unfortunately, not everyone still manages to have a differentiated view to serve the users here [...] This happens due to lack of training or skills. Another great difficulty is the lack of professionals to meet all the*

demands. The teams are incomplete, and this hinders the service a lot". (P12)

"I think that the biggest difficulty is to keep patients, especially men, using the services. Even if men access the services, they rarely manage to keep up until the end of therapy. However, I realize that this is changing, and we are managing to raise awareness through health education activities". (M1)

"We are managing to rethink some actions to better serve users. [...] We are working on how to solve the case of the high number of alcoholic men, for example. We are already getting support from other agencies. We have to try to reverse this situation now before it gets worse because it can even generate an increase in cases of violence, especially domestic violence". (M3)

It was identified that the difficulties received more focus as both study participants' ideas converged. Fourteen (82.35%) participants reported that the quilombola men experienced difficulty in accessing health services, especially regarding preventive care, in their communities. Moreover, they pointed out that it was difficult to keep them using the services and receiving care.

This can be related to the social construction of men as being physically and psychologically strong. As a result, they refuse to take care of themselves, postponing, or denying preventive treatments aiming at health promotion and protection. In this sense, it is verified that the illness process is difficult to accept. Despite the fact that people can recognize the importance of preventive actions, they do not perform them nor seek health services for preventive purposes. Consequently, they become more exposed to risks and diseases that are difficult to detect and treat.[13]

Most men are not in the habit of taking care of their own health and only seek care when they cannot cope with the repercussions of their diseases alone. Two reasons justify these attitudes. Firstly, men are viewed as invulnerable beings. Secondly, they avoid developing certain characteristics thought to be related to women, such as care, sensitivity, fragility, and dependence.[14]

The health care teams try to involve these rural men in care activities through new strategies aimed at raising their awareness about self-care. For example, they can receive health education in waiting rooms and be invited to undergo medical or nursing evaluations while they seek medication or accompany a family member during consultations in health units.

These strategies are in line with the concept of care management, which focuses on transdisciplinary work and not on individual work, reaffirming the need for health care teams to have responsibility, autonomy, and commitment so that health can be promoted. One of the main management challenges is to perform actions that promote the participation and involvement of the actors seeking to bring workers closer to users.[15]

The study participants recognized the importance of the bond between professionals and users. This bond goes beyond a simple professional relationship, evolving into something more complex and closer to the user's reality. The participants also sought to identify the context in which individuals and their relatives are inserted as well as users' health conditions and emotional aspects.

The formation of the bond between professionals and users promotes a relationship of trust and respect through the identification of the users' needs. It is an essential tool for their adherence to pharmacological treatment, as well as to the goals of the FHS program. To this end, it is essential to establish strong interpersonal relationships that reflect the cooperation between professionals and users and, consequently, shared and humanized care. Accordingly, it can be inferred that the more appropriate the bond, the better the result since the exchange of knowledge between health care workers and users will be greater, deconstructing the idea that professionals are hierarchically above users.[16]

Concerning the professional team members, the majority (12/85.71%) reported having difficulty in focusing on important issues, such as the difficulty in dealing with differentiated users and recognizing their particularities in terms of social context and health determinants. The training of professionals is not always focused on traditional people's aspects. Nonetheless, this is a necessity in view of regional characteristics and the goals of policies and programs targeting quilombola men. Furthermore, the lack of complete health care teams, as it was in the case of the municipality of *Ananindeua*, increases this difficulty.

In order to satisfy the users' specific needs, health policies contain measures to improve access to health services in quilombola communities, indicating the need to rethink the process of training health care workers, which continue to be heavily influenced by the technical education model.

It is important that educational practices be organized according to the local population's health needs and daily work in health units, reducing the gap between the academic world and health services. To this end, it is necessary to always consider local populations' health conditions. Additionally, there is a need for the offer of continued education and professional training, especially for new professionals.[17]

With regard to the management activities of health policies and actions aiming at the promotion of planning meetings with the participation of health care teams and managers, as well as monitoring and evaluation of health actions, both managers and team members recognized that all of them needed to take action to better solve this problem:

"To tell the truth, we should meet more to discuss the community's cases. Communication between the professionals is done informally [...] This makes it very difficult for us to deliver care and we often get stuck with consultation records". (P4)

"We even try to meet to see what we can do to improve the situation, but it doesn't always work. Sometimes the demand is huge, and the number of professionals is not enough, but we do manage to meet sometimes, although the frequency of these meetings is uncertain". (P13)

"As we receive patients, we always evaluate the need to supervise the professionals' work. When facing any difficulty, we try to see them whenever possible so that you can satisfy user demands. To this end, we set up meetings for the whole team or some professionals". (M2)

"We try to set up meetings to check service weaknesses. We usually set up these meetings when there is some difficulty in satisfying the demand for inputs or when some community issue arises involving the health and well-being of quilombola people". (M3)

It became evident that management activities can influence the health practices adopted in the units. Most of the professionals (11/78.57%) reported the difficulty of holding meetings to discuss the reality of local demand regarding users' health and the lack of meeting schedules, making it difficult for everyone to participate.

Throughout the meetings, FHS workers and support teams plan, organize and evaluate the work process. It is a collective space for dialogue, opinions, project development, and service planning aimed at effective teamwork. To maintain the development of this construction process, it is essential that all actors take joint action based on teamwork.

The managers unanimously reaffirmed their commitment to the planning and monitoring of health actions. Even so, the statements showed that this is still a great challenge. If there are difficulties in organizing meetings to discuss the team's work and if the health management is not always able to satisfy the demands, there may be difficulties in implementing health policies and programs targeting quilombola men**.**

It is worth reflecting on what this can mean for the social development of the community, especially with regard to the health of men since they live within a strong context of vulnerability.

CONCLUSIONS

This study achieved its objectives by highlighting the FHS team members' and municipal managers' knowledge of and practices concerning the management of care for quilombola men.

The need to improve the care delivered to quilombola men was identified because, although they know the public policies, the participants reported needing to expand their knowledge about the health policies targeting these people, as well as their actions and guidelines, recognizing their importance in developing health practices in primary care units to better serve them.

It is necessary to accelerate the acquisition of knowledge and implementation of practices in health facilities. All social actors should participate in this process to provide the best possible care for quilombola men.

Issues related to the users and professional teams, such as the strategies designed to attract men to health services, establish links with these clients, recognize gender particularities, stimulate the management of preventive and self-care, as well as those related to the management of care, such as the planning, monitoring, and evaluation of actions were challenges to the implementation of health policies targeting quilombola men.

Therefore, it is important to take action to solve any difficulties encountered by professionals and managers, such as access to health services in quilombola communities, incomplete health care teams, the need to strengthen the link between professionals and users, inadequate training of professionals, and the need for continued education and professional training due to the high employee turnover.

Hence, it is necessary that both managers and professionals rethink their actions. The reason is that the current economic and health situation of Brazil evidence that there is a long way to go to face these obstacles and completely implement policies aimed at providing integral care for quilombola men.

The small number of managers constituted a limitation of this study because, although an initial survey showed that this number would not be large, a much smaller number of participants have indeed participated. Nonetheless, it is understood that those who participated greatly contributed to the achievement of the objectives by not hesitating to collaborate and discuss the issues inherent in the management of health care for quilombola men. As a limitation to the analysis of the results, it was evident that there was a lack of scientific production on the subject. Consequently, it was difficult to compare results and make inferences, which otherwise would certainly qualify and broaden the discussion on the theme.

It is expected that the knowledge shared through this work can help professionals, managers, and new researchers to ponder on their roles in the improvement of the quilombola men's health, since developing management methods compatible with professional practice and the objectives of the SUS contributes to the population's health and promotes equity and integrality, then solving major issues.

REFERENCES

1. Cecilio LCO. Apontamentos teórico-conceituais sobre processos avaliativos considerando as múltiplas dimensões da gestão do cuidado em saúde. Interface (Botucatu) [Internet]. 2011 Apr-June [cited 2017 Nov 15]15(37):589-99. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832011000200021&lng=en
2. Luzardo AR. Modelo de gestão do cuidado em Atenção Primária: reflexão sobre determinantes sociais da saúde do idoso. In: Pereira MF, Costa AM, Moritz GO, Bunn DA. Contribuições para a gestão do SUS. Florianópolis: Editora Fundação Boiteux; 2013. p. 13-28. Available from: http://gsp.cursoscad.ufsc.br/wp/wp-content/uploads/2013/03/Volume-10-Artigo-01.pdf
3. Arantes LJ, Shimizu HE, Merchán-Hamann E. Contribuições e desafios da Estratégia Saúde da Família na Atenção Primária à Saúde no Brasil: revisão na literatura. Ciênc Saúde Coletiva [Internet]. 2016 [cited 2017 Nov 16]21(5):1499-509. Available from: http://dx.doi.org/10.1590/1413-81232015215.19602015
4. Ministério da Saúde (BR), Secretaria de Gestão Estratégica e Participativa, Departamento de Apoio à Gestão Participativa. Política Nacional de Saúde Integral das Populações do Campo e da Floresta. Brasília: Ministério da Saúde; 2013. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2866_02_12_2011.html
5. Gomes R, Moreira MCN, Nascimento EF, Rebello LEFS, Couto MT, Schraiber LB. Os homens não vêm! Ausência e/ou invisibilidade masculina na Atenção Primária. Ciênc Saúde Coletiva [Internet]. 2011 [cited 2017 Nov 16]16(supl 1):983-92. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232011000700030
6. Bardin L. Análise de conteúdo. São Paulo: Edição 70; 2011.
7. Lima CA, Oliveira APS, Macedo BF, Dias OV, Costa SM. Relação profissional-usuário de saúde da família: perspectiva da bioética contratualista. Rev Bioét [Impr]. 2014 [cited 2017 Nov 16]22(1):152-60. Available from: http://dx.doi.org/10.1590/S1983-80422014000100017
8. Figueiredo EN**.** A Estratégia Saúde da Família na Atenção Básica do SUS [Curso de Especialização em Saúde da Família – UNA-SUS/UNIFESP]. São Paulo: Universidade Federal de São Paulo – UNIFESP; 2012 [cited 2017 Nov 16]. Available from: http://ares.unasus.gov.br/acervo/handle/ARES/169
9. Freitas DA, Caballero AD, Marques AS, Hernández CIV, Antunes SLNO. Saúde e comunidades quilombolas: uma revisão da literatura. Rev CEFAC [Internet]. 2011 Sept-Oct [cited 2017 Nov 15]13(5):937-43. Available from: http://www.scielo.br/pdf/rcefac/v13n5/151-10.pdf
10. Gomes R, Nascimento EF, Araújo FC. Por que os homens buscam menos os serviços de saúde do que as mulheres? As explicações de homens com baixa escolaridade e homens com ensino superior. Cad Saúde Pública [Internet]. 2007 Mar [cited 2017 Nov 14]23(3):565-74. Available from: http://www.scielo.br/pdf/csp/v23n3/15.pdf
11. Ministério da Saúde (BR). Política Nacional de Atenção Integral à Saúde do Homem: princípios e diretrizes. Brasília: Ministério da Saúde; 2009.
12. Mello MM. Mocambo: antropologia e história no processo de formação quilombola. Mana [Internet]. 2009 Oct [cited 2017 Nov 15]15(2):585-603. Available from: http://dx.doi.org/10.1590/S0104-93132009000200010
13. Silva PAS, Furtado MS, Guilhon AB, Souza NVDO, David HMSL. A saúde do homem na visão dos enfermeiros de uma unidade básica de saúde. Esc Anna Nery Rev Enferm [Internet]. 2012 July-Sept [cited 2017 Nov 14]16(3):561-8. Available from: http://www.scielo.br/pdf/ean/v16n3/19.pdf
14. Miranda HR, Corrêa JA, Nogueira LMV, Palmeira IP, Rodrigues ILA. Desvendando saberes e preocupações sobre a saúde entre homens ribeirinhos. Rev Enferm UFPE Online [Internet]. 2017 Sept [cited 2017 Nov 16]11(9):3446-53. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/download/110244/22183
15. Lacerda JT, Machado NMV, Magajewski FRL. Gestão do cuidado e dos serviços de saúde [Acervo de recursos educacionais em saúde – UNA-SUS/UFSC]. Santa Catarina: Universidade Federal de Santa Catarina – UFSC; 2012 [cited 2017 Dec 14]. Available from: http://ares.unasus.gov.br/acervo/handle/ARES/300
16. Santos RCA, Miranda FAN. Importância do vínculo entre profissional-usuário na Estratégia de Saúde da Família. Rev Enferm UFSM [Internet]. 2016 July-Sept [cited 2017 Nov 16]6(3):350-9. Available from: https://periodicos.ufsm.br/reufsm/article/view/17313
17. Marin MJS, Storniolo LV, Moravcik MY. A humanização do cuidado na ótica das equipes da Estratégia de Saúde da Família de um município do interior paulista, Brasil. Rev Latino-Am Enferm [Internet]. 2010 July-Aug [cited 2017 Nov 16]18(4):07. Available from: http://www.scielo.br/pdf/rlae/v18n4/pt_15.pdf

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