Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.3
DOI: 10.1590/1413-81232024293.01602023EN

Therapeutic itineraries in health care in Quilombola communities

THEMATIC ARTICLE

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Abstract *This article aimed to map therapeutic itineraries in health care within rural Quilombola communities in the north of Minas Gerais, Brazil. This is a section of a qualitative research conducted in six visited communities. The data was collected through 18 individual interviews, analyzed using the theoretical-methodological framework of Therapeutic Itineraries, and organized into three empirical themes. The narratives allowed for understanding the paths taken in health care by the Quilombola population, identifying the components of the popular subsystem (natural resources, the use of teas and home remedies), the family subsystem (transmission of knowledge and cultural heritage of care), and the professional subsystem (hospital level, medical care, primary and specialized attention). The difficulties of access are not only due to geographical distances, but also broader aspects of social determination, such as institutional racism, low availability of services, the need for payment for transportation and medical procedures. In this sense, it is necessary to have an approach and interventions from public policies to address ethnic-racial, economic, and access inequalities in health care services.*

Key words *African-descendant group, Health care, Health care models, Itineraries*

Introduction

The rural population in Brazil is characterized by a wide diversity of races, ethnicities, peoples, religions, cultures, social segments and production systems. The majority of productive activities are related to the rich biodiversity of ecosystems, with agriculture, livestock farming, and extractivism being prominent. In the northern region of the State of Minas Gerais, traditional populations such as *vazanteiros* (riverside communities), *cerrado* people, semi-arid inhabitants, *caatinga* dwellers, *campo* communities, *Quilombolas* (descendants of Afro-Brazilian slaves), riverine communities, and indigenous groups are present within the territory[1].

The remnants of *Quilombola* communities are recognized by article 2 of Decree No. 4,887 as "ethnic-racial groups, according to self-attribution criteria, with black ancestry and their own historical trajectory, endowed with specific territorial relationships"[2]. These rural black communities have their ways of life, production, and social reproduction related to the land and the struggle for constitutional rights[3].

The *Quilombola* population still lives in a situation of great vulnerability, resulting from the historical process of enslavement, which has led to social and health inequalities. They present low levels of education, income, precarious housing conditions, excessive workloads, difficulties in geographical access and transportation, which further contribute to exclusion and discrimination in healthcare services[4,5].

According to Souza *et al.*[6], the healthcare system in Brazil has been attempting to organize itself to provide comprehensive care for *Quilombola* populations through the implementation of public policies aimed at equity, such as the National Policy for Comprehensive Health Care for the Black Population (PNSIPN). However, the agreements made by health managers, service delivery flows, and the work process of healthcare teams do not necessarily coincide with the health needs and pathways followed by this population in their search for care.

In general, choices regarding health care reflect individual and collective constructions of illness experiences and forms of intervention, shaped by personal, cultural, and socio-environmental factors. The literature highlights that in *Quilombola* communities, care is practiced through traditional knowledge in contrast to biomedical interventions. The use and preparation of home remedies based on medicinal plants are presented as the most adopted and preserved practices[7].

Therapeutic itineraries refer to the paths traced and taken by individuals in their search for health care, mobilizing popular, religious, and scientific knowledge. The choices made by the *Quilombola* population are not random or arbitrary, but directly linked to the local and social resources available. In this process, the pursuit of *Quilombola* care mobilizes various health care systems that, in turn, are not dissociated from the broader aspects of this population's culture[7].

Different classifications of therapeutic systems have been suggested in an attempt to organize interpretations of the health-disease-care triad within a given society. The currently most widely used model is the one proposed by Kleinman[8], primarily focused on the study of medical and healing practices. The concept of a health care system involves a systematic articulation of different elements interconnected with health, disease, and care, with an emphasis on symptom experience, therapeutic practices, medical treatments, and evaluation of outcomes[9].

According to Kleinman[8], health care can be based on three distinct subsystems within which the experience of illness is lived at the professional, informal, and popular levels. The professional subsystem is established by scientific evidence and medical care. The informal subsystem consists of traditional practices developed by healers, prayer healers, and others. The popular subsystem refers to the lay field, where self-medication activities and the assistance of friends and family are found[10].

Research on therapeutic itineraries in *Quilombola* communities in Brazil and the care practices of this population are indeed underexplored. Understanding these pathways allows for greater visibility of the experiences lived and recognition of the care choices made by the *Quilombola* population.

National and international discussions have been developed to address the health demands and needs of traditional populations, specifically *Quilombola* communities, through the implementation of actions to promote and strengthen comprehensive care at various levels of the Unified Health System (SUS)[5]. In this regard, this article aimed to map therapeutic itineraries in health care within rural *Quilombola* communities in the North of Minas Gerais, Brazil.

Methodology

This is a section of a qualitative research study titled *"Health and work status of rural Quilombola families"*, conducted by a multidisciplinary team in the Graduate Program in Health Sciences at the State University of Montes Claros (UNIMONTES).

The study adopted the theoretical framework of Therapeutic Itineraries, based on the model of Health Care System proposed by Arthur Kleinman[8]. The use of therapeutic itineraries as a theoretical and methodological tool in the investigation allows for a revealing and effective practice in understanding the experience of illness and the search for care[11].

The study was carried out in the Northern macroregion of the state of Minas Gerais. In this state, there are 397 *Quilombola* communities, spread across over 155 municipalities. Of them, 310 have received certification from the Palmares Cultural Foundation. The north of Minas Gerais is the region with the largest concentration of *quilombos*, with 79 communities in 28 municipalities[12].

In this research, we used data from six visited communities, namely: Pé da Serra, in the municipality of Januária; Mocambo, in the municipality of Bocaiúva; Vila Nova de Poções, in the municipality of Janaúba; Brejo dos Crioulos, in the municipality of São João da Ponte; São Geraldo, in the municipality of Coração de Jesus; and Poções, in the municipality of Francisco Sá.

The project was presented at the monthly meeting of the Regional Quilombola Council to the leaders of each community. Contact was made with representatives of the Municipal Health Secretariats, Family Health Strategy (FHS) and Community Health Agents (ACS) of the territories. Sensitization took place during the field mapping of the communities, where the research team, the key informants and the ACS informed the residents present in the households about the study and sent out invitations for dialogues.

Data production in the field took place from January to September 2019, with the authors carrying out 30 semi-structured interviews, in their own homes and in spaces that ensured the privacy of conversations, with individuals over 18 years old, from both genders, self-identified as *Quilombolas* and residing in the visited communities.

We also registered systematic observations of the encounters with the interviewees in a diary research. In order to understand the Therapeutic Itineraries, we selected three users per community, totaling 18 narrative interviews, which brought deeper content on the subject and addressed guiding questions related to the experience of illness, practices developed and the paths taken in the search for health care.

The interviews lasted for an average of fifty minutes, and were recorded and later transcribed in full. Their content was submitted to analysis, coding, and comprehension and coherence check. The criterion used to finish the field research was data saturation[13]. As there was a decrease in the appearance of new discursive objects and theoretical consolidation based on empirical data available for analysis and interpretation by researchers, the sample was considered sufficient for an in-depth understanding of the phenomenon.

To interpret the data, we used the discourse analysis technique[13]. In the first stage, we performed the reading and rereading of all interviews, giving materiality to the speeches and inserting them in an Analysis Matrix elaborated by the authors. This procedure allowed the conversion of the linguistic surface (*corpus bruto*) into discursive objects. In the second stage, the passage from the discursive object to the discursive process occurred through the analysis of all discursive and ideological surfaces identified in the speeches (interdiscourse and intradiscourse). Finally, in the third stage, we constitute the discursive processes with the articulation of the utterance with the enunciation and understanding of the subjectivity processes present in the therapeutic itineraries covered.

The research project was approved by the Ethics Committee of the State University of Montes Claros (UNIMONTES), under the substantiated opinion No. 2.821.454 dated 14/08/2018. All requirements of Resolutions No. 466/2012 and 510/2016 of the National Health Council were met, ensuring the preservation of information confidentiality.

Results and discussion

Characterization of territories and participants

To understand the Therapeutic Itinerary in healthcare in *Quilombola* communities, an analysis of the territorial and sociocultural context was conducted, considering the various modalities and care practices present in these territories.

The general characteristics of *quilombos* resemble each other throughout the visited region. There are communities that are more structured, with houses located close to each other and asphalted streets, while other communities have dispersed houses, with some being quite distant from each other. In almost all communities, one can find a small Catholic Church, an Evangelical Church, and a Quilombola Community Association. The presence of *terreiros* for the practice of African diasporic religions and ceremonies was not mentioned. There are also small variety and beverage stores present in these communities. Most communities do not have schools, so students need to travel to larger rural districts or to the municipal headquarters for education. During the dry season, communities face a lot of dust and potholes on the roads, while during the rainy season, they encounter flooding, which lead to muddy roads and waterlogged areas.

Among the participants, ten were male and eight were female, ranging in age from 25 to 67 years old. Out of the participants, ten were married, five were single, and three were widowed. When it comes to religion, nine were Catholics, five were Evangelical and four practiced *Umbanda*. The majority of self-identified black individuals, with incomplete primary education, have their main occupation as rural workers and domestic helpers, and their family income is lower than the minimum wage.

The main health problems presented were alcohol abuse, depression, hypertension, diabetes mellitus, musculoskeletal disorders, respiratory and gastrointestinal diseases, and prostate and uterine cancers. None of the participants had health insurance and relied exclusively on traditional practices and the services offered by the Unified Health System (SUS).

The existence of health monitoring by Family Health Strategy (FHS) teams was observed in the *quilombos*. Doctors, nurses, and dentists provide care three to four times a week at basic health units in the larger districts. Some communities receive medical care once a month at the association headquarters, in sheds, or at a resident's house. Community Health Agents (ACS) provide disease prevention and care guidance through home visits and community meetings.

With the data analysis, the participants' statements were contextualized, and three empirical themes were identified to better understand the results: "Popular knowledge as healthcare practices among the *Quilombola* population," "The various points of professional care accessed by the *Quilombola* population," and "The difficulties faced by the *Quilombola* population in accessing healthcare." These themes will be discussed below.

Popular knowledge as healthcare practices among the *Quilombola* population

The narratives allowed for an understanding of the paths taken by the *Quilombola* people in healthcare. Faced with difficulties in accessing the components of the professional healthcare subsystem, this population seeks to address their health problems and illnesses based on traditional practices within the popular and family subsystem. In these communities, healthcare is linked to a broader dimension, associated with the historical determinants of each territory's way of life and ancestry[14].

Some interviewees emphasized the importance of popular knowledge in healthcare, which has been historically passed down and preserved by the community members:

We usually make home remedies. My backyard is like a pharmacy, there's a remedy for everything, my neighbors ask for them and I give them some. You can make tea, syrup, creams. Lemon grass and mint tea is good for the flu and cough (Woman 6).

If a child is crying too hard we give them a tea for colic. The first time my son went to the doctor, he was 2 years old. In the quilombo, when the kids get sick, we make them some tea (Woman 7).

I like to make tea for high blood pressure and diabetes. Mangaba (Hancornia speciosa), horsetail, lemon balm. Whatever people say it's good, I run to my wife and ask her to make it (Man 10).

In the popular and family subsystems, care is informally provided, usually by a family member or community member. This knowledge comes from common sense, passed down from generation to generation, including experiences and understandings of illness and care[8]. The visited communities directly depend on their way of life and plant resources for their healing practices.

The constant use of homemade remedies based on teas and medicinal herbs, as well as root mixtures and medicinal plants, strongly influences *Quilombola* culture[15]. Other commonly used popular care practices among this population include support from midwives, prayer healers, and pullers[14,16]. However, these care modalities, including seeking these traditional healthcare providers and practices related to Afro-descendant culture, were not mentioned by the interviewees.

Ciência & Saúde Coletiva, 29(3):1-10, 2024

It is noticeable that gender also influences popular care practices in *Quilombola* communities. Women, especially older women, demonstrated greater knowledge about the use of medicinal plants than men. This situation can be explained by the fact that *Quilombola* women, in addition to taking care of the house, are farmers, mothers, grandmothers, and wives, responsible for maintaining the family's health and cultivating medicinal plants in their backyards[14].

This popular knowledge is considered an important resource in healthcare, especially among more vulnerable families, such as *Quilombola* families. Kleinman[8] states that the "popular sector," composed of individuals, families, and the social arena, positively influences decision-making regarding care for acute or chronic illnesses. The rural territory also appears as an element in the reproduction of these traditional healthcare practices among the *Quilombola* population[13, 16].

Another point observed in the statements of the *Quilombola* people relates to transgenerational knowledge:

I learned from my mom and grandma that if we have some pain, there are some plants we can use. It's a tradition that the old folks teach us how to treat these things with herbs (Woman 3).

For the intestines, we take papaya leaves or orange leaves tea, which is what my grandma and my aunt taught me (Man 9).

We make a lot of medicine that the old folks teach us and that is good for the prostate… a Noni tea. I would make a whole bottle and drink it along with the medication the doctor gave me. That's what reduced the size of my prostate (Man 10).

The use of medicinal herbs, many of which are grown in their own backyards, is a centuries-old practice based on popular knowledge and transmitted orally. According to Souza *et al.*[6], the knowledge of plants and herbs, as well as the preparation of medicinal remedies, represents the traditional richness passed down by *Quilombola* ancestors over the years, reaffirming the trust in the beneficial effects of these plants and herbs used as the primary therapeutic strategy. When these problems are not resolved, they turn to the professional subsystem.

This transmission of knowledge from generation to generation expresses lived experiences and healthcare expertise, providing a set of meanings, expectations, and norms that guide *Quilombola* individuals, their families, and the community in maintaining care within the popular and family subsystems[15,16].

The various points of professional care used by the *Quilombola* population

Healthcare institutions, whether related to primary, secondary, or tertiary care, are components of the professional subsystem. These services are represented by professional care practices, which consist of assistance provided by healthcare workers at the middle, technical, and higher levels in the field of health[15].

It has been observed that there is a preference for hospital care among both male and female *Quilombolas* when it comes to resolving their health problems:

I felt a strong pain at the bottom of my belly, and it got worse and worse, and my father rushed me to the hospital(Woman 6).

I had a backache and the doctor prescribed some shots. The primary healthcare center (PSF) doesn't operate every day… so I had to go to the hospital in the city (Man 5).

I went to the hospital when I was going crazy at home. I left the house, aimlessly, at three in the morning. Whenever I feel like that, I go to the hospital and get an IV to calm down (Man 1).

For high blood pressure, I go to the hospital. Here in the community, we have a PSF, but it doesn't solve almost anything. So, I go straight to the hospital where they have a more complete care (Man 2).

In Brazil, the healthcare-seeking behavior is still predominantly based on a model that emphasizes spontaneous demand and intervention for illness and bodily conditions, as well as specialized procedures and services[17,18]. A study by Souza *et al.*[6] revealed that the perceptions of *Quilombola* individuals about health are still aligned with the biomedical model, with a hospital-centered view.

This preference for hospital care is influenced by a culture of immediacy, where the population seeks immediate attention, and also by the limited access to local healthcare services experienced by *Quilombola* individuals. This situation restricts the concept of health to the absence of illness, physical fitness, strength, and agility for work[17,18].

Despite the undeniable advances made by the Unified Health System (SUS) with the implementation of the Family Health Strategy (FHS), its guiding principles are not yet fully integrated into the daily reality of most healthcare services, especially in rural areas[5]. In Primary Health Care (PHC), the challenges posed by an urban model

of family health, replicated in rural and/or *Quilombola* territories, result in fragmented and insufficient care in relation to the health needs of these populations, leading them to seek hospital services instead[6].

Due to their extremely vulnerable condition, *Quilombola* communities have not yet effectively benefited from comprehensive, equitable, and resolutive primary health care services. It is important to highlight that these limitations and difficulties in accessing healthcare services in these territories exist and that advancements in health policies are necessary to strengthen the provision of comprehensive and longitudinal health care for individuals, families, and communities[5,6].

Through the perspective of therapeutic itineraries, we understand how users engage with health services, connecting to them through communicative flows where offers, demands, desires, and expectations are expressed and fulfilled[14,15]. Fernandes and Santos[14] have demonstrated that these choices and decisions that shape therapeutic itineraries are made within the realm of individuals' autonomy and power dynamics, where collectives negotiate their resources, knowledge, and influence, which can either limit or enhance the capacity for decision-making, choice, and action in healthcare.

In dialogues with some interviewees, it was possible to identify other points of care within the Health Care Network (RAS) that are sought by the *Quilombola* population. Among these services, those offered by the Family Health Strategy (FHS) stand out:

After the PSF [Primary Healthcare Unit] was established here [Vila Nova de Poções]… I go there. It's closer for us to go. They have a doctor and the ladies who measure blood pressure. I'm receiving follow-up care from them (Man 6).

I had a health issue, so I went to the PSF. It was some worms. The doctor prescribed medication for me to take, and I improved a lot (Woman 1).

I do everything at the PSF. I get the flu vaccine every year, and there's also a dentist who works at the health center. They treat us well (Man 5).

The creation of the Brazilian Unified Health System (SUS) represented the inclusion and expansion of access to public health policies, actions, and services. The FHS, in particular, is structured on recognizing the needs of the population as identified through the establishment of bonds between users and healthcare professionals[6]. In this sense, primary health care policies in *Quilombola* communities can provide high resolvability when effectively implemented and when the health teams in these territories carry out their actions[14].

The organizational arrangements of the Health Care Network (RAS) consist of different technological densities that, when integrated through technical, logistical, and managerial support systems, aim to ensure the comprehensiveness of care[19]. In *Quilombola* territories, this model has contributed to positive results, particularly for patients with chronic diseases, bringing about changes in the reality of *Quilombola* health indicators and guaranteeing the objectives of the National Policy of Integral Health Care for the Black Population (PNSIPN) through recognition of the heterogeneities experienced by the Black population in accessing healthcare[14].

It is worth noting that some interviewees recognize the importance of Psychosocial Care Centers (CAPS) for mental health care:

The doctor gave me a referral to the CAPS. After some time, I went there, and they talked a lot with me. We're supposed to have ongoing follow-up… I'm really liking it (Man 1).

I was hospitalized once because of drinking… but it was in Francisco Sá. Once, my mother tried to have me admitted to a clinic in Montes Claros, but I didn't go. I only went for a consultation at the CAPS (Woman 5).

Psychosocial Care Centers (CAPS) play a strategic role in the psychosocial care network, providing assistance to people with mental suffering, including those with needs related to alcohol and substance use, in their territorial area, both in crisis situations and in rehabilitation processes[20]. The study by Alciole and Silva[21], related to the psychological distress of the *Quilombola* population, revealed that hospitalization in psychiatric hospitals was one of the resources used.

Other points of attention within the SUS healthcare network were mentioned in the care itineraries of two interviewees who required specialized care in medium and high complexity:

I have diabetes, and I was losing weight, urinating a lot. The doctor at the FHS asked me to schedule an appointment with a specialist. The community health worker (ACS) scheduled it in Montes Claros. I consulted there because my case was high-risk (Woman 1).

I had a prostate blood test, and the results were abnormal. The doctor requested a biopsy, and it showed something bad… because she said: 'You'll have to see a specialist in Montes Claros,' and she referred me to the Dilson Godinho Hospital [a reference in oncology]. I didn't have surgery, only radiotherapy. Now, I have to go for check-ups every six months… (Man 7).

Many users with chronic diseases or complex cases require evaluation and assistance in specialized services, either for complementary tests not offered by primary health care or to optimize a previously provided treatment[22,23]. Souza *et al.*[6] reveal in their study that primary health care represents an important tool in promoting the comprehensiveness of *Quilombola* health care by directing users to services through territorial coverage and other available intersectoral spaces.

The difficulties faced by the *Quilombola* population in accessing healthcare services

The difficulties faced by the *Quilombola* population in accessing healthcare services are related mainly to geographical aspects and the limited availability of health services near their territories. Economic, social, cultural, racial, religious, epidemiological, and SUS network organization factors also play a role in these access problems. These difficulties in access were evident in the following narratives:

Here in the quilombo, it's very far from the city (São João da Ponte). The roads are in very bad condition, full of potholes, and during the rainy season, it's impossible to pass. We suffer a lot when we need medical attention (Man 3).

I live more than 60 km from Januária. Everything is far away, and there's no transportation to the city. We have to figure out how to go for consultations or tests (Woman 8).

When there's no doctor available here in the quilombo, I go to Janaúba or to the health center in the neighboring community. The problem is that I arrive late… because the walk takes a long time, and all the appointment slots are already filled, so I prefer to go to the city (Man 4).

In studies conducted by Burille and Gerhardt[11] and Soares *et al.*[24], the absence of personal means of transportation (bicycles, motorcycles, or cars) was highlighted as the main barrier to access for rural populations, who often have to travel on foot, school buses, or taxis. In their search for a solution to their healthcare needs, users navigate through numerous pathways within the SUS, shaping their therapeutic itineraries as depicted in Figure 1.

According to Siqueira *et al.*[15], the pilgrimage of *Quilombola* individuals searching for care is characterized as one of the ways in which they are exposed to institutional racism. Institutional racism in healthcare predominantly affects Black and Indigenous populations, including rural *Quilombola* communities, which face invisibility in terms of relevant health indicators, difficulty in being included in public health policies, limited access to supplies, medications, and support and logistical systems[25].

This situation results in disparities in illness profiles, care, and mortality between White and Black individuals. The National Policy of Integral Health Care for the Black Population (PNSIPN) aims to ensure equity in healthcare for this population; however, there are challenges in its implementation, and there is often a disconnect between what is recommended and the actions taken[14,15]. When addressing access to healthcare in the SUS for *Quilombola* populations, we must acknowledge the persistence of racial issues and inequities experienced by these communities.

Racism is part of the social determinants of health, affecting the *Quilombola* population at all stages of life and health care. According to Anunciação *et al.*[25], healthcare institutions within the Health Care Network, as part of a structurally racist society, are shaped by this same structure, resulting in distinctions in healthcare provision, inequitable access to services, and differences in care availability.

The respondents also mentioned the need to pay for transportation to healthcare facilities and for procedures not covered or scheduled by the SUS:

When people from the quilombo need to go to the city [Januária] for a consultation, they have to pay around 60.00 to 70.00 reais for a taxi. When they don't have the money for transportation, they can't seek medical care (Woman 2).

We live far from everything… it's very difficult to go to the city just for a consultation. It's very expensive, and sometimes we can't find transportation (Man 8).

Residents of rural communities have limited access to nearby healthcare services[26]. A similar reality was observed in a study by Soares *et al.*[24], where participants reported that the rural population bears the physical and financial burden of traveling to the city for medical exams, which creates new barriers to access due to the high costs of transportation.

Insufficient or non-existent availability of specialized consultations and procedures within the SUS also poses significant barriers to access for the *Quilombola* population. When these services are lacking, the healthcare needs of the interviewees are left unmet:

When I needed treatment for an intestinal ulcer, the surgery was expensive… Three thousand reais at that time (Man 2).

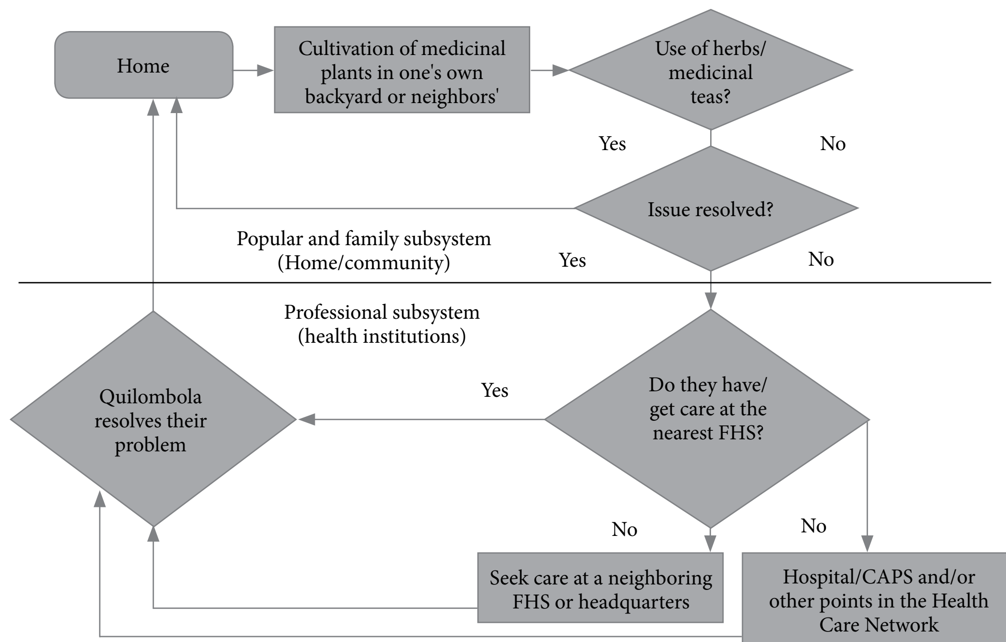

Figure 1. Flowchart of the Therapeutic Itinerary in healthcare in Quilombola communities

Source: Authors.

I'm undergoing treatment for a uterine condition, which I discovered through prevention with the nurse. Part of the treatment was free, but due to the long wait for an appointment, I had to pay (Woman 4).

We are poor… we work in the fields. When we get sick and need a test or a more advanced treatment, we can't get it for free because there are no specialized doctors or equipment available (Man 2).

In Brazil, the availability of public healthcare services is influenced by factors such as physical infrastructure, types of care provided, number of available spots, financial resources, ability to pay, continuity, and accessibility to healthcare services[1,27]. Among the possible causes of the problem of access to specialized consultations in the Brazilian Unified Health System (SUS), the following are identified: insufficient number of specialist doctors and health equipment, difficulty in retaining specialist doctors in rural areas, high dependence on the private sector, and reduced participation of the federal and state governments in the provision and financing of medium and high complexity services[27].

Specifically, the *Quilombola* population faces unfavorable socioeconomic conditions, with the majority living in extreme poverty, with a monthly *per capita* family income lower than half the minimum wage. Despite these conditions, they must provide for some healthcare expenses out of their own pockets. Assuming unexpected healthcare costs compromises the family budget and forces them to forego other essential goods[15,28].

Final considerations

This study allowed us to understand how therapeutic itineraries are constructed in visited *Quilombola* communities. The population itself establishes healthcare practices through the components of the popular, family, and professional subsystems. Popular knowledge continues to be a significant and powerful tool for the *Quilombola*'s healthcare, exercised within families and community contexts.

Women, especially older women, and *Quilombola* men make use of various natural resources, such as herbal teas and home remedies, for therapeutic purposes. The transmission of this knowledge occurs across generations, demonstrating a strong cultural heritage of care. The popular subsystem is the first resource sought, and when these care practices are not effective

or in more severe cases, individuals turn to the professional subsystem, represented by flows and services across different levels of care in the healthcare network.

Throughout these healthcare journeys, there is a tendency to prioritize hospital care for resolving health problems. This tendency is not solely based on *Quilombola* cultural beliefs, but also stems from difficulties related to access to primary healthcare. We also identified a demand for services and actions provided by Family Health Strategy (FHS) teams, as well as the need for mental health care through CAPS (Psychosocial Care Centers) and other points within the SUS network.

Access difficulties are related to racial aspects, with a notable presence and perpetuation of institutional racism, which hinders the establishment of comprehensive care and contributes to exclusion and illness. In addition to geographical challenges, there is a limited availability of primary healthcare services near *Quilombola* territories, the need for out-of-pocket payments for transportation, and the costs of procedures not covered by the SUS.

Therefore, it is necessary for public policies to adopt a continuous approach and interventions regarding ethnic-racial, economic, and healthcare access issues, which are causes of social inequities within the *Quilombola* population. *Quilombola* communities and healthcare professionals within the SUS network should strive to promote comprehensive health for this population, prioritizing the reduction of inequalities identified in therapeutic itineraries and the strengthening of the historical-cultural process.

Collaborations

RF Gomes, PSD Oliveira, MLO Silva e SVC Miranda collaborated in the planning of the study, in the collection, analysis and interpretation of the data, and in the writing and critical review of the article. C Sampaio collaborated in the planning of the study, in the interpretation of the data, critical review of the article and approval of the final version.

Acknowledgements

To the Quilombola men and women, who allowed us to learn about the paths taken in the search for health care, the research advisor, the students of voluntary scientific initiation and the Graduate Program in Health Sciences of the State University of Montes Claros (UNIMONTES).

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Article submitted 12/02/2023
Approved 17/06/2023
Final version submitted 19/06/2023

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva

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