

‘Leave it alone’: Therapeutic itinerary and access to health in rural communities of the Cerrado biome of Goiás

‘Deixa para lá’: itinerário terapêutico e acesso à saúde em comunidades rurais do Cerrado goiano

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ABSTRACT Therapeutic itineraries are adapted to the sociocultural context, revealing themselves as ways of caring for the body. In this sense, the objective was to describe the therapeutic itineraries of people living in two rural settlements and a quilombola community in the Cerrado region of Goiás. Data were obtained from the social actors’ accounts of the health-illness process, using a qualitative approach with participant observation, semi-structured interviews, and field diaries. The therapeutic itineraries of residents in rural Cerrado environments have a socio-historical trajectory marked by complex and often difficult pathways. They require experiences of seeking healthcare and the identification of possible routes. Thus, access and accessibility, knowledge, and acceptance are considered in relation to: a) the rural routes taken by their residents, whether in the twisted trees vegetation of the Cerrado in Goiás, or on winding roads, with poor or non-existent roads; b) experiences of suffering, illness, and bodily harms and their health as well as health practices that diverge between popular and scientific knowledge; and c) the resources used and the environment where they are obtained. The experiences of rural residents revealed ways of survival or care for the body and for the biodiversity of the Cerrado, demonstrating the difficulties, dangers, and harms, including those of social injustice and of a presumed urban progress.

KEYWORDS Effective access to health services. Rural health. Therapeutic itinerary. Quilombola communities.

RESUMO Os itinerários terapêuticos são adaptados ao contexto sociocultural, revelando-se modos de cuidado com o corpo. Nesse sentido, objetivou-se descrever os itinerários terapêuticos de pessoas que vivem em dois assentamentos rurais e em uma comunidade quilombola do Cerrado goiano. Os dados foram obtidos a partir da representação dos atores sociais sobre o processo saúde-doença, utilizando abordagem qualitativa com observação participante, entrevistas semiestruturadas e diário de campo. Os itinerários terapêuticos de moradores de ambientes rurais do Cerrado possuem trajetória sócio-histórica, percorrendo trajetos tortuosos. Exigem experiências de busca por saúde, desvendando os caminhos possíveis. Desse modo, têm-se os acessos à saúde, conhecimentos e aceitações sobre: a) trajetos rurais percorridos por seus moradores, seja na vegetação de árvores tortuosas do Cerrado goiano, seja nos caminhos sinuosos, com estradas intrafegáveis ou inexistentes; b) sofrimentos, aflições e agravos do corpo e da sua saúde, divergentes entre conhecimentos populares e os considerados científicos; c) produtos utilizados e do ambiente onde são buscados. As experiências de moradores rurais revelaram os modos de sobrevivência ou de cuidado com o corpo e com a biodiversidade do Cerrado, demonstrando as dificuldades, os perigos e males, incluindo os de injustiça social e os de um suposto progresso urbano.

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Engaging with therapeutic itineraries

Therapeutic itineraries and sociocultural pathways, whether shaped by individuals or by the community, require a deep understanding of the context-specific ways in which illness and bodily suffering unfold, as well as of therapeutic processes¹. Care practices are collectively produced and are what make access to health possible. Yet the mere existence of a service, the availability of a route to reach it, or the presence of ramps and stairs does not ensure that it will actually be used². For this reason, health services must be meaningful, acceptable, and intelligible to those who rely on them.

Therapeutic itineraries provide insight into how illness is understood from multiple standpoints, including biomedical knowledge and institutional health services, and individual and collective experiences. These meanings are also shaped through individual, institutional, and shared biographies. Therapeutic decisions emerge within specific contexts and reflect the range of possibilities available, formed through interactions with others in historically and culturally dynamic settings¹.

It is well established that the distance to institutional health services—such as hospitals or health centers—and the training of health professionals must be aligned with available resources and with how well these resources respond to users' needs. In addition, financial, organizational, geographic, and informational³ barriers must be taken into account. Therapeutic itineraries unfold over extended sociohistorical trajectories, shaped by diverse practices and by tensions between forms of knowledge found in rural and urban settings; yet it is through the urban perspective that what is considered legitimate knowledge and visibility tends to be structured.

In this sense, we can approach Brazilian rural therapeutic itineraries from both macro- and microsocial perspectives. In rural settings, one finds the dismantling of schools, the absence of health services, low population

density, and livelihoods based on agriculture, livestock farming, and the use of natural resources⁴ as part of therapeutic processes. Rural life also produces symbolic capital, shapes habitus and ways of life⁵, and bears the imprint of what is known as 'caipira' (a rural Brazilian sociocultural identity).

Going to the urban center may involve financial costs, as well as processes of identification, the reinforcement of social hierarchies, and misunderstandings surrounding healthcare networks. Access to urban services entails more than simply being able to reach a facility⁶. Manual labor, skin characteristics, physical strength, clothing, and even bodily appearance—often associated with self-care practices—may mark someone as a rural resident. In this sense, we are referring to forms of being and belonging in rural contexts. Through the lens of therapeutic itineraries, access to health can thus be critically examined.

Within these challenges, we encounter forms of discrimination in which rural identity operates as a social marker, structuring prejudice and reinforcing hierarchies. In this context, therapeutic itineraries become intertwined with life courses. Moving from rural areas to urban health services may evoke historical suffering and memories of discrimination that are not necessarily expressed in the symptoms present at the moment of seeking care, but that nonetheless point to neglect, exploitation, and death. It is within the urban sphere that the rural is often denied, where social markers are produced and where so-called scientific theories—including racial theories—have historically been constructed⁷.

Making decisions about one's own body and its care enables the construction of performative identities⁸, thereby shaping therapeutic itineraries. However, the process by which individuals and their spaces are defined by others may be embedded in coercive and discriminatory projects, giving rise to the attribution of 'owner' status (including of people, animals, land, houses, machinery, industries, companies, and 'truths') and 'non-owner'

status (workers for the 'owners'). The distinction between 'owner' and 'non-owner' is used here as a producer of social imaginaries. Here, the term 'owner' is deliberately used in a gendered sense, given that the concentration of power remains predominantly associated with men. In this sense, a housewife may be distinguished from a house owner. Therapeutic itineraries reveal understandings and experiences of the body, health, and illness in the search for care across different sociocultural¹ contexts, involving relations of power and hierarchies⁵. In these individual or collective quests, access to care is foregrounded.

Thus, working the land does not necessarily mean owning it. From this perspective, we may be led to think of an ongoing project of enslavement, since the absence of slavery should imply control over one's own labor. Yet the absence of land—despite its close connection to work—does not equate to freedom. Racism, as an urban, scientific, and Europeanizing project shaped by men, may seek to define the rural as a space of Black populations and their therapeutic itineraries, thereby shaping access to and the possibilities for health care.

If, in the initial phase of Brazilian slavery, Black people and land were both treated as property, only the so-called unproductive lands were left to those who resisted domination. As a result, quilombos⁹ and rural settlements were established in territories with these characteristics.

Decontextualized health interventions in rural settings, when designed from urban contexts, may contribute to iatrogenic effects by transforming social problems into health¹⁰ problems. Within this logic, the urban areas—despite concentrating business and commercial centers—turn rural areas into a stage for the introduction of industrial products such as medications, agrochemicals, processed foods, and machinery. This influx of industrial goods reveals a paradox: an attempt to sever the link between land and subsistence through the transformation of natural products into manufactured ones. Land as home ceases to matter,

and choices become justified by their capacity to generate capital and consumption, thereby reshaping the habitat⁴.

In this perspective, we are referring to rural community identities not as oriented toward capital accumulation, but toward survival, shaped by practices that seek to avoid harm to the environment in which people live. Moreover, respect for these identities contributes to the preservation of biodiversity. In this sense, being and living in rural contexts (working and residing in rural areas) functions as a social marker, producing discrimination within a hierarchical process that ultimately impacts health. Moreover, being and living in rural contexts may intersect synergistically with other social markers, such as skin color, difficulties in accessing products produced in urban areas, gender, and rural ways of life, thereby constituting intersectionalities¹¹. With health increasingly treated as a commodity, intersectionality, as it relates to therapeutic itineraries, becomes a determining factor in whether or not health is attained.

Exercising control over workers and their bodies often generates punitive and disciplinary responses to resistance. In this way, therapeutics and power, as well as politics and biology (biopolitics), become intertwined in the simulation of control¹², producing fear and forms of containment. It is through these resistances that quilombos can be understood as a threat to the exploitative hierarchies of enslaved labor in Brazil, from the colonial slave period up to the year 1888¹³.

Impositions that sustain subordination and generate capital gains often operate through scientific discourse, which is mobilized to produce hierarchies and bodily exploitation. Within this framework, and in relation to quilombos as spaces that sheltered enslaved fugitives, the psychiatric diagnosis proposed by the American physician Samuel A. Cartwright in the mid-nineteenth century—grounded in racist theories—was used to justify slavery and claims of Black inferiority. He argued that all Black people suffered from drapetomania

and dysaesthesia aethiopica, and that slavery was therefore necessary as a form of therapy. Drapetomania was described as a form of mania, or ‘runaway madness’, in which enslaved individuals were seen as breaking with a submissive order deemed natural by societal norms and ordained by divine will; whipping was prescribed as one of the principal forms of treatment. Dysaesthesia aethiopica referred to a condition considered specific to Black populations, particularly freed or free individuals, characterized by a supposed unwillingness to work, drowsiness, and alcohol use, with whipping likewise presented as the preferred treatment¹⁴.

As in enclosed institutions (such as asylums), the periphery is an open space marked by symbolic walls that hinder the integration of different forms of knowledge. From this perspective, the rural can be understood as a periphery produced through processes of industrialization and hierarchization, distancing those who have not conformed to forms of capital exploitation, as seen in rural settlements and/or quilombola communities. These are segregations imposed on lands deemed of little interest; yet at any sign of potential capital gain, perceptions of the periphery shift. At that point, negotiations and hierarchizing forms of possession begin to take shape.

When comparing rural populations, certain sociocultural characteristics stand out as particularly salient. According to the 2022 Census conducted by the Brazilian Institute of Geography and Statistics (IBGE), 61.71% of Brazil’s 1,330,186 quilombolas live in rural areas, a figure that rises to 87.37% within officially recognized quilombola territories. By contrast, the national average rural population stands at 12.6%. Quilombola territories are also marked by substantial deficiencies in basic sanitation, affecting 94.62% of households. The data further indicate that, up to the age of 54, mortality rates among quilombolas are higher than the national average, with the most pronounced disparities observed between ages 0 and 29¹⁵.

Thus, it is necessary to prevent a form of ‘urban ethnocentrism’, avoiding the emergence of hierarchizing conditions that undermine survival. The fatigue of enslavers—brought about by peaceful acts of non-subjugation by enslaved and formerly enslaved people, as well as by rising financial costs—gave rise to a kind of ‘leave it alone’ attitude, as refuges increasingly formed in hard-to-reach locations; a ‘leave it alone’ for which the Brazilian State bears responsibility. Within these refuges, in an effort at self-preservation, people became deeply intertwined with the land that sheltered them (the Cerrado biome), expanding the notion of merely ‘being present’ into one of ‘existing’. Within this logic, identities are both asserted and preserved.

It is often assumed that the hills of the Cerrado act as barriers to technology and to the commodification of rural life. This assumption, however, shifts when the prospect of capital accumulation emerges, as occurred with mining activities in the region of the municipality of Goiás, which generated significant environmental impacts⁹. Under this logic, any form of access—including access to health—tends to materialize only when it is tied to financial gain.

Rural areas have increasingly been drawn into more intensive modes of production, marked by the use of agrochemicals and heavy machinery, particularly on fertile, flat lands that allow the easy movement of tractors and harvesters. These lands—valued for their fertility and turned into arenas of dispute and expansion for agribusiness—often have their histories erased by monocultures (soybean, sugarcane, and others), driving local populations to migrate to urban centres¹⁶. Such commercial impositions, combined with the dismantling of schools and football fields, the absence of health services and electricity, poor road conditions, and exhausting labor under the sun, have contributed to the unmaking of the rural as a place of dwelling, recasting it instead as a site of business. Rural leisure is likewise eroded and redefined as something

that belongs exclusively to the city. It therefore becomes essential to reimagine the rural as home, rather than reducing it to a commercial asset—an approach that would enable the preservation of the biodiversity of the Cerrado.

Therefore, this study aimed to analyze the therapeutic itineraries and access to health care of residents in two rural settlements and one quilombola community in the Cerrado region of Goiás, focusing on how they develop and use health-related resources, as well as the actions and interactions established with healthcare services.

Methodological approaches to therapeutic itineraries

The data collection sites were located in the Cerrado region of the State of Goiás, in two rural settlements (Bom Sucesso and Buriti Queimado) in the municipality of Goiás, and in one rural quilombola community (São Domingos) in the municipality of Cavalcante. The study adopted a qualitative approach, describing access to healthcare and how rural residents understand the choices and pathways involved in seeking health care (therapeutic itineraries)¹.

Thus, it became possible to elucidate the social processes of specific groups through their discourses and lived experiences, using semi-structured interviews, participant observation, and field diaries. The aim was to immerse oneself in the field of investigation, to observe events from the participants' perspectives, and to exchange experiences through listening, speaking, observing, experiencing, and living them¹⁷.

Data collection took place in the rural settlements during 2016 (approval from the Research Ethics Committee of the Federal University of Goiás (UFG), Opinion no. 1182250), and in São Domingos in January and February 2025 (approval from the same Research Ethics Committee, Opinion no. 7.049.058), both under the Certificate

of Presentation for Ethical Consideration (CAAE) no. 46839015.0.0000.5083.

The two settlements share similarities in terms of living conditions and patterns of establishment. Before expropriation, the land belonged to a single family, and the communities remain interconnected, as reflected in kinship ties, friendships, and work/business relations among residents, as well as their proximity to the Serra Dourada environmental conservation park.

The municipality of Goiás is located in the northwestern region of the state of Goiás and has a population of approximately 24,000 inhabitants¹⁵. Buriti Queimado is the settlement with the longest stretch of unpaved road among the 23 communities in the State of Goiás (35 km of poorly maintained, potholed roads, with access also requiring the crossing of makeshift footbridges or ravines).

The sample in the rural settlements consisted of 58 participants (33 men and 25 women) from 40 households: in 17 of these, couples or two individuals were interviewed, while in the remaining households only one member participated. There were 15 refusals due to unavailability. In the quilombola community, 23 participants (11 men and 12 women) from 19 households took part: in 4 households there were two interviewees, including two couples and two mother-and-child pairs. Regarding participants aged over 60 years, 13 individuals were interviewed in the rural settlements (4 couples and 5 individuals), and 14 in the quilombola community.

In both studies, the same semi-structured interview guide was used with identical questions. Interviews were conducted during daytime visits to participants' homes while the researchers were in the field. Households were selected based on recommendations from residents and through participant observation, prioritizing those whose inhabitants were experiencing some form of health problem. We note that the real names of interviewees were replaced with pseudonyms.

The Buriti Queimado settlement served as a base for the research team's stay, as it was

the place where relatives of one of the authors lived, allowing the team to live in close contact with residents and share their daily routines in ways similar to those of the settlers, at different periods throughout 2016, including opportunities to observe the persistence of the phenomena under investigation. A similar situation occurred in São Domingos, where one of the researchers had relatives living in the community.

Data collection on therapeutic itineraries and access to healthcare was resumed in 2025, extending to the quilombola community located approximately 60 km from the city of Cavalcante. According to the 2022 Census conducted by the Brazilian Institute of Geography and Statistics (IBGE), Cavalcante is the third Brazilian municipality with the highest number of quilombola residents (57% or 5,473 inhabitants self-identified as quilombola)¹⁵, with 77 families reported in São Domingos in 2019¹⁸.

The areas where quilombola communities were established in Cavalcante are difficult to access, which directly shapes therapeutic itineraries. The region includes the Chapada dos Veadeiros National Park and can be understood as a form of refuge terrain:

The narrow paths wind and climb ever higher, almost lost in the midst of the bush. On the other side, the rock faces drop almost vertically into the lowlands of the valleys, like sheer walls impossible to cross⁹⁽²³⁾.

From this perspective, therapeutic itineraries and factors related to access to healthcare emerged from the coding and categorization of the data obtained through content analysis¹⁷. In the writing of this study, participants' identities were preserved. Through a qualitative approach, it is possible to describe the trajectories of participants' narratives in the search for treatment—trajectories that intersect and give rise to processes of intersectionality, hierarchies, and the visibility of social distinctions, discrimination, and conflict.

The time elapsed between data collection sessions in qualitative research is not the most significant factor; rather, what matters is the capacity to reflect upon and critically engage with the sociocultural context. In this sense, researchers-as-actors, by expanding the intersubjective relationships they continuously experience, go beyond analyses limited to the data collection period, enabling a deeper understanding. In qualitative approaches, knowledge of the context—even when considering sociocultural dynamics¹⁷—becomes more important than the number of participants. If time and sample size were the primary priorities, the study would not be able to represent—even minimally—an understanding of rural Goiás. Instead, we focused on the sociocultural dynamics shaping the context of the Cerrado in Goiás, thereby capturing the persistence of certain patterns despite temporal change.

Results and discussion: intersecting itineraries

"Should I head into town? Is there any help there?" (Florence)

The lived experiences of settlers and quilombola communities are intertwined throughout the research process, clarifying how actions that shape therapeutic itineraries and influence access to healthcare are articulated. In this context, when we refer to therapeutic itineraries, we are reflecting on users and their understandings of the body, health, illness, and therapeutic processes. This perspective goes beyond merely identifying the availability of services, focusing instead on the meanings attributed to therapeutic choices as shaped by the sociocultural context¹—here represented by the rural Cerrado in Goiás. Although different forms of access to healthcare can be identified, we treat access as constituted by the contextual conditions that enable such

choices. In this sense, the therapeutic itinerary emerges as a lens through which access to healthcare can be assessed.

Some points of convergence were identified across the different fields studied. Among the 58 settlers and 23 quilombola participants, the most frequently reported health issues included hypertension, headaches, and pain affecting the spine and the body more broadly; and incidents associated with rural life, such as falls on uneven terrain and accidents related to handling animals.

The sites studied can be characterized as spaces shaped by the pursuit of freedom, where memories of captivity and resistance are preserved. Historically, enslaved people were concentrated in gold mining, including in the region that is now the Serra Dourada State Park, in the municipality of Goiás/GO, and in the rural area of Cavalcante, which would later become a refuge for those fleeing slavery⁹. For enslaved populations, the dream went far beyond the gold mines themselves. Accordingly, therapeutic itineraries take on distinct forms in line with their socio-historical trajectories.

In addition to selling their labor to local landowners, households in rural settlements earned income from retirement benefits and the sale of milk and dairy products (such as cheese, cream cheese, and homemade preserves), honey, *rapadura* (unrefined cane sugar), eggs, and free-range chickens. In São Domingos, income was derived from animal husbandry, the sale of '*garrafadas*' (herbal medicinal preparations), the marketing of agricultural and livestock products, as well as employment at the local school and retirement benefits.

Through therapeutic itineraries, access to care and the availability of resources are shaped in a process grounded in the lived experiences of those seeking treatment.:

The idea of a therapeutic itinerary refers to a chain of successive events that form a coherent whole. It is a form of human action constituted

by the combination of distinct acts that together produce an articulated unit. Two aspects can be highlighted here. First, the therapeutic itinerary is the outcome of a particular course of actions—either the action itself or the state of affairs it brings about. Shaped by distinct acts that succeed and overlap one another, the therapeutic itinerary names a set of plans, strategies, and projects oriented toward a pre-established goal: the treatment of distress¹⁽¹³³⁾.

Therapeutic itineraries showed that the first option was to seek immediately available resources or treatments, such as medicinal plants, syrups, or *garrafadas* prepared by residents, followed by the use of healthcare services, except in emergencies (such as a broken leg or a deep wound). However, even in these cases, one does not replace the other; rather, both are used concurrently.

Regarding the use of industrialized medications, two interconnected therapeutic itineraries were identified: (a) without a prescription from healthcare services, obtaining treatments through their own knowledge or through family members, neighbors, friends, vendors, and pharmacy staff; and (b) with a prescription from healthcare services, accessing treatments in hospitals, primary healthcare units, medical and dental clinics, or pharmacies.

In different locations, participants reported a lack of healthcare services, such as a permanent family health unit, with only itinerant services available, where healthcare professionals provide care in alternative settings (such as schools and churches). Healthcare services, including primary care units, are concentrated in urban areas. Health workers and services travel to rural areas, but are not based there.

Although data collection in the rural settlements of the municipality of Goiás, in the State of Goiás, took place approximately ten years ago, they remain socio-historically relevant, particularly in rural areas. They reveal processes of exploitation inherited from the period of slavery, which continue to produce social exclusion and hinder access to care networks.

Moreover, these records remain consistent with the reality observed in the more recent data collected in the São Domingos community, demonstrating the continuity of socially and historically produced conditions in rural Brazilian contexts within the rural Cerrado of Goiás. Moreover, we observed that access to the range of therapeutic possibilities and characteristics—such as the use of medicinal plants, medications, and healthcare service networks—remains limited, with no implementation of medicinal gardens, community herbal pharmacies (*farmácias vivas*), or new public healthcare services.

Therapeutic pathways address the following question: what is available (in terms of access) for seeking healthcare, and how is what is available understood and interpreted? In this context, traditional remedies were emphasized as the first option, most of them being used by the participants themselves. Given the difficulties encountered in accessing healthcare services, medicinal plants are readily available, as reported by a quilombola interviewee: “*Yeah, that’s why I don’t go to [health services]. Why did God leave the roots? The roots of the bush? Weren’t they meant for people to use? Weren’t they?*” (Timóteo).

Lack of access to a car, as well as the absence of roads, were reported as limiting factors, contributing to the widespread use of medicinal plants among quilombola participants: “*There was no car. To leave here and go to Cavalcante, you had to have an animal to ride there*” (Timóteo). In addition, financial constraints point to the persistence of difficulties in reaching the city:

I’m not going there. [...] The only time she went to claim her pension, I had to pay for transport—just the car hire for four people was 350 [...] plus money for them to eat there (Timóteo).

Faced with the inability to resolve or prevent health problems within their own communities, residents seek treatment in urban areas, often relying on private services,

which highlights the lack of continuous access to public healthcare. This situation is compounded by expenses related to food and transportation, as well as costs for consultations and examinations, as evidenced in the study¹⁹.

People who are bedridden or living with disabilities often leave rural homes and relocate to urban areas due to the costs of travelling to the city, the strain placed on animals under their care, and the exhaustion of repeated journeys. The combined burden of these expenses, together with reduced income after settling in the city, sometimes leads to the sale of all their assets.

Thus, examining access to healthcare among rural residents makes it possible to describe the sociocultural context not as an ordered structure, but as a lived experience¹. The social and cultural dimensions are mutually shaped, as are the meanings attributed to illness and treatment, grounded in the communicative and interpretative capacities of those born and living in rural settings. We suggest that, through the range of choices and forms of access to healthcare, a process of cultural negotiation unfolds between rural and urban worlds, as well as between biomedical knowledge and popular practices. In this sense, the presence or absence of healthcare services shapes the meanings attributed to available treatments.

Preventive practices based on natural products were less frequently reported in the rural settlements, whereas they were more prominent in São Domingos. In addition, quilombola residents were born and have lived within the quilombo community, with limited contact with urban areas, while the life trajectories of settlers tend to be more closely connected to urban environments.

The distance of the settlements from their municipal center—Goiás/GO—was considered significant, particularly due to the poor quality of roads, including the lack of asphalt paving and the presence of streams and muddy stretches that hindered the movement of both healthcare professionals and residents. As a result, reaching the intended destination was

often described as uncertain, especially during the rainy season. In addition, unfamiliarity with rural road networks, with their multiple forks and intersections, could lead drivers, including ambulance personnel, to fail to reach their destination promptly. On this issue, one settler interviewee stated:

I cut my arm at two o'clock in the afternoon—do you know what time I was finally taken for care? Seven o'clock in the evening. [...] They picked me up, put me on a bed, tied me down, and took me to that gate at the exit. The SAMU [Mobile Emergency Care Service] ambulance pulled up there. They took so long because they kept going around—on the way from Goiás Velho, they went to Colônia and then back to Lajinha. Look at the confusion they caused. When I arrived in Goiás, they said, 'send him back, he'll die on the road' [...]. I went to Goiânia, to the Goiás Emergency Hospital-HUGO (Justino).

Difficulties are not limited to distance and travel time; they also extend to how people feel during the journey. Ambulances should be properly equipped for this rural context, including suitable vehicle traction, appropriate tires, tools for getting out of mud, and better-padded interiors to reduce jolts during patient transport, as well as road signage indicating location. Drivers should be familiar with local routes and the surrounding area, and health-care professionals should also have knowledge of rural healthcare contexts.

Moreover, many treatments involve long journeys, as patients are referred to major urban centers such as Brasília/DF (approximately 370 km from São Domingos) or Goiânia/GO (about 570 km from São Domingos and 160 km from the settlements), as reported by another settler:

I've already been bitten by a snake here [...] If I had stayed and waited here, I could have been seriously harmed [...], because at the time the road and the bridge were damaged, and I had to take a detour (Anselmo).

It is believed that the difficulties in seeking healthcare services in urban areas encourage their use primarily for curative purposes rather than preventive care, given the absence of healthcare services in rural settings: “A doctor comes today, and then maybe next month he won't come, and you need medication and have to go there [to the city of Goiás] (Ronaldo).

In addition to access difficulties related to road conditions, there are financial barriers which, in rural contexts and from an intersectional perspective, may compound the effects of ageing, as illustrated by an elderly interviewee:

[...] I receive my monthly benefit, and then I go straight to the pharmacy [...], and it already comes to 400 reais just for the medications I use in a single month. [...] It's everything—high blood pressure, Chagas disease, a blockage, and arrhythmia (Iracema).

Staying home: therapeutic itineraries and symbolic distances

The experiences of suffering among men and women revealed different therapeutic itineraries, reflecting distinct forms of silencing. ‘Fear’ of illness expresses underlying economic constraints (‘fear of spending money’) and was more prominently reported among male interviewees and in the quilombola community. In this sense, resistance is not limited to avoiding healthcare services but also extends to their use, with a preference for quick solutions that allow an immediate return to the rural environment and to home. Long waiting times or the need to remain in the city for several days discourage the willingness to seek care, particularly preventive care.

It is observed that the fear of being perceived as incapable is associated with production and work, particularly among rural men, who may postpone healthcare-seeking behaviors. Rural labor requires physical strength and manual work, which are closely linked to masculinity.

This condition leads to a continuous demonstration of strength, such as comparing the ability to carry heavy objects (firewood, or to lift or restrain animals, among others).

In this context, the consumption of distilled alcoholic beverages, such as *cachaça* (a Brazilian sugarcane spirit), is also associated with masculinity, expressed in heavy drinking without losing control, which is taken as a sign of a 'strong man'. Admitting illness is framed by a specific threshold: no longer being able to carry out rural work. Even when the body can no longer withstand the demands of labor, there remains the insistence that one is still able to continue.

From this perspective, describing the other—under conditions of unequal power—as strong aligns with the exploitation of labor. This practice is closely linked to rural settings and may be reinforced by racism. As a result, preventive health measures tend to be avoided, particularly because seeking or receiving care requires time. A moral dimension is thus reconfigured around suffering or the endurance of pain associated with rural work, thereby reinforcing processes of social segregation.

Hierarchies between urban and rural areas reinforce fears of hospitals and needles, as these are also perceived as part of processes of exclusion, as stated by a quilombola interviewee:

I do, I'm very afraid. Once I went through something there in... I went to Campos Belos, Brasília, and I suffered a lot there. I became afraid of hospitals [of being admitted]. And now I'm even afraid of getting an injection (Ambrósio).

Additionally, other forms of hierarchy are also at play. Difficulties related to pregnancy point to an implicit pressure for women to move to urban areas, intersecting multiple social markers (woman, mother, limited direct access to income, pregnant, Black, rural resident, quilombola, settler, among others) that may hinder access to healthcare.

[...] If a woman is pregnant and in pain, she still has to stay there, working hard, grinding away, until... There's no one else, you know—especially for women, it's harder, it's more dangerous. And when someone gets sick, there's no one to help quickly, right? [...] There's no one here. Not even to weigh the baby... Who can manage to carry both the woman and the child? (Anastasia).

In this way, pregnancy, childbirth, and the postpartum period—including care for the child—are not fully supported by permanent healthcare services. The importance of traditional knowledge is therefore underscored, particularly the role of midwives, as observed in other quilombola communities, which helps to ensure care and reduces the need for travel to urban areas or permanent relocation to the city²⁰.

In both research settings, distances and difficulties in reaching care were emphasized; however, symbolic and geographical distances were more prominent in the interviews with quilombola participants:

Then early the next day, we set off, and I slipped. The shotgun—I don't know what happened—I was holding it, bracing it. I can't really remember anymore. The stock was forward and the barrel back, right? Then I slipped and let everything go. The shotgun went off right here, look [...] And then they took me on an animal, in a hammock, so I could ride—I said, I couldn't take it anymore [...]. I stayed at the Hospital de Base for three months, all by myself (Timóteo).

A lack of clear guidance or information about which healthcare services serve each community was observed, as explained by one settler:

You know how it goes: 'you don't belong to this health unit'. Let's say you leave here sick, arrive at the clinic, and ask, 'Is there a slot available?' Then they check and ask, 'Where are you from?' 'From Bom Sucesso'. 'Oh no, then this isn't your catchment area—you don't belong here [...]' (Calista).

When travel back and forth becomes more frequent and unavoidable, particularly due to the chronic nature of illness, the journey becomes one of no return, requiring people to settle in the city, as one settler explained: “[...] *this year it got serious [cancer], and you can't stay on the farm anymore, you have to stay close to care, if you need to rush to the hospital, you have to be there*” (Casimiro). The paths taken and the distances travelled come to be experienced as bodily pain and suffering, reshaping understandings of illness and treatment.

Furthermore, ways of speaking, dressing, and rural customs stand in contrast to what is observed in urban centers and their healthcare services, reinforcing distances and the marginalization of rural populations in relation to urban contexts. Healthcare professionals and rural residents thus become symbolically even more distant, hindering interaction and dialogue and undermining the effective guarantee of the right to health.

“It’s just a simple remedy, it’s quicker” (Constância)

As difficulties in accessing medical consultations—often involving long waiting times—self-medication becomes common, reshaping therapeutic itineraries. As a result, trips to the city tend to strengthen relationships with pharmacy or drugstore staff, and medicines are used primarily in response to symptoms rather than as part of treatments based on formal diagnoses. In São Domingos, the presence of a travelling vendor who also sold medicines to quilombola residents was reported. It is suggested that figures such as herbalists, healers, and even healthcare professionals may be replaced by sellers, whose explanations of illness are limited to symptoms, displacing more contextualized and scientifically grounded understandings.

The travelling vendor was described as being more regular than healthcare professionals, with some residents reporting that

he visits the community every fifteen days and others saying he comes once a month. Through the vendor, residents gain access not only to medicines but also to other everyday goods: “*the vendor comes. Every month on the 8th—he’s arriving today, actually*” (Ambrósio).

Ultimately, settlers viewed diagnoses that require ongoing medical follow-up as a potential source of financial hardship, since they demand more time and sustained engagement with consultations and treatments. Consequently, healthcare is not readily understood as the outcome of coordinated teamwork among health professionals. As one settler explained:

My husband always prefers to go to the pharmacy, if it's nothing too serious, you know. He'd rather go there [...] it's better than staying at the hospital waiting and ending up not being seen (Vera).

The use of medicinal plants to address various health conditions was also reported among settlers, including: (a) leg fatigue: *cipó-do-canduê*, *cupisco-preto*, *pocová* leaves with *vinhático*; (b) flu or cough: *quina*, *fede-goso mentrasto*, *porrete-de-malina*, *capitão* with *jatobá*; (c) anti-inflammatory purposes: avocado seed (*semente de abacate*), *banana de Imbé*, *pacari*, *mangabeira*; (d) diabetes: eggplant (*berinjela*), *guatambu*, *aroeira*; (e) calming effects: *erva-cidreira*, mint (*hortelã*); (f) menstrual cramps: *mastruz*; (g) antibiotic use: *erva-de-lagarto*; (h) depurative: *algodão-zinho*; (i) prostate conditions: *cansanção*; (j) diarrhoea: *rubi*; (l) back pain: *nó-de-cachorro*; (m) renal colic: *espório-de-galo*, *congonha-de-burro*, tamarind leaves (*folha de tamarindo*), *escorrega-macaco*, *porrete-de-malina* and *quina*; *cana-de-macaco* and blackberry (*amora*); *ameixinha* with *quebra-pedra*; *pé-de-perdiz* with *velame-branco*, *algodãozinho*, *mama-cadela*, parsley root (*raiz da salsinha*), and *carrapichim*.

The use of medicinal plants was more prominent in São Domingos than in the settlements. One interviewee from São Domingos illustrates

the convergence of perspectives—between the pharmaceutical industry and medicinal plants—through what she referred to as her ‘bag’ of medications, which included dipyron, perindopril, arginine, indapamide, amlodipine, vitamins, calcium, famotidine, dimethicone, domperidone, simvastatin, metformin, pantoprazole, paracetamol, acetylsalicylic acid, and metoprolol, alongside medicinal plants such as *colônia*, *erva-cidreira*, *folha de chuchu*, *velame-branco*, *velame-vermelho*, *pé-de-perdiz*, *roseta*, *salsa*, *caroba*, and *carobinha*. However, she went on to say:

The tea is also used to make garrafadas. When I say garrafada, I mean mixed with white wine or água inglesa [a bitter herbal tonic]. That’s really something meant for us women, you know? But I haven’t... wow, ever since I changed churches, I haven’t drunk that stuff anymore (Odete).

The use of *garrafadas* made with various medicinal plants—and even combined with pharmaceuticals—prepared with either white wine or *cachaça*, as well as syrups, was highlighted by residents of São Domingos.

The discontinuation of *garrafadas* or medicinal plant use is also shaped by religious factors. This is believed to be related to the spread of Protestant churches in both the rural settlements and the quilombola community. However, it is observed that Catholicism had a stronger influence⁹ in the past and may now be being replaced, as reported by a resident of São Domingos: “Yes. Then the churches said it was macumba, and I said, I’m here, whatever God wants, so be it, right” (Iracema). In São Domingos, no Afro-Brazilian religions such as Candomblé or Umbanda were observed.

The interaction between the pharmaceutical industry and the Cerrado is expressed through bodily care practices. It is not a matter of choosing one or the other, but of using them together. Medicines are combined with medicinal plants, as reported by a quilombola interviewee:

Drop by drop. But when it’s in tablet form, I don’t like taking too much, because the effect is stronger. What I use is 30 drops of liquid dipyron in syrup. I took it myself and also gave it to my children (Jovita).

The most frequently mentioned medications in the settlements and in São Domingos were those used for pain and inflammation (dipyron, nimesulide, diclofenac, Torsilax®, among others). This is believed to be related to the types of work performed, which often result in pain and injuries, such as carrying heavy loads, working in uncomfortable positions, and injuries resulting from falls.

Planning healthcare access for rural residents involves recognizing the potentialities of each context, and making universal design possibly becomes necessary—that is, ensuring accessibility for all people. For example, the Cartilha do Programa Aquilomba Brasil²¹ (Aquilomba Brazil Program Handbook) could be applied to any rural community, given that Black populations are present across different quilombola and non-quilombola settings, whether in relation to land access, infrastructure, quality of life, social inclusion, rights, or citizenship.

We are not referring to a ‘universal’ as a static model that promotes power and discrimination, as in racist eugenic theories that emerged from a European paradigm (Eurocentrism). Such theories served as a framework for social exclusion, using phenotypic characteristics—such as skin colour⁷—as markers. In this sense, therapeutic itineraries expand into survival itineraries, shaping choices and historical and social paths of resistance.

In the Cerrado, we observe a context marked by dispute and conflict, in which social demands and the need to protect the biome coexist with the exploitation of natural resources and workers, producing environmental violence and undermining health. In this sense, survival often leads to displacement, creating migrants and revealing the continuity of a colonizing process. The rural environment thus loses its meaning as ‘home’. On the other hand, it is recognised that current

comprehensive health policies for rural, forest, and riverine populations, as well as for traditional peoples and communities, aim at equity and social justice, respecting cultural values and addressing vulnerabilities²²⁻²⁴. However, there is still a long way to go to protect and respect the Cerrado biome, reaffirming its meaning as home and dwelling—as a place of living, rooted in its land and under its shelter

In a process of colonization, we can identify different frontiers—territorial markers shaped by commerce, agribusiness, and industrialization—that establish hierarchies and distinct social temporalities. These frontiers are also reflected in differences in vegetation through types of cultivation, in the appearance and presence of houses, and in whether residents are permanent or temporary²⁵. At these boundaries, *habitus*⁵ emerges as a social marker intertwined with the flora and fauna of the Cerrado. In this sense, calloused hands, skin color and its sun-induced effects, clothing, relationships with time and space, and the language of those who live in and belong to rural areas differ from those who are engaged in the exploitation of rural territories

When describing therapeutic itineraries, it becomes possible to develop a socio-historical analysis in which access to healthcare may also be associated with iatrogenic effects¹⁰ within a process of cultural acculturation. Furthermore, therapeutic choices (medicinal plants from the rural Cerrado and pharmaceuticals from the city) emerge as a boundary, revealing the persistence of conflicts and highlighting the construction of 'another' (rather than a 'we'), referring to those who are subjected to neglect or only recognised when subordinated. Moreover, access to healthcare does not necessarily translate into care and may instead function as a strategy of subordination.

It is interesting to note that, when the sense of being and living in rural areas is incorporated into the term 'agriculture' (caring for the land), culture, care, and land become intertwined²⁶, coming closer to agroecological perspectives¹⁶. In this sense, caring for

oneself would also mean caring for the land. It is therefore suggested that agroecological practices may integrate knowledge related to the Cerrado context, allowing for deeper understandings of a culture, understood as care for the Cerrado.

Therapeutic itineraries have historically been interconnected with social discrimination and hierarchies, leading us to crossroads, intersections, and intersectionalities. Through therapeutic itineraries, different colors and forms of power become visible according to one's social position. Different colors are noted in the 'main houses' or 'great houses' in contrast to those found in the so-called '*retiros*' (outstations)—places where people live and work. '*Retiro*' holds the meaning of a 'retreat' for the wealthy, yet a 'work outpost' for the poor. Thus, the word '*retiro*' connects to concepts such as 'leave it alone', segregation, and the term '*retirante*' (displaced migrant). What quilombos and rural settlements seek is equity: to give the '*retiro*' rest and peace, self-management, and the meaning of a home with labor, without the subject having to leave the countryside and become a *retirante* in urban peripheries—within a monitored, controlled, and disciplinary environment that heightens disputes among residents and dependence on others for survival. The therapeutic itinerary unites forms of knowledge: providing science to the popular and vice versa.

Beyond therapeutic destinations: final considerations

It is believed that this research may contribute to a better analysis of the health situation and the health map of the rural population, while specifically favoring quilombola communities through the effective implementation of the National Policy for the Comprehensive Health of the Quilombola Population (PNASQ), the enforcement of which is essential. Therefore, it

is necessary to expand or intensify the actions suggested in the conclusions. The proposal is the development of ‘rural and community services’, which distinguishes them from health services aimed merely at ‘serving the rural’.

Therapeutic itineraries reveal histories of health inequities and the need to prioritize permanent multidisciplinary health teams in rural areas. In addition to primary care, the structuring of specialized services that integrate scientific and popular knowledge is suggested, such as the creation of medicinal gardens and ‘living pharmacies’, grounded in the Saúde Única (One Health program) perspective²⁷ and agroecology¹⁶. Such an approach requires intersectoral actions (health, education, environment), involving professionals from human and animal health, agricultural sciences, and social sciences, including a rural health surveillance system.

Improving access requires infrastructure, such as permanent road maintenance, regular public transport, quality communication and internet services, and the expansion of telehealth. It is fundamental to establish a universal design for health access that respects sociocultural differences, regardless of the residents’ social and cultural backgrounds. Emphasis is placed on the need for rural health

planning to be autonomous from urban planning, strengthened by the implementation of rural health councils and education tailored to rural needs, leading to the emergence of management pacts.

Respecting ways of being and living in rural areas, both in quilombola communities and settlements, requires qualified professionals and preventive actions aimed at addressing injustices and inequities. Such an approach should ensure health promotion that values community identity, territoriality, and local knowledge, while also enabling the empowerment of rural residents and the preservation of biodiversity.

Authorship contributions

Mendonça RT (0009-0008-5860-8947)* contributed to the study design, data collection, data analysis and interpretation, manuscript writing, critical revision, and final approval of the manuscript. Espíndula GVS (0009-0006-3929-5063)* contributed to manuscript writing, data collection, and data analysis. Silva PGF (0009-0006-8228-2823)* contributed to manuscript writing, data collection, data analysis, and final manuscript revision. ■

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