DOI: 10.1590/1413-81232015211.20472014

The therapeutic itinerary in urgent/emergency pediatric situations in a maroon community

Samylla Maira Costa Siqueira [1]
Viviane Silva de Jesus [1]
Climene Laura de Camargo [1]

Abstract *The goal was to understand the therapeutic itinerary of Maroon children in urgent/emergency situation. Is a descriptive research with a qualitative approach that uses the Health Care System model of Arthur Kleinman as its theoretical support. Participants included 12 mothers of children who had experienced any urgent or emergency medical situation. Data collection took place from December 2013 to June 2014 through semi-structured interviews with a thematic analysis of the data. The care of the child started in the "informal" subsystem, and access to a "formal" subsystem was characterized as a pilgrimage for health services. A development of specific strategies is needed to ensure and facilitate full access to the services of the professional subsystem for Maroon communities.*
Key words *Child care, Emergency Medical Services, Demand for health services*

[1] Programa de Pós-Graduação da Escola de Enfermagem, Universidade Federal da Bahia.
smcsiqueira@hotmail.com

Introduction

The term "therapeutic itinerary" (TI) refers to the search for treatment and seeks to describe and analyze individual and socio-cultural practices, in terms of the paths taken by individuals to solve their health problems[1], including the logic that drives this pursuit, which is woven in multiple formal and informal networks of support to which a person belongs[2].

The early work on TI originated from the term illness behavior - translated as sick behavior - which was assumed to be the conduct of individuals searching for care and was rationally oriented, considering the question of cost-effectiveness. This behavior was considered voluntary, rationalistic and individualistic. Later, this concept was expanded to include cultural values in the responses of individuals[3]. Thus, culture can be considered a determining factor of TI, as culture influences how people communicate, perpetuate and develop knowledge and activities in relation to life, including the realm of health care[4].

Since the 1980s, the influence of culture on the perceptions of health, disease and health care has been addressed by anthropologists such as Arthur Kleinman, who recognized the existence of a cultural system, i.e., the Health for Care System, which includes three interrelated subsystems: the popular subsystem, the folk subsystem (informal system) and the professional subsystem (formal system)[5]. The explanatory models for these subsystems are based on concepts that lead to the perception and interpretation of disease and allow for developing different curing mechanisms consistent with the cultural context of each individual and group[6].

In addition to reflecting the cultural factors, the transit of individuals by social devices in search of care demonstrates the influence of socioeconomics on healthcare, as TI practices reveal strategies for populations to cope with their health problems[1], especially the poor, who stand out among Maroon populations.

Maroons, defined (in Brazil) as ethno-racial groups of black ancestry and distributed throughout this country[7], have consolidated territories in peripheral regions[8] and are therefore subject to the consequences of geographic isolation, one factor that causes uncertain access to health care services, especially more complex health care such as urgent or emergency services.

Situations characterized as urgent/emergency conditions are unforeseen health problems in need of immediate medical attention because of the potential risk to life, be it imminent or not[9].

Although they affect people of all age groups, urgencies/emergencies in children have a significant importance due to both psychological and biological idiosyncrasies, as well as the physical and cognitive abilities, dependency levels, activities and risk behaviors of the children[10]; in addition, mechanisms to cope with health problems have not been developed in children, and this fact characterizes these individuals as vulnerable beings.

Urgent/emergency situations in childhood, especially those related to external causes, persists as a major public health problem that requires urgent attention and is the leading cause of death among children worldwide; this is especially true in in low- and middle-income groups, which account for more than 95% of cases, because children living in poverty and in rural and remote areas are more vulnerable[10], as is usually the case with children in maroon communities.

Given this context, questions arise regarding how people in Maroon communities proffer care to children in urgent/emergency situations in the healthcare system; here, this topic is analyzed from the aspect of TIs.

There are recent studies regarding TIs in Brazil[11]; however, they do not focus on maroon communities. Conducting research to reveal the care practices and difficulties faced in the search for health services in these communities is important in order to support the development and implementation of public policies that enable full access to healthcare for these individuals.

Given the abovementioned facts, this study aims to evaluate the TI adopted by Maroons in emergencies and pediatric emergencies and to demonstrate the care practices of the informal subsystem, including the journeys made in the formal system, focusing on user access.

Methods

This is a descriptive research study with a qualitative approach that uses the healthcare system model of Arthur Kleinman as is theoretical support[5].

The locus of the study was the maroon community of Praia Grande, located on Maré Island in Salvador (BA). This community was chosen because of its lack of emergency services and because it is a population with a broad cultural heritage, which is related to an African heritage.

The eligibility criteria for participants were inhabitant of Praia Grande aged over 18 years at the time of conducting the survey; father, mother

or guardian of a child age 0 to 11 years, 11 months and 29 days (the Statute of Children and Adolescents[12] considers one a child up to the age of twelve years) who has received any type of care in an emergency situation; voluntary participation in the study; and without any verbal or cognitive disabilities.

The number of participants was not defined prior to the study. Thus, the interviews were held until a repetition in the responses, with the corresponding theoretical saturation of data, was observed[13].

To identify children in the community who had experienced any urgent/emergency medical situation, we utilized a partnership with community health workers (CHW), representatives of NGOs and the support of the people themselves who, through a snowball effect, were referred by others who met the inclusion criteria of the study[14]. We used a classification system of a health service of São Paulo[15] to classify the urgency/emergency pediatric, which was elected to be the only system specifically directed to the age group studied.

Data were collected from December 2013 to June 2014 after approval by the Ethics Committee of the Federal University of Bahia, and the study respected the ethical principles established by Resolution 466/12 of the Ministry of Health[16].

The data collection techniques were 1) an application form based on the VIGITEL questionnaire, proposed by the Ministry of Health, which assessed the socio-demographic characteristics of participants and children to whom assistance was given; 2) a semi-structured interview, which was to implement a guide that consisted of semi-open questions allowing for each child's TI to be traced by focusing on the care provided to these children and their paths involving the social apparatus.

The interviews were individually conducted in a place chosen by the participants. The interviews were recorded and lasted an average of ten minutes. Later, the interviews were transcribed and coded with the letter E, followed by a number in the order in which they were carried out: E1 to E12.

For data analysis the thematic analysis[17] was used. The phrase was defined as a registration unit (UR), and 105 units of thematic analysis emerged, which were grouped into 26 themes that will be discussed in two categories: the popular subsystem, which was the gateway to the care, and the formal subsystem, which was the pilgrimage in search of care.

Results and discussion

First, the socio-demographic characteristics of the participants (Table 1) and the children (Table 2) will be discussed. Subsequently, from the categories that emerged from the analysis, the interviewees' perspective will be given, demonstrating the adopted TIs in urgent/emergency child care.

All the participants were women, mostly black, and were mothers of the children for whom care was provided in a situation characterized as urgent/emergency. At the time of data collection, the majority of the women were aged 30-39 years, married or in a stable relationship, had only one child and declared themselves to be of an evangelical religion (Table 1).

Regarding education, the women had either completed or were attending elementary school. Regarding occupations, the women predominantly worked in the shellfish and other professional activities that did not require qualification in higher education were also cited, including artisan, housewife, merchant, child development aid (ADI) and cleaner (Table 1).

For income, almost all participants were beneficiaries of the Family Grant Program, with a median family income of R $ 890.00 and a household per capita of R $ 212.50, which classifies these participants as a vulnerable group at a socioeconomic low level, according to the municipal income human development (MIHD) index[18,19] (Table 1).

In terms of the children's characteristics, the majority (N = 7) of the children were boys, and the predominant age group (N = 7) was 1-4 years, followed by children 5-8 years (N = 3) and children younger than 1 year (N = 2) at the time they received urgent/emergency assistance (Table 2).

In terms of their health characteristics, the majority (N = 10) of children had no underlying disease; asthma was found in two children, and in both cases, the asthma caused the emergency situations. Almost all (N = 10) children did not have health insurance, and most (N = 8) of the children used to public service when professional care was needed. More than half the cases (N = 7) revealed that the child had undergone routine medical care during the previous year (Table 2).

With respect to the children's presenting problems, five diseases were noted, and most of the diseases were clinical in nature: febrile seizures (N = 5), fever (N = 3), asthma exacerbation (n = 2), dehydration related to diarrhea and emesis (N = 1) and burn (N = 1), especially with secondary convulsions and fever.

Table 1. Participant characteristics (N = 12). Salvador-BA, Mar. 2013 - Jan. 2014.

	N	%
Genre		
Female	12	100
Age Group		
≤ 19 years	1	8,3
20-29 years	4	33,3
30-39 years	7	58,3
Education		
Elementary School	6	50,0
High school	5	41,7
Post high-school level	1	8,3
Number of Children		
One	6	50,0
Two	3	25,0
Three	1	8,3
Four	2	16,7
Occupation		
Seafood industry	6	50,0
Others	6	50,0
Income		
Family (R$)		
Per Capita (R$)		
Kinship		
Mother	12	100
Religion		
Evangelical	5	41,7
Catholic	4	33,3
No religious affiliation	3	25,0
Marital Status		
Single	4	33,3
Married/Stable Relationship	7	58,3
Divorced	1	8,3
Race/Skin Color		
Black (black/dark-skinned)	9	75,0
Yellow	1	8,3
White	1	8,3
Other	1	8,3
Social Benefit		
Social welfare	11	91,7
None	1	8,3
Nº (%) or Median (IQR)*		
890,00 (605,00; 1100,00)		
212,50 (151,65; 286,65)		

* Nº = number; % = percentage; IQR = Interquartile Range.

Popular subsystem: care gateway

The care provided in the popular subsystem is informal in nature, and the medical knowledge is derived from common sense, including the family's understanding of the illness and the care, as well as the influence of the individual's social network and community[5].

In the TIs of this study, the community was the starting point for care provided in this subsystem, and the TI began with the assistance provided by the family, as care is primarily a family matter; it is the family that struggles with the activities of daily living and that handles the pain and existence of serious health problems[20], as observed in this study, and this circumstance is corroborated by other authors[21,22].

Kleinman and Geest[20] recognized the existence of a strong gender bias in the act of caring, so that the family network of care is dominated by women. In agreement with this bias, the all-female composition of the study participants is noted. Males were also invited to participate in the survey; however, they refused and called their wives or other women to do so on the grounds that the women were better able to provide the interview, as they were more knowledgeable about the facts and care provided to the child.

This phenomenon is related to the historical and cultural context of women, in which the female figure is responsible for taking care of her own, and this function or responsibility is considered by all to be innate and natural[22]. In this way, the woman becomes the protagonist in the provision of health care and is responsible for assisting the family; she is the primary, and sometimes the only, caregiver and manager of care in the family, as is shown in related studies[23-25].

In the TI of children, the woman-mother usually stands out as the main caregiver. Thus, as shown in Table 1, all study participants were mothers of the children for whom medical assistance was provided. This is in agreement with the study by Milk and Vasconcelos[26] showing that for children's diseases, the mother is the protagonist of care, with an almost constant presence. This finding is similar to the results presented by other authors[27,28].

In terms of care practices, resources corresponding to the explanatory model of the popular subsystem were noted, especially with the use of herbs and fruits to prepare home remedies, baths and showers, as seen in the following statements:

I just gave a home remedy. I gave a piece of paper. It is the pineapple, the pineapple syrup that my mother also makes; the ichneumon banana syrup she makes, and it is syrup ... the sheet is ... lemongrass, black maria, and quioiô. That is what you can do to fight. (E8)

The neighbors came, and she was given a leaf bath [quioiô] *and the remedy* [dipirone] *until she came back to us. (E6)*

Table 2. Characteristics of the children. Salvador-BA, Mar. 2013 - Jan. 2014.

Participant	Age*	Gender	Health problem	Health insurance	Service type	Routine visit	Presenting problem
E1	2 years	M	No	No	Public	No	Febrile Seizure
E2	11 months	F	No	No	Public	Yes	Febrile Seizure
E3	7 years	F	Yes (asthma)	No	Public	Yes	Asthma Attack
E4	3 years	M	No	No	Private	No	Burn
E5	1 year	F	No	Yes	Private	No	High Fever
E6	1 year	F	No	No	Both	Yes	Febrile Seizure
E7	1 year	F	No	Yes	Private	Yes	Febrile Seizure
E8	6 years	M	Yes (asthma)	No	Public	No	Asthma Attack
E9	10 months	M	No	No	Public Private	No	Dehydrating for Diarrhea and Vomiting
E10	3 years	M	No	No	Public	Yes	Febrile Seizure
E11	7 years	M	No	No	Public	Yes	High Fever
E12	1 year	M	No	No		Yes	High Fever

* Age at which the child presented with the characterized urgency/emergency.

The terms *neighbors helped* and *the people taught me* reveal, as in the study of Budó et al.[23], strengthening of family care by a social support network comprising relatives, friends and neighbors. This phenomenon is a hallmark of the informal subsystem, described by Kleinman as the "popular subsystem" composed of individuals, families and the social arena in which decisions are made about the disease, care and treatment guidance[6]. This network is considered by Gutierrez and Minayo[22] as a valuable resource and the main source of support, especially among poor families.

In addition to the natural resources used in the familiar and popular subsystem[29], self-medication and practices concerning the professional subsystem, such as the use of prescribed medications, were also described. Therefore, there was reconciliation between the resources of the formal and informal care systems, as evidenced in the study by Maliska and Padilha[30]. The medications used included bronchodilators, antibiotics, painkillers and anti-inflammatory agents, especially the informal care system, and this is similar to the results of a study by Souza[31]:

I used a puffer that the doctor himself taught me how to use. In addition to this device that I use when she has this issue, I make her tea ... (E3)

For medicine, I gave her dipyrone and homemade teas. Holy grass tea, lemon balm, fennel, which could be the right vapors? (E5)

As in other studies[25,29,31], there is evidence of a cultural influence related to the use of tea and manufactured non-prescription drugs[23,25,29,31]; this is especially true for dipyrone, which is also highlighted by Pereira et al.[32] as a drug of choice for controlling fever because it is freely traded in Latin America, Europe, Africa and Asia and is thus easily available to most of the population[32]. Self medication might even stem from the difficulty of obtaining assistance in the professional subsystem[33].

In addition to using natural remedies and manufactured drugs, this study also highlighted the use of physical steps to decrease a child's temperature, for example, bathing with alcohol or immersion in cold water:

The other day, he had a seizure at night. Because I have had experience with a girl who was given a bath with alcohol, the alcohol was already purchased and left at home. [...] *Then, I did the same thing. (E1)*

We put the child in cold water. We actually put the child inside the barrel ... after adding cold water and placing a damp cloth in the barrel. (E2)

Such treatments are considered[34] ineffective because they do not alter the hypothalamic set point and hence do not act in the pathophysiological mechanism of fever. However, as explained Arcanjo et al.[33], behavior in sickness relates to cultural values, and the choice of treatment demonstrates the expression of the population and is characterized by the use of physical means, defined by Gutierrez and Minayo[22] as a culturally crystallized element. As a popular practice inhe-

rent to the subsystem, these methods are used both in maroon communities and by other individuals.

In such care strategies, "massage" is used and is also referred to by Neves and Nunes[35] as adjunctive therapy in the informal subsystem of health care:

[...] *My mother took her (the child) and began beating her ... she began to massage her (the child's) chest ... Then, the house began to fill, the massage continued, and then she started to return to normal* .... (E7)

Religiosity appears as a background, so that mothers look to God upon the occurrence of disease in their children, seeking divine guidance about how they should proceed for the resolution of the problem, as seen in this interview:

And I pray; I am still praying and asking for guidance from God, a light ... (E1)

According to Arcanjo et al.[33], recent surveys show the link between health, beliefs and spiritual practices, including prayer, the search for religious services and faith in God. In this sense, seeking the religious sphere is a common strategy in the informal subsystem and is not particular to mothers in this study because this strategy has been identified by other authors[23,25,29,33].

In addition to being the place of delivery of care, the family is where a sick person is initially managed and valued[29]. As highlighted by Kleinman[5], it is in this area that decisions are made about when to seek other subsystems.

As Rati et al.[36] observed, we also noted that the mothers in this study were limited in caring for their children, and the search for institutionalized care in the formal system occurred, especially when the responses to informal subsystem resources were not positive. This phenomenon has been found in other studies[23,25,31]:

[...] *I took care of her at home; when it persisted and did not yield any result or with medication, then I took* [...]. (E5)

In this study, two of the participants revealed that care was provided only in the informal subsystem. Three participants appealed to the formal subsystem while paying appropriate attention to the informal subsystem. In one case (burn), the child directly entered the formal subsystem, and the remaining six participants completed the TI in the formal subsystem, after an inadequate response from the informal subsystem.

Formal subsystem: pilgrimage in search for care

The professional subsystem consists of scientific medicine[5], is characterized by organized healing professions and formal learning, is legally recognized and is represented in Western societies as biomedical knowledge[37].

According to Rati et al.[36], the institution of this subsystem depends on factors such as resolution, quality, specificity in pediatrics, accessibility, geographical location, positive experiences in the past and paid host. However, Marques et al.[28] noted that in the poorest strata, such as this community case study, primary care services are frequently used as a regular source of health care.

Similar to the study[28] conducted in a quilombo of Minas Gerais, it was observed that the institution representing the nearest formal system of the Maroon community consisted of basic health care services, and this institution was the main source of heat care for children in the event of injuries, including urgent/emergency cases.

It should be noted that the Family Health Unit (FHU) had not yet been established in the maroon community of this study, and the TIs of six participants, for whom the most frequent search for health institutions was in another location, is evidenced in the following interviews:

At that time, one had not been seen yet. [...] *We took him to Salvador*. (E11)

"However, even after the establishment of USF quilombo, this study showed that in constructing Tis for their children in urgent/emergency situations, mothers looked for help in another location":

I was not at the local clinic, no. I went to Salvador instead. I prefer to take savior. You arrive at the station ... it is not every day that one finds a doctor, right? (E4)

This statement reflects the mother's preference to move her child to another location, showing that the population considered care provided in the community as poor, especially with regard to assistance in emergencies and pediatric emergencies. Furthermore, the operation of the local clinic have hours that are limited to the daytime. Thus, this service is unable to meet the needs of night-time injuries, and people need to resort to the mainland for professional care, as voiced by one of the participants:

(Did you take your child to the post?) *No, because it was early, and the post was closed here.* (E7)

Some mothers (N = 3) showed that the onset of this subsystem in a TI was due to primary

care from the USF. In one case, the participant said the station provided useful assistance. In two other cases, the interviewees reported that they received no assistance from the USF and were told to go to the mainland:

I went to the post but, at the same time, they sent her to Salvador. (E3)

Primary care assistance in cases of urgency and emergency is legally established[38]; therefore, this level of care is characterized as a gateway to the Unified Health System (SUS) and as a component of the health care network of the State of Emergency and Emergency Systems that should offer the first service to patients with acute and/or adequate transportation to a hierarchical health service.

As noted in the study of a maroon community by Marques et al.[28], when mothers are instructed to report to another service, it is considered to be a socioeconomic difficulty, and the vulnerability of this population to obtain primary care are large, depicting the perverse wickedness that the Maroons are submitted to.

This experience breaks the link that should be established between the health care user and this level of health care provided. The bond breakage causes the population to discredit the service, as highlighted by the research of Lago et al.[39], who describe the TI of users seeking assistance in an emergency department (ED) and the reasons behind this occurrence. The authors showed that 82.6% of participants did not address the core network because they have experienced situations in which they did not receive care for their own medical problem(s) at this level of care. A similar opinion was voiced by one of the mothers in this study, who discredited the health center and considered it as a place only for the realization of "basic advice":

What is there must come down. There is nothing. It is a place just for basic queries. It is to obtain a referral, because no relief is ever given. If you come to the station, you die here. I do not take the same position. If it is a serious case, I do not go there. I'll be straight forward with my opinion, because when arriving there, they send you away, send go outside anyway. (E2)

In this perspective, the place chosen for treatment reflects the urgency/emergency and is the first patient option due to the lack of confidence in the primary care system, as noted in other studies[36,39]. It should be noted that access of this population to urgent and emergency services requires users to travel great distances because these services are located far from the community.

In pursuit of an ED, study participants revealed that they had to provide for their own means transport to the mainland because there was no connection between primary and emergency care for these cases:

You must go by boat here, you have to take a boat. (E8)

Some reports highlighted the difficulties encountered in the transport of sick children:

On Wednesday, it was back again, the fever, the moaning. So I said 'I will not wait for a seizure'. My brother was taking me to Botelho. I was walking, braving the mud and all, to take the boat to the hospital. (E1)

This statement confirms the proposition made by Guerin et al.[40] that to access health services and resolve health problems, the user takes many paths and creates the most appropriate TI. However, as analyzed in this report, in the most appropriate TI design, these people are often exposed to inhuman conditions in order to access the institutions of the formal subsystem and ensure the necessary care.

It must be noted that shuttle islanders have fewer difficulties because in some communities that are isolated by a river or the sea, such as the community in this study, rescue transport consists of ambulanchas, which are aquatic vehicles for the provision pre-hospital care. A person can request a ride by number 192 of the Emergency Mobile Emergency Service (EMES), and this can be done either by the maroons or by the health center professionals. In this study, we noted that neither triggered the ambulancha; therefore, in all cases, the participants used the private boats of community residents:

[...] *I paid to go. For the boat and car.* (E6)

The interview above shows that the mother paid for both the crossing and the inland transport to the US when they reached the continent; at no time in the itinerary was EMES requested. Multiple reasons were cited for not requesting an ambulancha, especially the lack of response to the calls:

Because I remembered not seeing [an ambulancha]? What I found at the time...I had a boat available, I thought it best to opt for it. Because it is a protocol [to call the ambulance], *ok?* (E12)

If you expect the ambulance here, you die. (E2)

These statements demonstrate the difficulty experienced in the TIs of these people regarding access to emergency transport. This is not restricted to the maroon community of this study was and has also been cited by other autors[8,41].

Arriving on the continent was not necessarily synonymous with a resolution; thus, in some ca-

ses, the suffering experienced by these mothers did not cease, and the search for care became a pilgrimage within the formal subsystem:

[...] *spent time in State General Hospital SGH thinking I was being attended to, but I was not. Then, I was talking and she* [bus passenger] *saw him moaning. Then, she did so* [...] *Look, past the Itapuã post* (UPA)*, there is a station that meets and serves people well and gives all tests. I say, is it? I'm already here, I'm going to jump. I thanked her and went down. I went there, to the pro Itapuã post. I arrived at night. That's when he was hospitalized.* (E1)

The pilgrimage to seek care is characterized by Deslandes[42] as one of the user forms of exposure to institutional violence. In this sense, we glimpse that this violence is not only witnessed in the arduous journeys undertaken by members of the maroon community to access the formal subsystem but also seen in the treatment given by the professionals of this subsystem, as translated in the following statement:

[...] *When one will suit us all ... is very aggressive with us, does not have the patience to refer us to the right person, calmly, sometimes not even giving a shit, right?* (E11)

In this report, professionals have a clear disregard for caring for people with low socioeconomic status, which characterizes health inequity. With similar results, Sisson et al.[43] demonstrated in their study that, among other things, dissatisfaction was related to the quality of care provided by professionals such as receptionists and was also related to the lack of individual and special attention given to the patient.

A service is considered good that responds to user demands, which a determinant of satisfaction with the service. To frequently achieve satisfaction, users have to turn to other institutions, as seen in the following statement:

Then, the doctor also treated me very well, you know what is very well? He did take it; he took the X-ray. That's when he saw that he had a respiratory infection. (E1)

Given the abovementioned details, we note that to achieve the desired care in this subsystem, mothers had to go through multiple paths, which were characterized as a pilgrimage for health services, occurred early on the island and were only completed after attempts to seek care on the continent.

As Ceccim et al.[44] noted, the creation of the SUS represented the extension of "public access to the actions and health services needed by individuals." We agree, in part, with this statement because the difficulties imposed by access are increased, either by the level of care of these services or by the conduct of the professionals of this subsystem, which sometimes make the paths to achieve care tortuous and therefore cruel.

As Guerin et al.[40] noted, we believe that the pilgrimage mothers who seek to resolve the health issues of their children bring implications of the health system in their itineraries into focus, demonstrating the resoluteness and what "escapes" these services and thus highlighting aspects requiring change to achieve comprehensive care and the resolution of health problems.

Our findings reaffirm that the black population, especially the maroon community, is vulnerable. The question of access to and use of health services was reported by Silva et al.[41]. The analysis of TIs for urgency/emergency situations in this community highlights the experiences and trajectories of these people, which may lead to the formation and development of individual projects within this field[3], and is characterized as a study with the potential to spur governmental action, thus contributing to overcoming the demographic and epidemiological invisibility of this population[45].

Conclusion

This study showed that in urgency/emergency situations of children in a maroon community, the construction of the therapeutic itinerary takes place both in the informal formal subsystems of health care.

Care began in the popular subsystem with the family and social support network. As a feature of this subsystem, resources of daily life were exploited, with evidence for the use of teas, home remedies, massage and self-medication, all demonstrating the strong cultural mark of this community.

The search for help within the professional subsystem occurred after careful attempts to resolve the health problem in the popular subsystem. This act was seen as a true pilgrimage to health institutions and was characterized by the difficulty of access of the maroon community to the formal health care system. The pilgrimage began in the community with the search for basic services, which proved ineffective in providing assistance in these cases. The pilgrimage continued to other locations, where access to health services was revealed as difficult, and the inequities in health care experienced by the maroon community

when they require professional assistance were highlighted.

Determining the therapeutic itinerary of this population reveals more than the trajectory of seeking care, because mothers were allowed to share their experiences and express the difficulties faced when they required access to health services. This process unveiled the lack of resolution and welcoming in the professional subsystem, either on their own island or on the mainland.

These results indicate that the maroon population does not have the benefit of full health care and could serve as a basis for formulating public policies to guarantee such access. This access includes the effective implementation of primary care as a gateway and the proper functioning of ambulances to ensure resolution and completeness of SUS.

Collaborations

SMC Siqueira, VS Jesus and CL Camargo participated in all stages of the construction of this article.

References

1. Gerhardt TE. Itinerários terapêuticos em situações de pobreza: diversidade e pluralidade. *Cad Saude Publica* 2006; 22(11):2449-2463.
2. Thaines GHLS, Bellato R, Faria APS, Araújo LFS. A busca por cuidado empreendida por usuário com diabetes mellitus - um convite à reflexão sobre a integralidade em saúde. *Texto Contexto Enferm* 2009; 18(1):57-66.
3. Alves PCB, Souza IMA. Escolha e avaliação de tratamento para problemas de saúde: considerações sobre o itinerário terapêutico. In: Rabelo MCM, Alves PCB, Souza IMA. *Experiência de doença e narrativa*. Rio de Janeiro: Fiocruz; 1999. p. 125-138.
4. Geertz CA. *A interpretação das culturas*. Rio de Janeiro: LTC; 1989.
5. Kleinman A. Concepts and a Model for the Comparision of Medical Systems as Cultural Systems. *Soc Sci Med* 1978; 12(2B):85-93.
6. Kleinman A, Sung LH. Why do indigenous practitioners Successfully heal? *Social Science & Medicine* 1979; 13(1):7-26.
7. Secretaria de Políticas de Promoção da Igualdade Racial (SEPPIR). *Programa Brasil Quilombola: diagnóstico de ações realizadas*. Brasília: SEPPIR; 2012.
8. Silva DO, Guerrero AFH, Guerrero CH, Toledo LM. A rede de causalidade da insegurança alimentar e nutricional de comunidades quilombolas com a construção da rodovia BR-163, Pará, Brasil. *Rev. Nutr.* 2008; 21(Supl. 0):83-97.
9. Brasil. Resolução nº 1451, de 17 de março de 1995. Define critério do plantão médico de urgência e emergência. *Diário Oficial da União* 1995; 17 mar.
10. World Health Organization (WHO). *World report on child injury prevention*. Geneva: WHO; 2008.
11. Pinho PA, Pereira PPG. Itinerários terapêuticos: trajetórias entrecruzadas na busca por cuidados. *Interface (Botucatu)* 2012; 16(41):435-447.
12. Brasil. Lei nº 8.069 de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e dá outras providências. *Diário Oficial da União* 1990; 13 jul.
13. Polit DF, Hungler BP. *Fundamentos de pesquisa em enfermagem*. Porto Alegre: Artes Médicas; 1995.
14. Scarparo AF, Laus AM, Azevedo ALCS, Freitas MRI, Gabriel CS, Chaves LDP. Reflexões sobre o uso da técnica Delphi em pesquisas na enfermagem. *Rev Rene* 2012; 13(1):242-251.
15. Atenção Primária à Saúde Santa Marcelina. *Manual de acolhimento com classificação de risco em assistência médica ambulatorial*; 2008. [acessado 2013 mar 10]. Disponível em: http://www.aps.santamarcelina.org/aps/Pdf/normas/Manual_Acolhimento.pdf
16. Brasil. Resolução nº 466 de 12 de dezembro de 2012. Sobre pesquisas envolvendo seres humanos. *Diário Oficial da União* 2013; 13 jun.
17. Bardin L. *Análise de conteúdo*. Lisboa/Portugal: Edições 70; 2010.
18. Secretaria de Assuntos Estratégicos – SAE. *Veja diferenças entre conceitos que definem classes sociais no Brasil*; 2013. [acessado 2014 set 5]. Disponível em: http://www.sae.gov.br/site/?p=17821
19. Programa das Nações Unidas para o Desenvolvimento – PNUD. *Atlas do Desenvolvimento Humano dos Municípios;* 2013. [acessado 2014 set 5]. Disponível em: http://www.pnud.org.br/IDH/Default.aspx?indiceAccordion=1&li=li_AtlasMunicipios
20. Kleinman A, Geest SVD. 'Care' in health care: remaking the moral world of medicine. *Medische Antropologie* 2009; 21(1):159-168.
21. Budó MLD. A família rural e os cuidados em saúde. In: Elsen I, Marcon SS, Silva MRS. *O viver em família e sua interface com a saúde e a doença*. Maringá: EdUEM; 2004. p.77-96.
22. Gutierrez DMD, Minayo MCS. Produção de conhecimento sobre cuidados da saúde no âmbito da família. *Cien Saude Colet* 2010; 15(Supl. 1):1497-1508.
23. Budó MLD, Resta DG, Denardin JM, Ressel LB, Borges ZN. Práticas de cuidado em relação à dor – a cultura e as alternativas populares. *Esc Anna Nery* 2008; 12(1):90-96.
24. Fundato CT, Petrilli AS, Dias CG, Gutiérrez MGR. Itinerário terapêutico de adolescentes e adultos jovens com osteossarcoma. *Rev Bras de Cancerologia* 2012; 58(2):197-208.
25. Trad LAB, Tavares JSC, Soares CS, Ripardo RC. Itinerários terapêuticos face à hipertensão arterial em famílias de classe popular. *Cad Saude Publica* 2010; 26(4):797-806.
26. Leite SN, Vasconcellos MPC. Negociando fronteiras entre culturas, doenças e tratamentos no cotidiano familiar. *História, Ciências, Saúde – Manguinhos* 2006; 13(1):113-128.
27. Oliveira BRG, Collet N, Mello DF, Lima RAG. The therapeutic journey of families of children with respiratory diseases in the public health service. *Rev Latino-Am Enferm* [serial on the Internet]. 2012 May-Jun [cited 2014 ago 15]; 20(3):[about 8 p.]. Avaliable from: http://www.scielo.br/pdf/rlae/v20n3/a05v20n3.pdf
28. Marques AS, Freitas DA, Leão CDA, Oliveira SKM, Pereira MM, Caldeira AP. Atenção Primária e saúde materno-infantil: a percepção de cuidadores em uma comunidade rural quilombola. *Cien Saude Colet* 2014; 19(2):365-371.
29. Rosa LM, Radünz V. Itinerário terapêutico no câncer de mama: uma contribuição para o cuidado de enfermagem. *Rev Enferm UERJ* 2013; 21(1):84-89.
30. Maliska ICA, Padilha MICS. AIDS: a experiência da doença e a construção do itinerário terapêutico. *Rev Eletrônica Enferm* [periódico na Internet]. 2007 Set-Dez [acessado 2014 ago 10]; 9(3):[cerca de 12 p.]. Disponível em: http://www.fen.ufg.br/revista/v9/n3/v9n3a09.htm
31. Souza AC. *Como manda o figurino: a medicalização das práticas de terapêuticas entre idosos de Porto Alegre* [dissertação]. Porto Alegre: Universidade Federal do Rio Grande do Sul; 2005.
32. Pereira GL, Dagostini JM, Dal Pizzol Tda S. Alternating antipyretics in the treatment of fever in children: a systematic review of randomized clinical trials. *J Pediatr* 2012; 88(4):289-296.

33. Arcanjo GN, Silva RM, Nations MK. Saber popular sobre dores nas costas em mulheres nordestinas. *Cien Saude Colet* 2007; 12(2):389-397.
34. Murahovschi J. Fever in pediatric office practice. *J Pediatr* 2003; 79(Supl.1):55-64.
35. Neves RF, Nunes MO. Da legitimação a (res)significação: o itinerário terapêutico de trabalhadores com LER/DORT. *Cien Saude Colet* 2010; 15(1):211-220.
36. Rati RMS, Goulart LMHF, Alvim CG, Mota JAC. "Criança não pode esperar": a busca de serviço de urgência e emergência por mães e suas crianças em condições não urgentes. *Cien Saude Colet* 2013; 18(12):3663-3672.
37. Amadigi FR, Gonçalves ER, Fertonani HP, Bertoncini JH, Santos SMA. A antropologia como ferramenta para compreender as práticas de saúde nos diferentes contextos da vida humana. *Rev Min Enferm* 2009; 13(1):131-138.
38. Portaria n.º 2048/GM de 5 de novembro de 2002. Aprova o Regulamento Técnico dos Sistemas Estaduais de Urgência e Emergência. *Diário Oficial da União* 2002; 12 nov.
39. Lago LM, Martins JJ, Schneider DG, Barra DCC, Nascimento ERP, Albuquerque GL, Erdmann AL. Itinerario terapéutico de los usuarios de una urgencia hospitalar. *Cien Saude Colet* 2010; 15(Supl. 1):1283-1291.
40. Guerin GD, Rossoni E, Bueno D. Itinerários terapêuticos de usuários de medicamentos de uma unidade de Estratégia de Saúde da Família. *Cien Saude Colet* 2012; 17(11):3003-3010.
41. Silva MJG, Lima FSS, Hamann EM. Uso dos Serviços Públicos de Saúde para DST/ HIV/aids por Comunidades Remanescentes de Quilombos no Brasil. *Saúde Soc. São Paulo* 2010; 19(Supl. 2):109-120.
42. Deslandes SF. *Frágeis deuses: profissionais da emergência entre os danos da violência e a recriação da vida*. Rio de Janeiro: Fiocruz; 2002.
43. Sisson MC, Oliveira MC, Conill EM, Pires D, Boing AF, Fertonani HP. Satisfação dos usuários na utilização de serviços públicos e privados de saúde em itinerários terapêuticos no sul do Brasil. *Interface (Botucatu)* 2011; 15(36):123-136.
44. Ceccim RB, Armani TB, Oliveira DLLC, Bilibio LF, Moraes M, Santos ND. Imaginários da formação em saúde no Brasil e os horizontes da regulação em saúde suplementar. *Cien Saude Colet* 2008; 13(5):1567-1578.
45. Guerrero AFH, Silva DO, Toledo LM, Guerrero JCH, Teixeira P. Mortalidade infantil em remanescentes de quilombos do munícipio de Santarém - Pará, Brasil. *Saúde Soc. São Paulo* 2007; 16(2):103-110.

Article submitted 29/09/2014
Approved 27/05/2015
Final version submitted 29/05/2015