

Together in the Circle: Dialogues of Life and Comprehensive Care for Women in Primary Care in a Riverside Community

Juntas no Círculo: Diálogos de Vida e Cuidado Integral para as Mulheres na Atenção Primária em uma Comunidade Ribeirinha
Juntas en el Círculo: Diálogos de Vida y Cuidado Integral para las Mujeres en la Atención Primaria en una Comunidad Ribereña

RESUMO

Objetivo: Analisar as percepções de mulheres ribeirinhas sobre saúde, autocuidado e acesso à Atenção Primária em Saúde, a fim de subsidiar estratégias de cuidado integral que articulem saberes populares e práticas médicas. **Método:** Estudo exploratório qualitativo com sete mulheres de uma comunidade ribeirinha, utilizando a técnica de grupo focal. Os dados foram analisados pelo software IRAMUTEQ por meio da Classificação Hierárquica Descendente. **Resultados:** A análise evidenciou barreiras de acesso ao sistema de saúde (demora em exames, rotatividade profissional), a sobrecarga emocional do cuidado familiar e vivências de violência. Os discursos apontaram a necessidade de redes de apoio institucional e comunitário. **Conclusão:** As mulheres ribeirinhas vivem um ciclo de vulnerabilidade por desigualdades de gênero e fragilidades da Atenção Primária, usando o apoio comunitário como resistência. É crucial a criação de políticas públicas intersetoriais que valorizem suas vozes e integrem saúde, gênero e cultura para um cuidado integral.

DESCRIPTORES: Atenção Primária à Saúde; Saúde da Mulher; Pesquisa Qualitativa; Vulnerabilidade Social.

ABSTRACT

Objective: To analyze the perceptions of riverside women about health, self-care, and access to Primary Health Care, in order to support the creation of comprehensive care strategies that articulate popular knowledge and medical practices. **Method:** An exploratory qualitative study with seven women from a riverside community, using the focus group technique. The data were analyzed by the IRAMUTEQ software through Descending Hierarchical Classification. **Results:** The analysis showed barriers to accessing the health system (delays in exams, professional turnover), the emotional overload of family care, and experiences of violence. The discourses pointed to the need for institutional and community support networks. **Conclusion:** Riverside women live in a cycle of vulnerability due to gender inequalities and weaknesses in Primary Care, using community support as a form of resistance. The creation of intersectoral public policies that value their voices and integrate health, gender, and culture for comprehensive care is crucial. **DESCRIPTORS:** Primary Health Care; Women's Health; Qualitative Research; Social Vulnerability.

RESUMEN

Objetivo: Analizar las percepciones de mujeres ribereñas sobre salud, autocuidado y acceso a la Atención Primaria de Salud, con el fin de subsidiar estrategias de cuidado integral que articulen saberes populares y prácticas médicas. **Método:** Estudio exploratorio cualitativo con siete mujeres de una comunidad ribereña, utilizando la técnica de grupo focal. Los datos fueron analizados por el software IRAMUTEQ a través de la Clasificación Jerárquica Descendente. **Resultados:** El análisis evidenció barreras de acceso al sistema de salud (retraso en exámenes, rotación profesional), la sobrecarga emocional del cuidado familiar y vivencias de violencia. Los discursos señalaron la necesidad de redes de apoyo institucional y comunitario. **Conclusión:** Las mujeres ribereñas viven un ciclo de vulnerabilidad por desigualdades de género y fragilidades de la Atención Primaria, usando el apoyo comunitario como resistencia. Es crucial la creación de políticas públicas intersectoriales que valoren sus voces e integren salud, género y cultura para un cuidado integral. **DESCRIPTORES:** Atención Primaria de Salud; Salud de la Mujer; Investigación Cualitativa; Vulnerabilidad Social.

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INTRODUCTION

Primary Health Care (PHC) is widely recognized as the fundamental pillar for promoting equity and universal access to health services, constituting the main gateway to the Unified Health System (SUS) since the promulgation of the Federal Constitution of 1988⁽¹⁾. According to the National Primary Care Policy (PNAB), PHC is organized as the basis of the health system, guided by the principles of comprehensiveness, equity, and decentralization⁽²⁻³⁾.

Despite the progress achieved, structural and cultural challenges persist, especially in rural and remote areas, where geographical barriers and social inequalities limit the effectiveness of care. In these contexts, women face multiple vulnerabilities, ranging from difficulties in physical access to services to the invisibility of their specific demands⁽⁴⁾. Policies such as "Comprehensive Health Care for Rural and Forest Populations"⁽⁵⁾ and "Comprehensive Women's Health Care"⁽⁶⁾ seek to reduce these inequalities, but studies indicate that access remains fragmented and insensitive to local cultural particularities⁽⁷⁾.

Historically, women's health policies have focused on the reproductive cycle, neglecting dimensions such as mental health, autonomy, and living conditions. This reductionist approach is still reflected in PHC practices, which do not always recognize women's leading role or the reproduc-

tive workload to which women are subjected. In vulnerable areas, these gender inequalities are compounded by infrastructure limitations, increasing the risk of physical and emotional illness.

Another central element is the often tense coexistence between traditional knowledge and the biomedical model. In rural communities, ancestral practices—such as the use of medicinal plants and healing rituals—continue to play an important role in everyday care, but are often disregarded by formal health services⁽⁹⁾. This disconnect contributes to mistrust of the institutionalized system, weakening the bond between professionals and the community.

Given this scenario, it is essential to value the dialogue between popular knowledge and biomedical practices, recognizing the legitimacy of both in the construction of comprehensive and culturally sensitive PHC⁽¹⁰⁾. Such an approach is aligned with the principles of equity and social justice that guide the SUS, while promoting the autonomy of women as protagonists of their own care.

The creation of spaces for collective listening and exchange of experiences has proven to be an effective strategy for integrating different types of knowledge, allowing women to share perceptions, identify barriers to access, and jointly build alternatives for coping. In addition to promoting the production of relevant qualitative data, these spaces act as instruments

of empowerment, strengthening community ties and promoting critical reflections on care⁽¹¹⁾.

Therefore, understanding how riverside women perceive their health, their modes of care, and the difficulties they face in PHC is essential to support public policies that are more sensitive to the local reality. At the same time, it provides an opportunity to value women's narratives that have historically been invisible in institutional health spaces⁽¹²⁾.

Given the above, the general objective of this study is to analyze the perceptions and experiences of riverside women regarding health, self-care, and access to primary health care through focus groups, in order to support the development of comprehensive care strategies that combine popular knowledge and medical practices.

METHOD

The study population consisted of riverside women aged 18 years or older, residing in the community of Fazendinha, located in the municipality of Bragança (PA), which has approximately 130,000 inhabitants and a diversified economy that combines traditional activities, such as fishing and agriculture, with informal and precarious occupations.

In the sample planning, the geographical domain was limited to the community of Fazendinha, located approximately 5 km from the munic-

ipality's headquarters. Under these conditions, several communities face significant challenges in accessing basic services, including health and sanitation⁽¹³⁾.

Specifically, the community of Fazendinha, located on the banks of the Caeté River, maintains a local economy based on the artisanal production of clay objects, such as tiles, bricks, and household utensils, a traditional practice passed down through generations. This social and economic reality contextualizes the experiences of women in the community and underpins the relevance of the proposed research. In addition to difficulties in accessing health and sanitation services, women face situations of domestic and gender-based violence, which directly impact their physical and emotional health.

The study included seven women aged 18 years or older, residing in the Fazendinha community, in a situation of social vulnerability, characterized by low income, limited access to basic services, and/or a history of gender-based or domestic violence. Those who did not fully participate in the planned activities or who refused to sign the Free and Informed Consent Form (FICF) were excluded.

The study was approved by the Research Ethics Committee of ITPAC Porto Nacional – Instituto Tocantinense Presidente Antônio Carlos Porto S.A., under protocol number 85786925.0.0000.8075. To ensure confidentiality, participants were given pseudonyms, used in all stages of the study, to prevent their identification.

The data collected were kept confidential, stored in a secure environment, and accessible only to the research team. All participants were duly informed about the objectives, risks, and benefits of the research and expressed their agreement by signing the TCLE before inclusion in the study.

The study design was exploratory and observational, with a quantitative-qualitative approach, oriented toward the constitution of knowledge from an ontological perspective. To this end, various theoretical references were used, as well as the focus group technique, which allowed for the creation of a space for collective dialogue and critical reflection⁽¹⁵⁾.

Four meetings were held with women from the Fazendinha community, guided by previously prepared questions. The first meeting addressed mental health and emotional well-being, with the central question: "What most affects your emotional well-being?" The second meeting discussed sexual and reproductive health, guided by the question: "Are there difficulties in performing routine gynecological exams, such as preventive exams?" The third meeting addressed the issue of gender violence, with the question: "Do women feel safe to talk about situations of violence?" Finally, the fourth meeting addressed access to health services, based on the question: "What are the main difficulties in accessing medical care in the community?"

All meetings were mediated in a way that encouraged active participation and collective construction of meaning, valuing the knowledge and experiences of the participants. The data collection process was conducted with rigor and sensitivity, being recorded through audio recordings, photographs, and field notes. The recordings were made only with the consent of the participants, ensuring confidentiality, security, and exclusive use for scientific purposes. This care was taken to ensure the accuracy and reliability of the information and, at the same time, to preserve the women's identities.

The data analysis combined quantitative and qualitative procedures. Sociodemographic information was organized in Microsoft Excel® soft-

ware and subjected to descriptive statistics, with the results presented in tables. Textual data from the meetings were processed in IRAMUTEQ (Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires) software, version 0.8 alpha 2, which enables advanced lexicographic analysis. This resource was used in content analysis, including verification of keyword frequency, construction of word clouds, similarity analysis, and Descending Hierarchical Classification (DHC), allowing the grouping of texts according to vocabulary similarity.

RESULTS

Seven women participated in the focus group, with a mean age of 40.3 years (± 7.2). Regarding marital status, 42.9% were married and 28.6% were single; 14.3% were divorced and 14.3% were in a stable relationship. The number of children ranged from 0 to 3, with 42.9% having two children.

Regarding education, 57.1% had completed high school; 14.3% had completed higher education, 14.3% had incomplete higher education, and 14.3% had incomplete elementary education. Regarding occupation, 42.9% had formal paid work, 28.6% had informal activities, and 14.3% were unemployed or performed unpaid domestic work.

The monthly income was up to one minimum wage for 57.1% of the participants, between one and two minimum wages for 14.3%, and above three minimum wages for 28.6%. All reported regular access to the Unified Health System (SUS) (Table 01).

Table 1: Distribution of sociodemographic characteristics of participants (n=7)

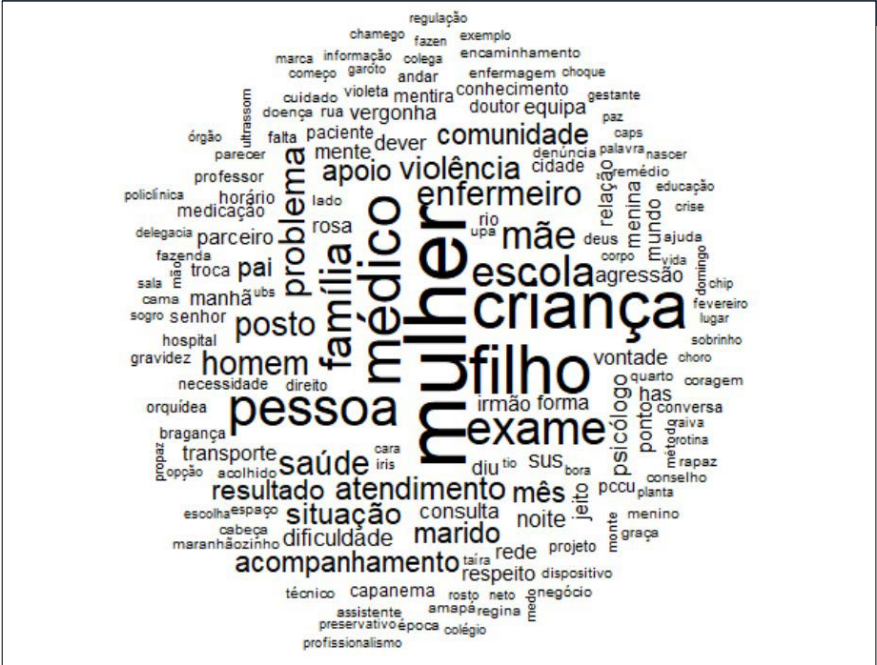
Variable	Category	n	%
Age (years)	Mean ± SD	—	40,3 ± 7,2
Marital status	Married	3	42,9%
	Single	2	28,6%
	Divorced	1	14,3%
	Common-law marriage	1	14,3%
Number of children	0	1	14,3%
	1	1	14,3%
	2	3	42,9%
	3	2	28,6%
Education	Incomplete elementary school	1	14,3%
	High school completed	4	57,1%
	Incomplete higher education	1	14,3%
	Complete higher education	1	14,3%
Main occupation	Formal employment	3	42,9%
	Informal work	2	28,6%
	Unpaid domestic work	1	14,3%
	Unemployed	1	14,3%
Monthly income	≤1 minimum wage	4	57,1%
	1–2 SM	1	14,3%
	>3 SM	2	28,6%
Access to SUS	Yes	7	100%

*SM = Minimum wage in Brazil; SD = Standard deviation.

Word Frequency and Word Cloud

Frequency analysis of the corpus revealed that the most recurrent terms were “woman” (50 occurrences), “son” (38), “child” (37), “doctor” (32), “house” (32), “person” (29), “exam” (26), “family” (22), “school” (22), “unit” (22), “mother” (19), “nurse” (17), and “health” (16). Other semantically relevant terms included “situation” (18), “problem” (18), “support” (≈17), “violence” (≈15), “community” (≈15), “care” (≈14), and “psychologist” (≈13). The word cloud (Figure 1) reinforces these results, visually highlighting the greater emphasis on “woman,” “child,” “doctor,” “exam,” and “person” (Figure 1).

Figure 1: Word cloud



Similarity Analysis

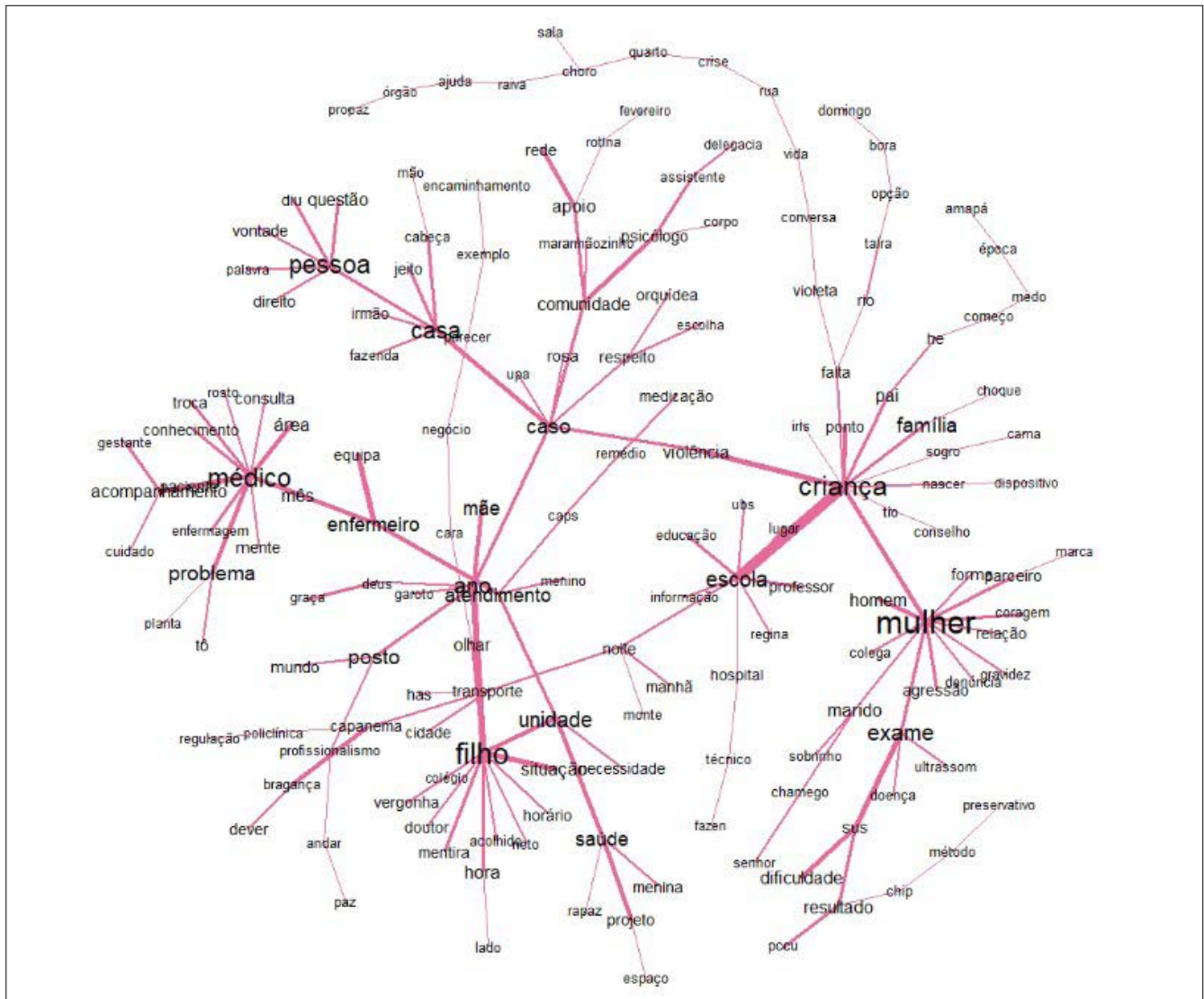
The similarity analysis showed that the discourse is organized around strongly interconnected central nodes. The terms “woman,” “child,” “son,” “doctor,” “home,” “person,” “school,” “exam,” and “family” constitute the main nodes of the network, from which significant semantic associations are distributed. Similarity analysis, as a technique based on graph theory, allows us to identify the strength of occurrence between words, revealing how terms are inter-

connected and enabling the visualization of the structure and organization of discourse.

The term “woman” is related to words such as man, husband, exam, and aggression, highlighting connections with social gender roles, experiences of violence, and specific health demands. The core “child” is linked to school, family, father, and teacher, emphasizing the centrality of school life and the child care network in the statements. In the case of the term “child,” there is a direct association

with mother, unity, care, and health, indicating the overlap between motherhood and access to health services. In the services axis, “doctor” is related to nurse, clinic, and problem, highlighting both the relevance of the health team and the challenges experienced in relation to the system. Finally, the “home” nucleus connects to the person and community, representing the domestic and community space as integrated dimensions of daily life, essential for understanding care practices (Figure 02).

Figura 2. Rede de similitude do discurso: núcleos centrais e associações semânticas.



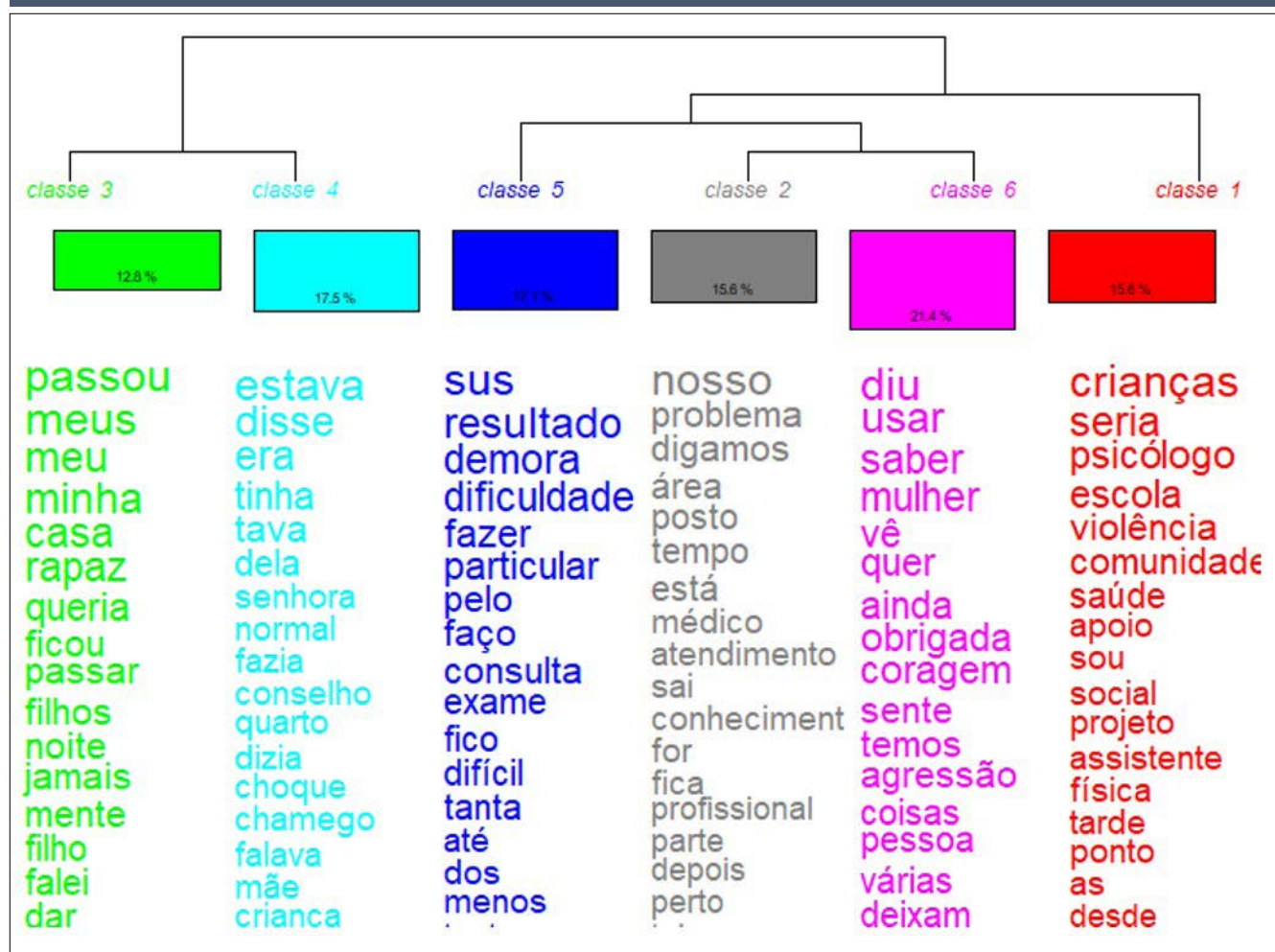
Descending Hierarchical Classification (DHC)

The corpus analyzed by the IRaMuTeQ software gathered reports from women about their perceptions of health, self-care, violence, and access to Primary Health Care. To conduct the focus group, trigger ques-

tions were used related to medical follow-up during pregnancy, barriers to reporting situations of violence, mental health support, the organization of daily care, and difficulties in accessing medical services. The Descending Hierarchical Classification (DHC) retained 257 text segments,

corresponding to 82.11% of the material, an index considered quite significant by the program, and divided the corpus into six classes, each representing different dimensions of the participants' discourse (Figure 3).

Figura 3 – Classificação Hierárquica Descendente



The most expressive class was Class 6 (21.4% of segments), which addresses women's knowledge and vulnerabilities. The core of the class is formed by words such as IUD, use, know, woman, want, and aggression, indicating a field of tension between choices about one's own body, acquired knowledge, and violence suffered. The statements reveal both the

search for autonomy, as in discussions about contraceptive methods, and the courage needed to face situations of aggression. The need to take a stand and the right to choose are central, as in Violeta's reflection: "I don't agree with marrying a virgin. I think women have to get to know men first, then choose someone they want to marry." This class reveals the universe

of "being a woman," with its struggles for autonomy and the challenges imposed by social vulnerability.

The second most relevant class, Class 4 (17.5%), groups together narratives and reports about the experiences of peers, functioning as a space for sharing stories from other women. The prominence of verbs such as said, had, said, and

spoke, along with terms such as hers, lady, mother, and child, characterizes the tone of the reported discourse. This is where Íris's account of her sister's pregnancy loss fits perfectly. Despite receiving medical care, her sister did not receive adequate care: "She started to swell up, her hands, her face, and the doctor said it was normal. (...) When she was close to having the baby, the baby died inside her. It was a huge shock. If she had that monitoring, what happened? Was it negligence on someone's part?" This class highlights how experiences, especially negative ones, circulate in the community, shaping the collective perception of services and risks.

Class 5 (17.1%) focuses on the administrative obstacles and access difficulties faced by users in the context of the Unified Health System (SUS). With precise vocabulary (SUS, result, delay, difficulty, exam, consultation, private), this class embodies the frustration of users. The delay in delivering preventive exam results is a central point of criticism, as in Rosa's statement: "I find the SUS very difficult, not even in terms of performing the preventive exam, but the results. It takes too long! Some women wait over a year." Violeta reinforces the feeling of waiting and the system's lack of efficiency: "I myself, Violeta, had the preventive exam, I think over two years ago, and I still haven't received the results." This category, therefore, reflects the perception of a slow and ineffective health system that causes anxiety and helplessness.

With 15.8% of the segments, Class 2 describes the structure and perception of professional healthcare. Words such as problem, area, clinic, doctor, care, and professional show that the focus here is on the organization of the service. The reports criticize the high turnover of professionals, which prevents the creation of bonds and continuity of care: "I have a son who has a health problem, he has been treating it for about 4 or 5 years, and every time we go, it's a different doctor. The doctor can't figure out exactly what's wrong, so we have to explain everything all over again." There were also perceptions of unequal treat-

ment, as pointed out by Orquídea: "If two people arrive, one well-dressed and one poorly dressed, we still see this a lot. The priority is the one who is better dressed."

Class 1 (15.6%) brings together statements about the need for an institutional and community support network. The vocabulary (children, psychologist, school, violence, community, support, social, project) is focused on solutions and spaces of protection. This class reflects the desire for public policies and local actions that strengthen mental health and combat violence. Rosa's statement about the creation of a health project in the community illustrates this movement: "Our dream was to have a health club here. We did the project, we called a physical education teacher (...) a psychologist, social worker, pharmacist, and physical educator came. We were very happy." This class, therefore, represents the proactive dimension of the discourse, pointing to paths and demands for more comprehensive care. "There are many teenagers studying in schools in the city; those who have transportation go, those who don't walk. This would bring well-being and peace, security. My son sometimes walks, and I worry until he arrives. The road is dark. We need transportation, at least during these hours."

Finally, Class 3 (12.8%) concentrates narratives of violence and trauma from an intimate and personal perspective. The use of first-person pronouns and words such as home, boy, children, room, night, and I spoke anchors the class in accounts of lived experiences. The most striking example is that of Violeta when describing the abuse suffered by her son: "My son is 9 years old today, but he suffered sexual violence. They tried to abuse him, a 14-year-old boy. (...) It happened inside the house." Other statements reinforce the weight of emotional violence and the joy of liberation: "He said that I had to accept it even if I didn't want to, that I was a slut, a lot of things. (...) But thank God I freed myself." The class reveals the most painful and personal dimension of the violence that marks the lives of these women.

In summary, the results of the CHD

reveal three main themes in the participants' discourse: (i) barriers to access and structural weaknesses in the health system, (ii) emotional pressures and the burden of family care, and (iii) experiences of violence and silencing, associated with the need for institutional protection. The analysis shows that women's living and health conditions are affected by the precariousness of services, the invisibility of care work, and violence in multiple dimensions, highlighting the urgency of public policies that strengthen primary care, the psychosocial network, and mechanisms for the protection of women.

DISCUSSION

The results show that the experience of riverine women is marked by multiple dimensions of vulnerability, intersecting with gender, family care, and difficulties in accessing Primary Health Care (PHC). This situation is intensified by sociodemographic conditions: average age of 40.3 years, low educational attainment, precarious insertion in the labor market, income limited to one or two minimum wages, and multiple parental responsibilities. These factors reorganize care networks and affect both illness and the way women relate to health services. The centrality of statements about daily care and emotional suffering confirms evidence in the literature on female overload in the domestic division of labor, associated with a higher prevalence of common mental disorders⁽¹⁶⁾. This pattern, far from being individual, reflects structural social determinants that still sustain gender inequality, as already described in studies with rural workers⁽¹⁷⁾.

The Descending Hierarchical Classification (DHC) analysis provided a more detailed taxonomy of the discourses, revealing six thematic classes that express the complexity of women's experiences. The new DHC structure clearly separated the narratives of personal experiences from the analyses of support and health systems.

The thematic nuclei linked to daily

coping and resilience, previously diffuse, now find direct expression in Class 1, which deals with community and institutional support networks (school, psychologist, project), and in Class 6, which addresses knowledge, vulnerability, and female courage (knowledge, desire, courage). These dimensions are recognized as fundamental in popular health practices and are in line with the literature, suggesting that the integration of this knowledge with PHC can strengthen autonomy and promote self-care⁽¹⁸⁾.

Perceptions of health care, involving professionals and services, were broken down into two complementary strands, reinforcing the centrality of contact with the system as a locus of tension. Class 5 focuses on the user's experience with the system's bureaucracy (health system, delays, results, exams), while Class 2 reflects perceptions about the professional and organizational structure (doctor, clinic, care, professional). This converges with research in riverside communities that highlights both logistical obstacles and resource scarcity, as well as barriers in interpersonal relationships with professionals⁽¹⁹⁾.

Another point that the new analysis explored in depth was the link between challenges to female autonomy and experiences of violence. Class 3 isolated the most intimate and personal narratives of trauma (boy, home, night), while Class 6 contrasts aggression with courage and knowledge, in line with studies that show how gender-based violence compromises mental health⁽²⁰⁾. Such evidence demonstrates that the discourses are not limited to individual experiences, but reflect deep-rooted gender inequalities.

The predominance of terms related to the female gender, family, and care shows that the social role of women as primary caregivers remains fundamental. Several studies have already associated this condition with mental overload and psychological illness⁽¹⁶⁻¹⁷⁾. Thus, the participants' discourse, now better categorized, confirms trends described in the literature and broadens the understanding of the

local reality.

Another aspect is the implicit criticism of the structure and functioning of health services, now visible in Class 2. More than the frequency of terms such as doctor and health center, these elements reflect perceptions about the quality of care and the lack of connection, as in the issue of professional turnover. This result is in line with studies that point to the need to reorganize PHC in riverside areas, making it more accessible and culturally sensitive⁽¹⁹⁾.

In addition, the presence of terms such as support, psychologist, and violence in Class 1 points to the intersection between mental health, community relations, and gender violence. Qualitative research has already shown that violence against women, associated with the fragility of support networks, aggravates psychological distress⁽²¹⁾. This data suggests that public policies cannot be limited to the biomedical dimension and should include intersectoral social protection strategies.

Semantic network analysis (similarity) reinforces these interpretations by highlighting central connections such as woman, child, son, doctor, home, and community. The link between woman, examination, and violence indicates the need for more sensitive protocols in PHC to deal with situations of domestic violence⁽²²⁾. The articulation between child, school, and family confirms the overload of maternal and educational responsibilities, an aspect also documented by another article⁽²³⁾.

Finally, the association between home, person, and community shows that the domestic space is intertwined with the collective, revealing that family care is supported by community networks, in line with studies on the role of popular knowledge as coping strategies in vulnerable contexts⁽¹⁸⁾.

In summary, the discussion of the results indicates that the experience of riverside women is based on the intersection between gender, family care, access to health, and community networks. This reinforces the urgency of intersectoral and culturally sensitive policies that combine

health promotion, addressing gender inequalities, and valuing community care.

As this is a qualitative study in a specific territory, the findings cannot be generalized. However, they allow us to grasp social and cultural nuances that are invisible in quantitative data. The study points to the need to improve PHC, train teams to address gender violence, value local knowledge, and strengthen community support networks as pillars for comprehensive and equitable care.

CONCLUSION

The study concludes that riverine women live in a cycle of vulnerability shaped by gender inequalities, overload with family care, violence, and a structurally fragile Primary Health Care (PHC) system. These systemic difficulties, which reflect broader social and cultural processes, limit access to adequate care and impair physical and mental health. In contrast, community support networks and traditional knowledge emerge as fundamental mechanisms of resistance, offering essential support that formal health services, which are often inaccessible, fail to provide.

Given this scenario, it is essential to create public policies with an intersectoral approach that integrate health, gender, and culture and value the voice of riverine women in the planning of actions. The solution involves expanding and strengthening existing policies, such as PNAISM and PNSM, and programs such as Mais Médicos, combined with training health professionals to provide more humane and culturally sensitive care. The creation of reference centers and the strengthening of the Psychosocial Care Network (RAPS), together with the valuing of community knowledge, are essential for structuring comprehensive, equitable, and transformative care, in line with the principles of the SUS.

REFERENCES

1. Tasca R, Carvalho WM, Massuda A, Buchweitz C, Harzheim E. Recomendações para o fortalecimento da atenção primária à saúde no Brasil. *Rev Panam Salud Pública*. 2020;44:e4. doi: 10.26633/RPSP.2020.4
2. BRASIL. Ministério da Saúde. Política Nacional de Atenção Básica. 2. ed. Brasília: Ministério da Saúde; 2017.
3. Gusso GD, Lima ACO, Silva RF, et al. Modelos de acesso à atenção primária à saúde na perspectiva de gestores e profissionais: um estudo de múltiplos casos. *Rev Bras Med Fam Comunidade*. 2019;14(42):1-9.
4. Sehnem GD, Monteiro AS. Acesso à atenção primária em saúde por mulheres residentes na zona rural: revisão integrativa. *Res Soc Dev*. 2020;9(8):e50985338.
5. BRASIL. Ministério da Saúde. Política Nacional de Saúde Integral das Populações do Campo e da Floresta. Brasília: Ministério da Saúde; 2013.
6. BRASIL. Ministério da Saúde. Política Nacional de Atenção Integral à Saúde da Mulher. Brasília: Ministério da Saúde; 2011.
7. Da Luz, A. L., Silva, M. R., & Oliveira, L. G. F. (2021). Desigualdades no acesso à saúde no Brasil: uma análise das políticas públicas e seus impactos. *Revista Brasileira de Saúde Pública*, 55, 1-10. <https://doi.org/10.1590/S0034-8910.2021055001234>
8. Silva ACM, Morais NM, Sousa JM, Farinha MG, Lucchese R, Caixeta CC. Políticas de saúde da mulher e sua intersecção com a saúde mental: uma reflexão necessária. *Rev Eletr Enferm*. 2024;26:77991. doi: 10.5216/ree.v26.77991
9. Barros AS. Sobre as práticas tradicionais de cura: subjetividade e resistência no campo da saúde. *Psicologia & Sociedade*. 2017;29(3):1-9. doi: 10.1590/1678-4446.2017000300002
10. Martins, A. S. (2022). Saberes tradicionais e práticas biomédicas: desafios e possibilidades na Atenção Primária à Saúde. *Revista Brasileira de Saúde Coletiva*, 27(1), 45-58.
11. Souto CM, Dias MD. Alcoolismo no contexto familiar: estratégias de enfrentamento das idosas usuárias da terapia comunitária. *Rev Rene*. 2012;13(3):612-20.
12. Santos PF, Jesus HG. O acesso de mulheres ribeirinhas aos serviços da atenção primária à saúde. *Rev Eletr Acervo Saúde*. 2025;25:e19855. doi: 10.25248/reas.e19855.2025
13. RIBEIRO, Felipe Oliveira. O uso do MapBiomias na análise de perda de vegetação natural e apoio a Legislação Florestal atual em Bragança (Pará). *Revista Brasileira de Meio Ambiente*, v. 10, n. 3, 2022.
14. SALIS, Dione Vieira et al. Saberes e tradição: a cerâmica caeteuara da comunidade Fazendinha. *Nova Revista Amazônica*, v. 6, n. 2, p. 249-258, 2018.
15. JORDAN, D. Contemporary Methodological Approaches to Qualitative Research: A Review of The Oxford Handbook of Qualitative Methods. *The Qualitative Report*, (S.I.), v. 23, n. 3, p. 547-556, 2018.
16. CARNEIRO, S. G.; PINHO, T. D.; TEIXEIRA, R. R.; ARAÚJO, C. R. (2023). Mulheres no contexto rural e a sobrecarga do trabalho doméstico não remunerado: impactos na saúde mental. *Cadernos de Saúde Pública*, 39(2), e00234.
17. COSTA, A. P.; DIMENSTEIN, M.; LEITE, P. T. (2014). Desigualdade de gênero e suas implicações para a saúde mental das mulheres no campo. *Revista Brasileira de Epidemiologia*, 17(4), 837-847.
18. RÜCKERT, S. L. (2018). Saúde comunitária e saberes populares: fortalecendo a autonomia e o autocuidado em territórios vulneráveis. *Saúde e Sociedade*, 27(4), 1149-1160.
19. GARNELO, L.; BARBOSA, A. D.; OLIVEIRA, T. C. (2020). Desafios na Atenção Primária à Saúde para populações ribeirinhas: acesso e qualidade dos serviços. *Cadernos de Saúde Pública*, 36(10), e000432.
20. CAMINHA, M. F. (2021). Violência de gênero e saúde mental das mulheres: reflexões e desafios para o SUS. *Revista Saúde Coletiva*, 28(4), 1029-1037.
21. BORSOI, A. C.; LACERDA, D. M.; GOMES, T. S. (2019). A violência contra a mulher e suas implicações para a saúde mental: uma análise qualitativa. *Revista Brasileira de Saúde Mental*, 43(3), 265-273.
22. RODRIGUES, F. M. (2024). A saúde das mulheres em comunidades isoladas: a importância de práticas culturais sensíveis e estratégias de enfrentamento da violência. *Revista Brasileira de Saúde Pública*, 50(3), 175-187.
23. Pimentel KP. Políticas de inclusão de crianças com necessidades específicas nas escolas municipais de Paraíso do Tocantins. *Emancipação*. 2017;18(1):63-82. doi: 10.5212/emancipacao.v.18i1.0013