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Article

Where life follows the river: the territory as a social determinant of health in the Furo Gentil river on the islands of Abaetetuba – Pará

Onde a vida acompanha o rio: o território como determinante social de saúde no rio Furo Gentil nas ilhas de Abaetetuba – Pará

Donde la vida sigue al río: el territorio como determinante social de la salud en el río Furo Gentil en las islas de Abaetetuba – Pará

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Abstract

Objective: To analyze the barriers to the exercise of equity and universality in health care for riverside populations in Abaetetuba, Pará, based on the experience report of the interactive activity "Riverside experiences and health in the amazon territory". **Methodology:** This is a qualitative, descriptive research, of the experience report type, based on participant observation. **Results:** the territory presents itself as a structuring social determinant, with geographic isolation and the influence of tidal cycles imposing severe logistical barriers to access to essential services. This context is aggravated by the precariousness of formal assistance, marked by the insufficient frequency of visits to the River Family Health Unit, which compromises the continuity of care. A conflict of rationalities was also evident, culminating in the dehumanization of medical care, due to the use of inaccessible technical language and the lack of qualified listening, reinforcing the social invisibility of these populations. On the other hand, the study highlights the power of traditional

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knowledge and robust community solidarity networks as mechanisms of resistance and mutual care in the face of state absence; **Conclusion:** geographic isolation and communication barriers impede equity in the Unified Health System, considering the vulnerabilities and invisibility of the riverside, making it imperative to have humanized, ethical medical training adapted to Amazonian realities, which recognizes territorial vulnerabilities as inseparable from clinical practice.
Keywords: Social Determinants of Health; Riverside Population; Humanization of Assistance.

Resumo

Objetivo: analisar as barreiras ao exercício da equidade e da universalidade no atendimento à saúde de populações ribeirinhas em Abaetetuba, Pará, a partir do relato de experiência da atividade interativa 'Vivências ribeirinhas e saúde no território amazônico'. **Metodologia:** trata-se de uma pesquisa qualitativa, descritiva-analítica, do tipo relato de experiência, fundamentada na observação participante. **Resultados:** o território se apresenta como determinante social estruturante, em virtude do isolamento geográfico e a influência dos ciclos de maré que impõem severas barreiras logísticas ao acesso a serviços essenciais. Este contexto é agravado pela precariedade da assistência formal, marcada pela periodicidade insuficiente das visitas da Unidade de Saúde da Família Fluvial, o que compromete a continuidade do cuidado. Evidenciou-se o conflito de racionalidades que culmina na desumanização do atendimento médico, devido ao uso de linguagem técnica inacessível e à falta de escuta qualificada, reforçando a invisibilidade social dessas populações. **Conclusão:** o isolamento geográfico e as barreiras comunicacionais impedem a equidade no Sistema Único de Saúde, considerando as vulnerabilidades e a invisibilidade ribeirinha, sendo imperativa a necessidade de uma formação médica humanizada, ética e adaptada às realidades amazônicas, que reconheça as vulnerabilidades territoriais como indissociáveis da prática clínica. O estudo ressalta a potência dos saberes tradicionais e das robustas redes de solidariedade comunitária como mecanismos de resistência e cuidado mútuo diante da ausência estatal.
Palavras-chave: Determinantes Sociais da Saúde; População Ribeirinha; Humanização da Assistência.

Resumen

Objetivo: Analizar las barreras al ejercicio de la equidad y universalidad en la atención de salud para las poblaciones ribereñas de Abaetetuba, Pará, a partir del relato de experiencia de la actividad interactiva "Experiencias ribereñas y salud en el territorio amazónico". **Metodología:** Se trata de una investigación cualitativa, descriptiva, del tipo relato de experiencia, basada en la observación participante. **Resultados:** el territorio se presenta como un determinante social estructurante, con el aislamiento geográfico y la influencia de los ciclos de mareas imponiendo severas barreras logísticas para el acceso a servicios esenciales. Este contexto se ve agravado por la precariedad de la asistencia formal, marcada por la insuficiente frecuencia de visitas a la Unidad de Salud Familiar del Río, lo que compromete la continuidad de la atención. También se evidenció un conflicto de racionalidades que culminó con la deshumanización de la atención médica, debido al uso de un lenguaje técnico inaccesible y a la falta de escucha calificada, reforzando la invisibilidad social de estas poblaciones. Por otro lado, el estudio destaca el poder de los conocimientos tradicionales y las sólidas redes de solidaridad comunitaria como mecanismos de resistencia y cuidado mutuo ante la ausencia del Estado; **Conclusión:** el aislamiento geográfico y las barreras de comunicación impiden la equidad en el Sistema Único de Salud, considerando las vulnerabilidades e invisibilidad de la ribera, haciendo imprescindible una formación médica humanizada, ética y adaptada a las realidades amazónicas, que reconozca las vulnerabilidades territoriales como inseparables de la práctica clínica.
Palabras clave: Determinantes Sociales de la Salud; Población Ribereña; Humanización de la Atención.

Introduction

Social Determinants of Health (SDH) encompass the conditions in which individuals are born, grow, live, and work, these being shaped by the distribution of power, income, and resources at various levels of society. In other words, SDH constitute the set of living conditions and social structures that run through individuals' trajectories, directly affecting their physical and mental well-being[1]. These structuring factors are responsible for delineating the reality experienced by populations, decisively influencing the level of access, use, and continuity of health services and care[2].

In the Brazilian context, Law No. 8.080/90[3], a pillar of the Unified Health System (SUS), provides for the principles of universality, equity, and comprehensiveness as fundamental guarantees for health care. However, a paradox is observed between the normative framework and the reality of traditional populations, especially riverside communities, where the place of residence acts as a critical determinant that restricts access to basic rights such as sanitation, education, and health[1].

Riverside communities in Brazil face social and health challenges arising from the territorial social determinant, which influences living conditions and the guarantee of the constitutional right to health. Franco et al. point out that this group, for the most part, has a low level of education and lives in territories with remote access, which reinforces vulnerabilities and limitations in access to health services[4].

The situation of vulnerability experienced by riverside populations is the result of health inequities generated by the intersection of multiple determinants. Among these structuring factors, geographic obstacles linked to river dynamics, socioeconomic fragility, the lack of basic sanitation infrastructure, and the community's own lack of information about public policies in force stand out[5].

On the islands of Abaetetuba, in Pará, the riverside population experiences heightened vulnerability compared with the urban context. Located in the Amazonian region of Pará, the municipality of Abaetetuba has a complex territorial structure that encompasses the so-called "Territory of the Waters". This is its Riverside Rural Zone, formed by 72 islands crisscrossed by river networks (rivers, channels, and streams), where a floating population with very distinctive life dynamics is concentrated[6].

Geographic isolation, strict dependence on river transportation, and the influence of natural cycles, such as tides and the ebb regime, impose structuring barriers that challenge the implementation of Primary Care. Silva et al. indicate that, for teams serving riverside residents, river transportation is often the only viable means, and this geographic peculiarity imposes major difficulties in movement that impair access to health care[7]. In addition to logistical obstacles, the distance between biomedical rationality and traditional experiences precipitates communication barriers and feelings of social invisibility, directly violating the principle of equity. Dantas explains that the organization of services is often centered on the "biomedical model" and insufficiently sensitive to diversity, which generates "incomprehensible technical language" and alienates traditional populations. The author argues that these factors produce 'invisible inequalities' and directly compromise equity and the right to health[1].

In view of this scenario, the present study starts from the following guiding question: in what way can the disregard of social determinants in care for the riverside communities of Abaetetuba,

PA, especially in the Furo Gentil river, contribute to the production of exclusion and to the violation of the SUS principles of universality and equity?

To respond to this problem, this article establishes as its general objective: to analyze the barriers to the exercise of equity and universality in health care for riverside populations in Abaetetuba, PA, based on the experience report of the interactive activity 'Riverside experiences and health in the Amazonian territory'.

Methodology

This is an experience report, with a qualitative descriptive-analytical approach, grounded in participant observation[8] and systematic recording in field diaries of the interactive activity 'Riverside experiences and health in the Amazonian territory', linked to the course 'Health, environment, and regional social determinants'. The activity was carried out by 20 students, 11 men and nine women, aged between 20 and 30 years. Of this total, 35% consider themselves Brown or Black, and all are in the first semester of the medical program at the Higher School of the Amazon (ESAMAZ), Abaetetuba-Pará campus, under the supervision of the instructor of the module in question. According to the program's curriculum, this course is included in the first semester with the objective of developing ethical competencies and humanization in medical conduct, especially in relationships with traditional peoples and communities.

The thematic content analysis technique was used to systematize and analyze the data collected in the field diaries. From immersion in the empirical material, three analytical categories emerged that structure the discussion of this report: i) the territory as a social determinant, addressing the geographic and logistical implications of riverside life; ii) the clinical encounter and communication barriers, which analyzes the clash between the biomedical model and traditional knowledge, as well as communication difficulties between professionals and users; and iii) medical training in the Amazonian setting, with a discussion of the importance of cultural sensitivity and empathy in the clinical practice of these future professionals.

The river crossing and the perception of geographic isolation

The experience took place on December 4, 2025. The journey began at the Abaetetuba Waterway Port, bound for the islands. Transportation was carried out by regional boat (Figure 1), facing immediate logistical challenges, such as the inadequacy of the pier for boarding, since it does not provide easy access to enter the boats.

It is important to point out that the boats for the crossing are available on weekdays, weekends, and holidays, according to the demand required, and the travel time to the islands of Abaetetuba depends on the destination locality and the tide, so there is no exact duration. In addition, with the renovation of the riverside terminal, which took place in 2025, there are more boats and safety has increased, since most of them have protective equipment; however, problems such as those mentioned above are still faced.

Figure 1. Regional boat used in the river crossing from Abaetetuba to Furo Gentil



Source: The authors' field diary.

During the journey along the rivers, the students were guided by a person belonging to the Furo Gentil riverside community, who explained the local geography, especially Pacocá Island, and shared the legends that are part of the riverside people's imagination, such as the legend of Demócrates, which symbolize the community's subjective relationship with the river. In view of this, it was possible to observe the appreciation of traditional knowledge and oral tradition, expressed through local legends and narratives that connect natural phenomena to the community's historical and symbolic experiences. It is important to emphasize that these stories emerge not only as cultural elements, but as ways of explaining and working through the real difficulties faced.

During the journey, a critical incident occurred: the boat ran aground on a sandbank due to the low tide, which served as observational data on the geographic barriers faced daily by riverside residents in accessing health services. Dependence on river transportation and natural conditions, such as tides, ebb, and sandbanks, becomes evident as a structuring factor of everyday life, directly influencing mobility, access to services, and the population's very survival.

Arrival in the territory and immersion in riverside identity

Upon disembarking at Sítio Gentil, located on the Furo Gentil river, the students were welcomed by the residents with a regional breakfast. This welcoming moment allowed recognition of the territory and local economy, marked by the transition from the historical production of cachaça to the cultivation of cacao and cupuaçu. The immersion included direct experience with cacao and recognition of native trees (Figure 2), demonstrating the sustainable use of natural resources and the community's strong productive identity.

Figure 2. Students' immersion experience with cacao and recognition of native trees in the Furo Gentis river



Source: The authors' field diary.

The conversation circle on health and invisibility

The core of the activity consisted of an encounter of knowledge between academics and residents (Figure 3). After lunch, which was also provided by the community, with typical foods such as fish and açaí, a conversation circle took place with eight residents of the Furo Gentil river, six women and two men, mostly elderly, with a community teacher and a community health worker present.

Through active listening, the students heard reports about the precariousness of care, such as the visit by the River Basic Health Unit (UBS Fluvial), which occurs only every three months. The residents expressed feelings of social invisibility and reported experiences of dehumanization in formal medical care, arising from the use of incomprehensible technical terms and the lack of empathy among health professionals. In contrast, the resistance of folk medicine, the use of teas and oils, and the community solidarity network in transporting the sick in rabetas and other types of available boats became evident, to reach the municipality of Abaetetuba and try to obtain better medical care.

Figure 3. Conversation circle on health with the residents of the Furo Gentil river



Source: The authors' field diary.

Results and discussion

The river territory as a social determinant

The municipality of Abaetetuba is located in the Lower Tocantins region, in the state of Pará, and has 72 islands belonging to its territory, inhabited by approximately 2,000 families, with a total of 172,344 inhabitants[6].

Riverside peoples establish a relationship of profound interaction with the rivers, which represent their main means of travel. The river is used for daily travel, access to health services, education, commerce, and the performance of everyday activities such as fishing and extractive activities. In this circumstance, the boat reaffirms itself as a central element in maintaining the riverside way of life.

Even so, it was observed that periods of ebb significantly affect this flow. With the reduction in the tide level, sandbanks along the river are among the obstacles faced by this population, making navigation more difficult and risky. The presence of these banks causes route deviations, resulting in increased travel time and greater fuel consumption. In addition, boats frequently run aground during this period, interrupting journeys, causing delays in access to essential services, and, in some cases, making travel to certain localities completely impossible.

Thus, it becomes evident that the river's natural conditions, especially during ebb, impose real limitations on this population's mobility, intensifying territorial isolation and directly affecting their daily activities and access to basic rights, such as health. These factors show that the structural vulnerability of these communities in the face of dependence on and instability of the river reinforces its importance as a determinant of their socioeconomic organization[9]. Social vulnerability concerns the means that individuals or collectivities have to face health problems and recover. This scenario is shaped by these groups' own characteristics and available resources; when such elements are limited in taking advantage of the opportunities offered by society, they end up dictating the level of harm to these people's quality of life[10].

Health care in the riverside community of the Furo Gentil river is marked by a lack of continuity of care, especially owing to the sporadic operation of the River Basic Health Unit (UBS Fluvial), which serves the localities only every three months, staying for only one day. This limited frequency compromises continuity of care, making it difficult to follow up patients with chronic diseases, carry out preventive actions, and adequately monitor pregnant women, children, and the elderly. The lack of regular care also affects adherence to treatments, updating of the vaccination schedule, and strengthening of the bond between the health team and the community, a fundamental element for the effectiveness of Primary Care[11].

Recurrently, it is important to observe the difficulties in accessing health services, above all due to the low frequency of visits by the UBS Fluvial, the precariousness of continuity of care, and the communication barriers between professionals and patients. Following this logic, care is perceived as insufficiently humanized and marked by the use of technical language, quick consultations, and a lack of listening, reinforcing feelings of social exclusion and invisibility. The UBS Fluvial should provide medical, dental, and nursing care, vaccination, rapid tests, wound dressings, specimen collection for the Cervical Screening Test (PCCU), distribution of medications and condoms, as well as emergency care; however, residents report that some of these services do not reach the communities.

By highlighting receptiveness, solidarity, and strong community unity, marked by mutual help in the face of the municipality's absence or insufficiency, it is perceived that this social cohesion manifests itself both in the sharing of resources and in support during emergencies. Despite the nuances of gaps in care, long distances, and high travel costs, riverside and traditional populations resort to the resources available within their own communities as the main strategy for resolving health problems[12].

In this context, local support is not configured as an isolated act, but as a community and relational process that produces the mutual recognition of the individual as belonging to that territory[13]. More than a mere survival tactic, such bonds reveal a profound collective consciousness, grounded in the perception that these individuals do not walk alone, but in a "constellation", preserving their integrity and cosmic connection[14]. When there is an emergency, the community turns to elders and to people who possess ancestral healing wisdom, such as puxadores, healers, and midwives; in addition, they also seek to use teas and bottled herbal preparations.

The National Primary Care Policy (PNAB)[15] establishes that Primary Health Care must be grounded in the principles of universality, accessibility, continuity of care, coordination of care and comprehensiveness, with the objective of guaranteeing longitudinal follow-up and permanent actions for health promotion, prevention, and recovery. In the riverside context, we can observe a

discrepancy between the guidelines advocated by the PNAB and the reality experienced by the population, since the low frequency of the River Family Health Unit (USF Fluvial) limits the effectiveness of continuous and territorially based care[15].

In addition, considering the geographic specificities and travel difficulties intensified by periods of ebb and boats running aground, the provision of care proves insufficient to meet the community's daily demands. This scenario demonstrates the need for organizational strategies better suited to river dynamics, with increased frequency of health actions, strengthening of the teams' presence, and adoption of measures that ensure greater regularity of care, in accordance with the PNAB principles and guidelines.

The clinical encounter in dispute

The communication barrier is one of the main obstacles to understanding between physician and patient, since medical scientific experiences are distant from the experiences of traditional populations. Biomedical hegemony establishes a technical-scientific rationality that often ignores patients' spiritual, territorial, and cultural dimensions, generating a systematic devaluation of traditional healing knowledge[16]. The distance between science and the local reality is reinforced by the use of technical and academic language that makes communication difficult and ultimately excludes traditional populations from active participation in health care and decisions[16].

The experience in the Furo Gentil river, with the community residents, gave the students the opportunity to listen to reports that illustrate this communication barrier. During the conversation circle, one of the residents reported that her "relative", upon becoming ill, sought a medical consultation; however, during the consultation, the physician used technical terms that were difficult for the patient to understand, which made the care ineffective for the care she needed. Thus, the need for medical training aligned with the determinants of the region where this professional will work is apparent; in addition, constant confirmation of the patient's understanding during the consultation is very necessary in all situations.

Furthermore, the production of illegible prescriptions is another factor that impairs communication, understanding, and trust between physician and patient. According to reports by one of the residents, her husband went to the physician and, after the consultation, discarded the prescription, claiming that he would not trust a physician who had not assessed him adequately and had also given him a prescription that was impossible to read. This communication distance is reinforced by the lack of qualified listening in health services, where neglect of the meanings attributed by the community to healing and the use of decontextualized language are perceived as a form of institutional violence, leading to the direct rejection of medical guidance and prescriptions that do not establish a real bond of understanding and mutual respect.

The figure of the physician is largely viewed as superior; this view results in the perception of the patient as inferior, a factor that is not true, since the patient must be the protagonist of their own health. In the face of this vertical structure, it is essential that individuals and communities be recognized as the real protagonists of their health, exercising their agency and critical capacity in conducting their care processes and defining their own destinies[17].

Health promotion carried out in the region by the riverside residents themselves was a matter of utmost importance during the conversation circle held with the Furo Gentil river community, because residents brought the figures of the midwife and the puxador to the discussion, two health

professionals who work in the region. The midwife is described as a woman with much knowledge; she prepares homemade remedies and has already delivered the babies of many women in the community. Currently, most riverside women go to the hospital to give birth, but the midwife continues to be respected and viewed as a person to whom the sick can turn. The puxador, in turn, is viewed as a massage practitioner, since this person helps people with torticollis, back pain, and "muscle strain".

Despite the importance of these professionals, one of the residents mentions that when resources are insufficient, they themselves advise patients to seek the Basic Health Units (UBS) in the urban center of the municipality of Abaetetuba, the Urgent Care Unit (UPA), and the hospitals in the city or region. From this, it is possible to observe the solidarity of people in the community, who, when a member is ill, lend means of transportation, such as a motorboat, so that individuals can travel to the municipality of Abaetetuba, in addition to bringing teas, ointments, and natural syrups, seeking to assist in treatment.

Medical training in the Amazonian setting

Medical training situated in the Amazonian setting transcends the mere transmission of biological content, since it requires the teaching-learning process to be legitimized by immersion in local experiences in order to develop a multidisciplinary and sensitive perspective. The National Curriculum Guidelines (DCN)[18] for the undergraduate medical program establish that graduates must have generalist, humanistic, critical, and reflective training, acting with social responsibility and commitment to human dignity[18].

In the Amazonian context, this normative premise translates into a pragmatic need. As Silveira and Pinheiro[19] emphasize, experiences of immersion and rural internship in the region provide students with unique opportunities to break with elitist conceptions of medicine, through direct contact with educational actions and the everyday life of the local community. Understanding care from the perspective of the territory proved, through field observation, to be the foundation for the development of critical and pluralistic thinking.

By recognizing that the health-disease process is permeated by cultural, social, and environmental dimensions unique to each population, the urgency of a break with the fragmented view of so-called traditional biomedicine, historically limited to clinical diagnosis, becomes evident. However, the deconstruction of this biomedical model is not sustained by theory alone; it indispensably requires immersion and the application of community practices.

From this perspective, the exercise of empathy proves to be an indispensable clinical competency for overcoming the region's structural barriers. It is imperative that the professional learn to put themselves in the patient's place to understand the limitations that directly affect the patient, such as functional illiteracy and geographic isolation. As Mardock and Brasileiro[20] point out in their studies on medical training in the Amazonian interior, humanized practice requires students to have the ability to move between technical knowledge and the understanding of each individual's vulnerabilities.

The transposition of this knowledge, however, fundamentally requires communication adaptation, because the excessive use of medical jargon and complicated clinical terms acts as a barrier that intimidates the user, limiting their ability to express doubts and excluding them from decision-making[21]. When incomprehensible technical language takes precedence over listening, it

makes the rapprochement between the community and services difficult, manifesting itself as an invisible inequality that impairs initial access and continuity of care. Consequently, this communication failure directly affects adherence, increasing treatment abandonment rates and expanding health risks for already vulnerable populations[1].

The use of incomprehensible technical vocabulary, associated with a lack of welcoming and professionals' unpreparedness to deal with sociocultural diversity, erects barriers that make it difficult for patients to approach health services. These invisible factors negatively affect the care experience, impairing both initial access and continuity of care, which frequently results in treatment abandonment and increased health risks for users[1].

The logistics of the waters and the long river distances impose real challenges, and it becomes a major obstacle to ignore that the distance between the user's residence and the health unit can mean hours of navigation and compromise the effectiveness of the therapeutic plan. Contact with this reality requires, as Silveira and Pinheiro[19] observe, heightened attention to listening and language, promoting a more humble attitude. Empathy thus materializes in communication adaptation and the development of feasible courses of action, ensuring that technical jargon acts not as an obstacle, but as a bridge for building a bond of trust.

From this logic, the need for the professional to practice care centered on each individual, respecting their needs and their understanding of becoming ill, becomes apparent. It is understood that the central characteristic of the Person-Centered Clinical Method (MCCP) is the individualization of care with a view to equality in care. In contrast, cultural competence acts as a tool focused on guaranteeing equity in care[21]. In addition, communication must therefore be dialogical and adapted, ensuring that medical knowledge does not become a barrier, but a bridge between physician and patient.

Alongside this professional adaptation, the results of the experience on the islands revealed a significant transformation in the community receiving care itself, characterized by the emergence of a strong awareness of rights. The care model grounded in historical-cultural passivity has given way to a critical and active stance on the part of users of the SUS, of the UBS Fluvial. The local population recognized its inalienable right to dignified and respectful care, no longer accepting conduct that reproduces mistreatment, neglect, or distancing supported by a supposed technical, academic, or class superiority of the physician.

This change reflects the materialization of humanization policies that require horizontal relationships in the care environment, a central aspect both in the DCN regulations[18] and in discussions about extending health care into the Amazonian interior[20]. For medical training, this scenario consolidates itself as a living school of ethics, teaching in practice that mutual respect is the basis of clinical effectiveness and that the professional's responsibility extends to the political commitment to act as a facilitator of person-centered care. Thus, medical training in the Amazon unfolds into learning about citizenship, in which professional ethics is grounded in the principle that the physician's responsibility does not end with the technical act, but with dignified and humane welcoming for the population.

Final Considerations

By analyzing the barriers to the exercise of equity and universality in riverside health care in Abaetetuba, in the state of Pará, especially in the Furo Gentil river, this experience report concludes

that the river territory acts as a structuring social determinant in the region. Geographic isolation and dependence on tidal cycles impose severe physical limitations that challenge the implementation of public policies and compromise the regularity of Primary Care.

The experience systematized in the field diaries proved fundamental for medical training, by shifting the student's perspective from the outpatient setting to the reality of the territory. Furthermore, it provided a moment of listening for the community, which was able to express its dissatisfaction with the current health system and professionals, which is important for jointly constructing a new way of guaranteeing the fundamental right to health for the riverside communities located in the municipality of Abaetetuba.

Regarding the perceptions of dehumanization reported by the community, the results demonstrated that these arise specifically from the conduct of the medical professional, materialized in the lack of qualified listening, the production of illegible prescriptions, and the use of incomprehensible technical language during quick consultations. Such actions erect communication barriers that intimidate the user, generate distrust, and produce the invisibility of traditional knowledge. In contrast, in the face of this state absence and ineffectiveness, the study confirmed the power of solidarity networks and folk medicine as the primary mechanisms of local care and survival.

Medical training in the Amazon requires an urgent break with elitist models. For clinical practice to be ethical and humanized, it is indispensable that immersion in the territory contribute to the development of students' cultural sensitivity, enabling them to recognize local vulnerabilities and transform technical jargon into a bridge for dialogue.

Academically, the research fills a fundamental gap by analyzing how social determinants, frequently ignored by biomedical hegemony, shape the care experience, contributing to the literature on public health in the Amazon and to the construction of medical curricula that prioritize cultural sensitivity and ethics. Socially, the study plays a reparative role by listening to the riverside populations of Abaetetuba, demonstrating the inequities arising from geographic isolation and the disarticulation of formal care. By documenting the resistance of these communities and the power of their traditional knowledge, the work encourages an indispensable debate about the need for more equitable public policies and a clinical practice that recognizes the territory not only as a setting, but as a determinant inseparable from life and care.

As a limitation of the present research, its nature as an experience report is pointed out, grounded in the observation of a limited group of students within a delimited geographic and temporal scope (Furo Gentil river). In addition, the investigation focused primarily on listening to the community's complaints, without considering the perspective of the health professionals of the UBS Fluvial themselves regarding their working conditions and logistical difficulties.

Finally, two main paths are suggested for future investigations: the development of studies directed toward management and logistics in river health care, with the aim of proposing organizational models that overcome the obstacles of the tidal regime and guarantee continuity of care; and the conduct of intervention research focusing on strategies for effective integration between scientific knowledge and traditional healing practices, aiming to strengthen the bond and the problem-solving capacity of Primary Care with these populations.

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