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Challenges to access health faced by rural population and their perception regarding healthcare

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ABSTRACT. The Brazilian nation has rich population diversity, and this makes it responsible for guaranteeing the social rights of all. In this perspective, this research seeks to categorize which are the main challenges in access to health that the rural populations face and to understand how the execution of this health care is carried out by professionals from the perspective of rural people. This is a cross-sectional study with a qualitative approach, carried out at the Nossa Senhora Aparecida Settlement, located in the municipality of Pesqueira (Pernambuco state) in 2018. The results demonstrate that the challenges faced by settled families are due to the difficulty of access to health services. In view of this, the rural population chooses to keep their cultural practices focused on their health alive. Therefore, it is common to use herbal medicines and mystics related to religious beliefs in self-care practices. It was concluded that the current public policies have gaps in their implementation, especially in terms of accessibility, security, health education, equity and respect for cultural differences. In addition, there is precariousness at the national level of studies focused on the health determinants and determinants of the rural population, which makes it necessary that more research be carried out so that new public policies can emerge.

Keywords: rural population; culture; nursing.

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Introduction

Brazil is composed of an extensive cultural plurality, being characterized as a heterogeneous country, which needs special public policies to meet socioeconomic vulnerabilities that each ethnic-racial diversity might express. So, for that to happen, some concepts such as: holistic view, cultural appreciation and respect for diversity, are important to be recognized so that the unique characteristics of this country can be kept (Rückert, Cunha, & Modena, 2018).

Among this diversity of people, the rural population is one of the largest. Data from the Ministry of Agrarian Development (MDA) show that about 36% of the Brazilian population is composed of people in the field and the Brazilian Institute of Geography and Statistics (IBGE) reinforces that 1/3 of the northeast population lives in rural municipalities (Instituto Brasileiro de Geografia e Estatística [IBGE], 2017).

Despite being numerous, the rural population still experiences several difficulties in the realization of their rights. These adversities are evident, especially in rural settlements where there are families who draw their income solely from agricultural activities, and due to the location of their homes have difficulties regarding access to education and health (Pessoa, Almeida, & Carneiro, 2018).

However, such fragility is not recent at all in the history of these people, since the time of Colonial Brazil, the rural population already faced these difficulties with high rates of child and youth and maternal mortality, outbreaks of endemics, high rates of illiteracy, unhealthy work, among other problems which contributed towards the increase of socioeconomic vulnerabilities of these individuals (Vilela & Oliveira, 2018). Especially, as regards the conditions of access and accessibility, mainly to health services, due to the geographical limitations in which they are located, characteristics of public institutions that do not fully meet the socio-cultural specificities and invisibility of the conditioning factors and determinants of health that surround the life of this population (Miranda, Oliveira, & Vasconcellos, 2020a).

The terms of access and accessibility are strongly linked to the historical difficulties of the rural population due to having as a concept, respectively: the act of accessing something or some service they have as a central activity, being a gateway to the Health Care Network (RAS); and features that facilitate or hinder the service-user relationship (Costa, Silva, Soares, Borth, & Honnief, 2017).

Thus, as a mitigating alternative to this problem, some public policies have been developed over the years, covering exclusively the central characteristics of the rural population. In this way, during the 14th National Health Conference, the National Comprehensive Health Care Policy for Rural and Forest Populations (PNSIPCF) emerged, portraying the conditions and determinants of health that involve the social categories mentioned above (Lima, Buss, Ruiz, González, & Heck, 2019).

Rural and forest people can be defined as communities whose ways of living, producing and reproducing socially are directly related to the field, forest, aquatic environments, agriculture and/or extractivism. In addition to that, they can also be referred to as family farmers, peasants, rural workers, riverside dwellers, traditional communities, quilombola communities, among others (Política Nacional de Saúde Integral das Populações do Campo e Floresta, 2013).

Furthermore, the Theory of the Cultural Care Diversity and Universality (TDUCC), developed by Madeleine Leininger, shows how the multiculturalism of individuals impacts on the effectiveness of health care provided. Because of this, it is also decisive in the way of doing health among the rural population, by reinforcing how practices that respect the core of individuals should be adopted, that is, their origins, beliefs, opinions and unique knowledge that make them unique people (Gerhardt, 2019).

Understanding the reality of these populations is of the utmost importance for establishing the development of foundations that converge with the basic principles of the Unified Health System (SUS). The guiding principles, such as completeness, universality and equity, are strongly interconnected with the weaknesses of these peoples. Mainly, because they result from the low amount of assistance from the State, when it does not contemplate what was pre-established by the Federal Constitution regarding the security of the social and health rights of all people (Souto, Sena, Pereira, & Santos, 2016).

Given this context, this study aims to categorize what are the main challenges in access to health that rural populations face, and understand how the performance of this health care happens, carried out by professionals from the perspective of rural people.

Material and methods

Cross-sectional study with a qualitative approach. This method was chosen because of the possibility of the researcher to be inserted in the sociocultural reality of certain social groups and experience situations the community lives on a daily basis (Boehs, Boehs, Fernandes, & Nascimento, 2018).

This study was developed in the rural settlement Nossa Senhora Aparecida, which belongs to the settlement movement of Pesqueira-PE, with a total population of 67.395 inhabitants (Instituto Brasileiro de Geografia e Estatística [IBGE], 2019).

This agrarian reform movement is part of the type of settlements of the Sustainable Development Project (PDS) and aims at making the development of productive agricultural activities compatible, especially family farming and the sustainability of local fauna and flora.

In addition, the non-probabilistic for convenience method was adopted as a sampling method when selecting the target audience through criteria. Inclusion groups were configured by: i) being a resident of the Nossa Senhora Aparecida settlement; ii) patriarchs or matriarchs of the family who are over 18; iii) residents who have lived in the settlement for more than five years. The exclusion method consisted of: not being at home at the time of data collection.

Data collection was carried out using the field observation techniques, the subjects' attitudes and behaviors through their responses about the RAS; conducting semi-structured interviews; and recording the impressions and facts considered relevant in a diary, such as the movement and attitude of the interviewees during the meetings.

Visits were carried out weekly with one visit per house, and the matriarch or patriarch was interviewed at the time, according to inclusion criteria, with an average duration of 30 minutes. Notes were also taken in a field diary, in which aspects observed during periods of immersion in the settlement were recorded. This stage lasted for seven months, from April to October 2018.

The collection tool used had variables related to: residents' experience in the settlement, basic living conditions (sanitation, treated water, etc.), education and access to education, socioeconomic and demographic characteristics, quality of life and access to health services.

It is emphasized that the privacy of the participants was ensured at each moment of the research by coding the data. Therefore, the sample size was 16 individuals, considered sufficient for an in-depth understanding of the phenomenon, in which after the interviews and data analysis, they were saturated.

To determine the reach of theoretical saturation in primary sources, five procedural steps were followed, namely: Step 1 - Record raw data (primary sources): in total, 16 individuals were interviewed. From the beginning of the collection, the interviews were recorded with the participants' authorization and immediately transcribed in full. Step 2 - Immersion in the data: there was a fluctuating reading of the data obtained through the interviews as they were carried out. Step 3 - Compilation of individual analyzes for each interview and thematic grouping: when carrying out the fluctuating reading, they were organized through coding. Step 4 - Allocation of themes and types of statements in a table: since it allowed the identification of the regularity of the findings in the statements, according to the themes and the verification of the consistency of the statements. Step 5 - Verification of theoretical data saturation by identifying the absence of new elements in each group (Fontanella et al., 2011).

As for the method of analysis, we opted for the content analysis of Bardin (2011), stratified in three phases, which are: pre-analysis, exploration of the material and treatment of the results. In the first stage, data were collected, which culminated in indicators that guided the interpretation and preparation of the material. This stage was carried out by two undergraduate nursing students.

Subsequently, the analytical categories of each answered statement were defined. This stage was conducted by four researchers: two doctors and two masters through a discussion round between the authors. Finally, distribution of results in different classes of results. Two master researchers participated in this stage. It should be noted that in the last phase, the data were crossed with the notes present in the field diary, in order to increase the quality of analysis.

Regarding the legal ethical aspects, all procedures were carried out in accordance with Resolution 510/2016 of the National Health Council (CNS) (Resolução n. 510, 2016) and consisted of the submission and approval of the Ethics and Research Committee of the Educational Municipality of Belo Jardim (AEB), under number 2.880.557, on September 7, 2018.

In addition, to participate in the research, each participant was given a Free and Informed Consent Form (ICF), which covered the risks related to the research, such as embarrassment about talking about their health care, their forms of attenuation and security so that they would not occur.

Consequently, there was also information regarding the research and the participant's rights concerning the preservation of their identity, giving up participation after data collection and eliminating their information together with their withdrawal.

Results and discussion

The results were structured in four analytical categories, namely: Sociodemographic profile; Challenges of access and accessibility to health services faced by settled families; Perception of health care and Care alternatives. Furthermore, as a means of protecting the identity of the interviewees, it was attributed to their coding. Thus, letter 'E' was used in conjunction with Arabic numbers from one to 16.

Sociodemographic profile of the studied population

Agricultural activities have been present since the beginning of human history. Because of this, extensive knowledge has been passed on empirically from generation to generation. In several peasant communities spread over the regions of Brazil, countless mystics involving work and even the quality of life of these individuals are still present in their culture (Miranda et al., 2020a).

As previously emphasized, the rural population of Brazil is characterized by an extensive ethnic-racial and cultural diversity, and this is the main characteristic that makes it unique. Thus, it is important to know the local reality of each one of them so that only then can they know which health and quality of life indicators are weakened (Rückert et al., 2018).

Among the 16 interviewees, eight (50%) were female, and four were considered matriarchs of the family, being responsible for income and other basic family needs. In addition, regarding the marital status of

female participants, only one (12.5%) was married. Among the eight male participants, two (25%) were married.

Furthermore, among the chronic diseases present in their families, reported by the interviewees, the one with the highest incidence was Systemic Arterial Hypertension (SAH), being reported by 11 (68.75%) participants, followed by Diabetes Mellitus (DM) (18.75%), mental disorders (18.75%) and cancer, which was present in two (12.5%) reports.

As for the education of individuals, ten (52.5%) had incomplete Elementary School I, which is an expected result due to the high illiteracy rates of the people living in the referred settlement. In addition, the observations made in the field diary show that this index is lower in people under 30 years old, and decreasing in the same proportion as the age of the individuals observed is reduced. As for the self-declared color/ethnicity, six (37.5%) declared themselves as brown and in their totality, all of them called themselves family farmers.

Such findings corroborate the literature when evidencing that the population residing in rural environments, present different characteristics in relation to the urban one, mainly concerning access to education and health, making these individuals vulnerable to suffer with inequities and impact on their quality of life (Pessoa et al., 2018).

Challenges of access and accessibility to health services faced by settled families

As already emphasized in this study, the rural population has, throughout their history, several scars that reflect on their health. The economic, political and cultural differences, added to historical milestones, such as: slavery, extermination of indigenous peoples, marginalization of peasant women, land concentration, among others, explain why there are so many vulnerabilities even today (Pessoa et al., 2018).

The spread of prejudices that originated from the bourgeois class towards this population is still present in several Brazilian municipalities. The impact they cause ranges from the widening of ethnic-racial inequalities to the fragmentation of the real identity of these peoples, culminating in the low recognition of the importance that people's popular culture plays in everyone's life (Lopes, Ferreira, & Friedrich, 2018).

PNSIPCF explores and accurately exemplifies the health inequities that this population group experiences daily, and points out strategies for solving these problems. However, even seven years after the implementation of the PNSIPCF, the marginalization of these peoples is still strongly present in society (Política Nacional de Saúde Integral das Populações do Campo e Floresta, 2013), especially on topics related to the access and accessibility of these individuals to health systems. As already reported in this study, the widespread access in the health field focuses on the sense that the services present in Primary Health Care (PHC) serve as a gateway for users to be welcomed and directed to the RAS service which better suits the solution for their problems (Garnelo, Lima, Rocha, & Herkrath, 2018).

However, this concept does not fully apply to the rural population due to the geographic location away from urban centers, which makes it difficult for both users of the system and the professionals themselves to move effectively to seek the resolution of their health problems and the provision of qualified health services, respectively. Therefore, this point expresses one of the greatest inequities related to the health context of the rural population when compared to people living in cities (Arruda, Maia, & Alves, 2018).

That said, when asked about how they felt about local management and accessibility of health services with actions focused on their reality, some of the answers were:

The difficulty is the distance, sometimes the person goes, but is not assisted and comes back feeling very angry [...] (E3).

[...] The worst thing is that we have to go there at dawn, being there at this time is dangerous, isn't it? (E9).

[...] To take a form there, we have to leave home at three-thirty or four a.m., some people get there at seven a.m. and there are no more vacancies (E16).

In addition to these requirements, some interviewees also pointed out as factors that hinder access to health services, the fragility in the professional training of the health teams that assist them. In the excerpt from the interview below, an interviewee comments on this, as follows:

[...] There is a man here who is my brother-in-law, he is about eighty years old, he goes the health unit, gets there, then the doctor looks at him and that's it, when he goes, right? [...] He's old, needs to talk, entertainment (E4).

As said, the rural population is filled with numerous cultural practices that translate their identity to society. Relationships and bonding between professionals and the community is a predisposing factor for the success of prevention and health promotion actions. Therefore, it is the duty of the professional who assists this population to know and respect these traditions, by including them in the therapeutic process of users with the appropriate guidelines of scientific knowledge they have (Lima, González, Ruiz, & Heck, 2020).

In addition to these issues, the budgeting difficulty that the rural population experiences is also a factor that interferes with the quality of life. Most people in this settlement do not have their own means of transport. Thus, they depend on public or private transport to move to the urban center.

Even if SUS provides health services free of charge to the population, they still have to pay for the financial resources inherent in their transportation to the service. This can be observed in the following statements:

To take care of my health I always work with agriculture to make some spare money, so that when I get sick I can pay, because waiting for a health agent or SUS [...] (E9).

[...] Here it works like this, if there is enough gas in the motorcycle you go to the health unit, but if there's not you don't go, and if you go there, most of the times there isn't a captopril at the drugstore (E4).

[...] While there is an old car that's great and when there isn't, when we don't have R\$ 80,00 to pay someone, when there's someone dying (E1).

In this context, it is perceived that the challenges faced by the rural population go through greater paths of inequality and marginalization when compared to other populations (Oliveira et al., 2019).

A prominent point that was present in the speech of two interviewees, reinforces how they feel helpless due to the lack of accessibility of services and the reception of professionals to meet their needs. Especially those who are closer to the reality of the community, which is the Community Health Agent (CHA).

It's been three months since she came here [...] (E4).

[...] The health agent is missing a lot now (E9).

The CHA is a key player in establishing the link between health services and the community. Their performance allows the practices of prevention, promotion and recovery of health to reach levels that go far beyond what can be imagined, increasing the users' awareness of self-care (Silva, Soares, Lacerda, Mesquita, & Silveira, 2020).

Due to the character of the actions developed with the community, the CHA is often seen as the professional who has the highest level of proximity to the families described as a result of the regularity of home visits that is performed. Thus, the agent is the first professional to diagnose numerous health problems, whether of sanitary, epidemiological or domestic origin. Therefore, the CHA's must have a good training on determinants and condition factors of health, since many do not have training in health (Arboit, Costa, Silva, Colomé, & Prestes, 2018).

One statement that reinforces this point was that of interviewee E9, when speaking about other weaknesses that involve his access to health and his relationship with the CHA's. For the interviewee, the rural population should, at least, have greater numbers of CHA's, and that these professionals had more professional training, as it can be seen below:

[...] To improve, there should be health agents who wanted to work and a place for appointments while a health unit is not built (E9).

Hence, it appears that the assistance provided by a professional brings with it the potential to expand the health system and promote health mediation that is configured as a form of institutional support for the assisted families. However, for this to happen, it is necessary that, in fact, the government agencies responsible for providing and maintaining health carry out the actions recommended by current legislation (Oliveira et al., 2019).

Based on that, it is clear that the difficulties experienced by rural communities are due to multiple social factors that are interconnected with the conditions and determinants of health, and that current public policies are still not enough to address these gaps, requiring greater investments by government agencies at different levels of management (Costa & Scarcelli, 2016).

Perception of healthcare

The individual's self-perception about their health is one of the most relevant factors for the continuity of self-care and health promotion. In the rural context, the conditioning factors and determinants of health change as a result of the lifestyle that this population adopts. Thus, their perception of what health is, often brings with it historical and cultural aspects, that the rural population only needs food to live with quality of life (Burille & Gerhardt, 2018).

This point is observed when the participants are asked about how they understood health care. The predominance of responses was aimed at adequate nutrition and physical activity, as expressed by the following sentences.

Taking care of health is going for a walk, preserve oneself [...] (E13).

It is to exercise [...] (E7).

It is to exercise, do not eat fat, eat vegetables [...] (E14).

It is to have food [...] (E11).

However, despite the fact that these points are, in fact, intrinsic to the quality of life, the way they are practiced by individuals plays an equally important role in obtaining good results. Unlike what happens in urban areas of municipalities, the majority of rural settlements do not have instructors, gyms in the city or other programs that encourage the practice of physical exercises in a correct, safe and effective way (Martins, Silva, & Hallal, 2018).

In addition, because these settlements are located at considerable distances from urban centers, the visit of professionals who can assist in this process, often happens only sporadically and with specific purposes to meet goals established by government agencies (Miranda, Oliveira, Moraes, & Vasconcellos, 2020b).

Another issue that interferes with the lives of people living in the countryside is related to access to treated water, basic sanitation, correct garbage collection and disposal and other actions related to good sanitary conditions. Among the interviewees, the speech that best expresses this reality is that of the interviewee E4, in which he emphasizes that:

[...] it is so much to take care of health. First of all it's cleaning, there has to be a city hall to pick up the garbage, but we have to burn it [...]. Every 'stink' and microbe all come in smoke. What about people who don't have a lot of health? Like my boy who has pneumonia, right?! He and I got pneumonia in the same week. Health comes from water, the treatment of water that is not provided (E4).

Thus, it is possible to observe the existing weakness in the implementation of public policies that should guarantee the right of these populations to health in its multiple aspects. As far as medical and nursing consultations are concerned, these are essential occasions for maintaining health and discovering various health situations that are still at an early stage. However, for the rural population, these consultations do not have a regular character (Oliveira et al., 2019).

Settled families, due to the location where they live, do not have the habit of attending the urban area for consultation, and therefore, tend to seek these services only in urgent and emergency situations, in acute and/or chronic acute events (Lima et al., 2020).

This is another point that reflects the fragility of assistance from government agencies regarding the provision of diversified ways for this population to have access to health and the decentralization of these services. When asked about how these consultations and the importance to people's lives, the answers were:

For me, taking care of health is to have a doctor and be taken to hospital [...] (E16).

Having a doctor, because it's very difficult for the guy to go [...] (E5).

It's to see a doctor, check what we're feeling, the doctor to prescribe some medicine [...] (E3).

Another counterpoint regarding the difficulty in accessing health services is the social practice of self-medication. The convenience of simply building up stocks of drugs purchased at pharmacies without the use of a prescription or nursing reinforces the extent to which the system still finds flaws to ensure the guidelines and principles set out in the SUS (Rückert et al., 2018).

A clear example of this is found in the interviewees' statements emphasizing that:

[...] Because the medicine, if it is diarrhea I know what it is, if it is a headache I know, fever, bone pain all this I know, look, if you have a child vomiting and have a fever you don't need to take them to the doctor, buy infectrin.

Then I don't hurry to see a doctor, I know what they'll prescribe, I can go to a drugstore to buy it. I take care of

health at home like this, with children, etc. [...] Then it's said, go see a doctor so that they prescribe a medicine for you to take, in my case I know what medicine it is, if it's for your back it's torcilan, it's a great pill [...] (E4).

[...] We can't afford to buy medicine, and we can't go on taking medicine like this, but sometimes we have to self-medicate [...] (E16).

Health education practices, at this point, are strategies that have a high power of modification through the dissemination of information regarding the risks inherent in the practice of self-medication. However, it only becomes efficient when there are trained professionals to mediate the construction of knowledge of the local population (Lima et al., 2019).

With the inclusion of Family Health Strategies (ESF) in the Health Care Network (RAS), the decentralization of health services became possible throughout the territory of the municipalities. However, this reality is often found only in urban areas. The rural area deals with the constant problem of low numbers of professionals who wish to work in the ESF's furthest from urban centers, due to the difficulties of access that these places present (Oliveira et al., 2019).

Care alternatives

The search for popular medicine before resorting to biomedical systems is recurrent in traditional communities and is linked to the cultural system which aggregates health concepts specific to these populations (Gerhardt, 2019).

Respondents cite cultural practices as a way of taking care of their own health and that of their family members, among them phytotherapy, religious beliefs as ways of taking care of health and bathing with herbs, as we can see in the following responses:

[...] Look, I'll be honest. I take care of myself a lot with homemade medicines, tea, 'lambedor' (a type of tea), things like that. I take care of my health a lot with bark [...] homemade medicine comes first... It is a cooking bath, a shell ginger bath, take five shell ginger leaves and take a shower from head to toe that serves for fever and infection. Eucalyptus is also a medicine for fever (E4).

[...] Drink the tea and the pain goes away, the lemon balm gives the woman strength to have her child and rue with 'cachaça', balances and serves to pass the pain of childbirth (E12).

This reality is not exclusive to this settlement. In several locations in the Brazilian territory, health care practices are still strongly present, based on the rites and myths of each population. The use of herbal medicines is a practice passed on from generation to generation, and although they do not yet have an extensive scientific basis to prove their effectiveness, the empirical knowledge of these peoples proves their effectiveness at different times in their lives (Rückert et al., 2018).

Furthermore, financial issues and accessibility to health services also contribute to rural communities opting for natural resources, due to the greater ease in obtaining the product. This was evident in the speech of one of the interviewees, when asked about their preference for medication, as provided below:

[...] Because taking care of health with homemade medicine is better than with a drugstore [...] it doesn't cost any money (E4).

In addition to the use of homemade medicines, it was possible to notice that there is a direct connection with myths and religious beliefs in the search for healing methods. These mystics strengthen the practices of popular care and have the function of support for families in the rural environment, who at various times choose to believe in some divinity, instead of the healing provided by the biomedical model (Rückert et al., 2018).

[...] There's this lady who prays, I give medicine and it doesn't go away, so it's evil eye, when she prays, the vomit stops (E4).

[...] I said I have faith in Our Lady that I will get better, so I got better [...] what a blessing I received (E6).

Going through and investigating these therapeutic paths experienced by these families is a practice that reveals the complexity involved in the search for care, in addition to showing how this search can be influenced by the various challenges and needs related to health (Burille & Gerhardt, 2018).

Conclusion

It is concluded that despite the loss of identity reflected in the rural exodus experienced by the peasant communities, these peoples still maintain their cultural health care traits, such as: herbal medicine, herbal baths and the mystics, originating from ancestry.

What is more, even though the advances achieved in the provision of health services, through public policies, there are still some gaps that need to be made visible for something to be done for the rural population in the country.

In this perspective, the findings point to the importance and need to ensure accessibility, resolution of health needs and maintain a dialogue between cultural care and professional care as a way to meet the demand and consider the peculiarities of these peoples.

Therefore, it is essential that the professionals who work in these areas have greater training aimed at valuing popular knowledge, unifying them with technical and scientific practices. Thus, it is essential to integrate the members of the most influential community, as these people play a fundamental role in how other individuals develop their conceptions about health care processes.

Furthermore, it is essential that the community has more space to act as representatives of their own way of conceiving its determinants and condition factors of health. For this, it is recommended that the CHA's are preferably members of the rural community itself, as they know the reality in which they live like no other. Therefore, it is integrated to this issue, that the municipal management develops a different look aimed at providing opportunities for their tenders or contracts in order to prioritize the population that resides in places further away from the urban center.

Additionally, in view of the lack of publications on the health of the rural population, the results obtained conceive significant subsidies that present us with the challenges of this population to have their rights guaranteed and also their perception of health care when considering aspects such as the housing area, education and cultural context in which they are inserted.

This is a limitation of this research, since the theoretical framework used was not always updated with the current socio-demographic, economic and political context of the country. In addition to the low sample size, since for the results to have a greater social impact, more immersion time would be needed in the researched community, in conjunction with crossing the data of the Settlement with other locations of similar or opposite reality.

Therefore, it is important to note that this research is still not enough to explain and make all the characteristic needs of the rural population known, which makes it important to carry out more studies covering the subject.

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