Revista O Mundo da Saúde

Self-classification of the health of residents belonging to rural settlements and their evaluation of the healthcare received

Lineker Fernandes Dias*
Gabriela Fernandes de Oliveira*
Caio Augusto de Lima*
Débora Maria Teixeira de Araújo*
Pedro Henrique Nascimento Theodoro*
Nicole Geovana Dias*

Abstract

Residents of rural settlements face difficulties in accessing health services. This is determined by the socioeconomic conditions of these populations. It is possible that these people rate their own health and the quality of public services they have access to as unsatisfactory. This study aimed to analyze the self-evaluation of health among residents of rural settlements and their assessment of the health services they use. This was a cross-sectional study, which interviewed, through a semi-structured instrument, residents of two rural settlements located in Uberlândia, Minas Gerais, Brazil. The instrument sought to analyze the epidemiological profile, the self-evaluation of the health of these residents, using an evaluative scale. Moreover, their assessment of the quality of the health services they access was evaluated. Twenty-four residents of two settlements were interviewed. 54.2% of them (n=13) had chronic diseases. The most reported were Systemic Arterial Hypertension and Diabetes Mellitus. Among residents, 45.8% (n=11) evaluated their own health as poor or fair and 45.8% as good. The analysis of the speeches indicated dissatisfaction with the quality of the health services used. The chronic disease rates found among residents of rural settlements may be due to the low coverage of Primary Health Care close to their homes. Improving the quality of the service provided by the Basic Family Health Units closest to rural settlements can reduce future cardiovascular disease rates among this population.

Keywords: Rural Population. Surveys and Questionnaires. Access to Health.

INTRODUCTION

The social, economic, cultural, and educational conditions of individuals directly interfere with access to public health services. Difficulties with transportation and the absence of health education actions are obstacles to the efficiency of health services in serving the population[1]. With regards to the rural population, several social movements seek to improve these living conditions, including those that fight for the implementation of Agrarian Reform in Brazil[2].

DOI: 10.15343/0104-7809.202145452462

*Universidade Federal de Uberlândia – UFU. Uberlândia/MG, Brasil.
E-mail: lineker-fernandes@hotmail.com

Agrarian Reform is defined as a set of measures aimed at the fair distribution of land ownership in Brazil[3]. This is due to changes in the land tenure and use regime, in order to effect social justice, sustainable rural development, and increased agricultural production in the country[3].

In this context, according to data from the National Institute for Colonization and Agrarian Reform (INCRA), in December 2017, there were 9,374 settlements in Brazil with 972,289 settled families. In the state of Minas Gerais, between 2010 and 2011, there were records of 15,675 families living in 339 settlements[4].

The unequal distribution of land in Brazil, despite being much discussed, is still a problem with few practical solutions. This lack of solutions may occur as a result of the failure to implement the Agrarian Reform with the neoliberal policy adopted in the last governments of the country[2,5].

Agrarian Reform implies improving the living conditions, including health, of the rural population[3,5]. In this sense, the struggle for adequate health conditions for rural populations is directly related to social struggles for the right to land, housing, and education. In this context, working conditions and lack of access to public goods and services lead this population to a lack of assistance and health care[6].

In addition, rural dwellers are exposed to specific chemical, physical, and environmental factors that can be harmful to health[7]. For example: handling machines, caring for animals, exposure to noise, contact with pesticides, infectious agents, dust, organic substances, exposure to high temperatures, solar radiation, as well as the risk of being bitten by venomous animals[8].

Historically, rural areas suffer from an unequal supply of public services when compared to urban areas. Furthermore, living in these vulnerable rural locations is associated with greater distance and difficulty in accessing public services[9,10].

One way to assess these discrepancies is through the self-classification and self-assessment of individuals who experience this reality. Self-classification is defined as the act of considering oneself to belong to a group or class[11]. Self-assessment, on the other hand, is a process in which a subject assesses a phenomenon from the author's point of view. Through this, they make a judgment of a scenario based on their point of view, values, and cognitive ability[12]. It is a pedagogical, diagnostic, and reflective practice[12].

Given these impacts on the health of the rural population and their difficulties in having quality health services, the hypothesis was raised that residents of rural areas negatively evaluate the health services they use and that they do not classify their own health as satisfactory. Therefore, this study aimed to analyze the self-evaluation of health among residents of rural settlements and their assessment of the health services they use.

METHOD

This is a qualitative, quantitative, and transversal study developed in rural settlements in the city of Uberlândia, Minas Gerais, Brazil. A qualitative and qualitative study aims to analyze, in addition to the numerical data collected, the hermeneutics of the study's objective, thus, the meaning that individuals attribute to it must be considered. Transversal research is defined as a study that assesses the phenomenon at a single moment in time, collecting and analyzing data from the same respondent without using analyses separated by time intervals[13]. All subjects in this study were interviewed between April and June 2018.

The city of Uberlândia is located in the Triângulo Mineiro mesoregion, in the western region of the State of Minas Gerais. The municipality has 3896.82 km² of rural area where 16,747 residents live[14]. The agrarian structure of the municipality is comprised of 842 rural properties destined for Agrarian Reform and 2,114 private rural properties. Of the rural properties destined for Agrarian Reform, all are classified as minifundios or small rural areas, a classification attributed to properties that have an area between 0 and 80 hectares (ha). As for the private rural properties, 506 are classified as medium rural properties as they have an area between 80.1 and 300 ha, and 236 as large rural properties as they have an area greater than 300 ha[15].

In Uberlândia there are 52 Primary Family Care Centers (PFCC) in the urban area and 6 in the rural area[16]. In the municipality, between 2009 and 2015, 2,092 families living in rural areas were accounted for by the Family Health Strategy. In 2013, the most recent data released by the Ministry of Health, the Family Health Teams (FHT) covered 1,068 people living in rural Uberlândia. In the urban area of the municipality, in 2015, 57,211 people were covered by FHT[17].

The participants in this study were selected from among the residents of the Dom José Mauro and Lucilene Fernandes - Fazenda Carinhosa settlements. The Dom José Mauro Settlement (Figure 1) began its occupation in August 2007 and was legalized in 2009[18]. This settlement is composed of 205 families and has an area of 44.706.366 ha[19]. The average area of the plots of land that each settled family occupies is 14 ha. The labor occupation of most families is with common jobs in rural areas, such as seasonal field workers, caretakers, and cowboys[19].

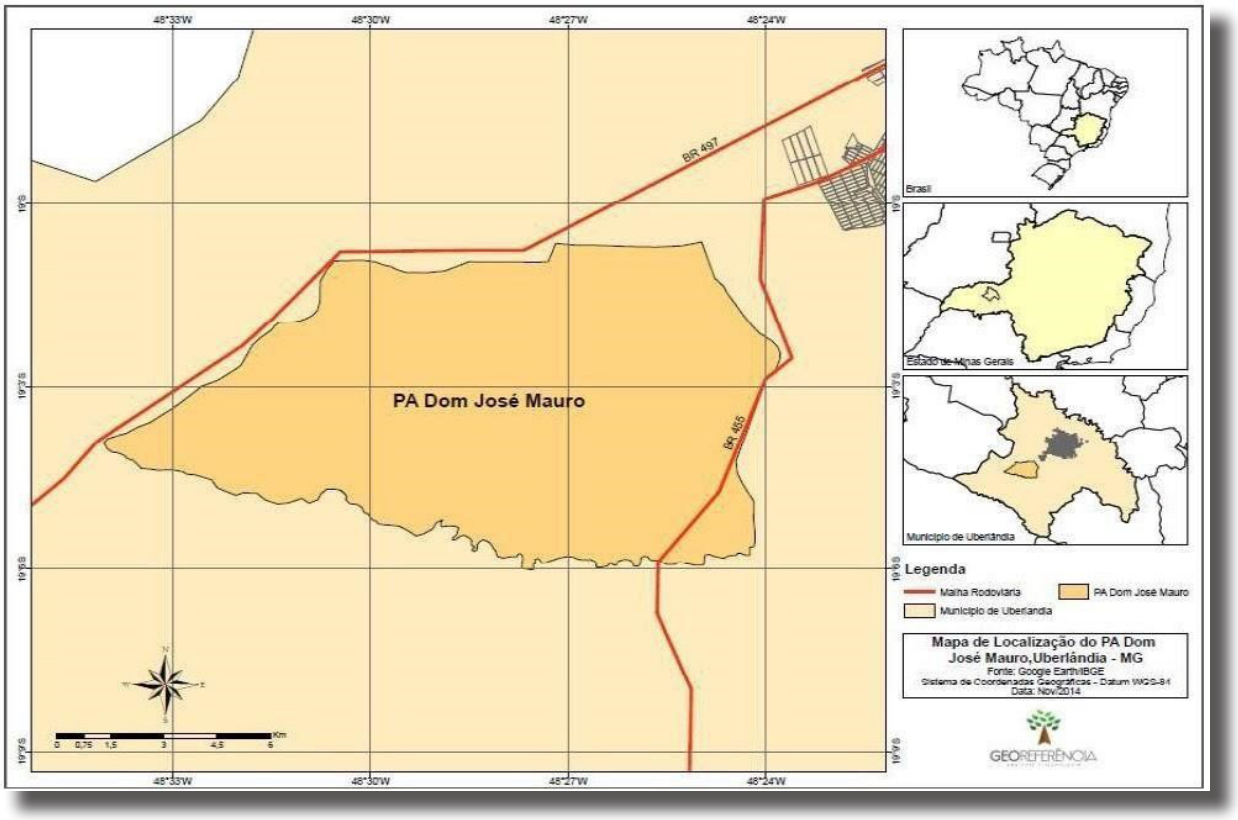

Figure 1 – Map of the Dom José Mauro Settlement (Belizário, 2014).

On the other hand, the Lucilene Fernandes - Fazenda Carinhosa Settlement (map of this settlement not located) is comprised of 60 families. Each of them lives on a plot comprising between 9 ha and 14 ha. 87% of them perform some productive activity on the land. In the settlement there is a basic sanitation structure based on a septic tank and electricity[18].

The sample of this research was defined by convenience. For the convenience sampling, research subjects to which the researcher has direct access were interviewed, without previous probabilistic calculations that define a minimum number of individuals to be interviewed[19]. Therefore, in this study, the leaders of the settlements were contacted, and they were asked about the possibility of participation of the inhabitants of the settlements in the study. Local leaders informed dates and times when most residents would be gathered in a specific place in the settlement so that it would be possible to carry out the interviews with as many participants as possible. This strategy was established in order to overcome the difficulties of displacement within the rural settlement, if individual interviews were carried out with each settled family.

The inclusion criteria for the participants in this study were: being a resident of the rural settlement; being over 18 years old; people of both sexes. Exclusion criteria were: incompletely answering the questionnaire or difficulty in comprehending the instrument's questions so as to compromise the answers

obtained.

A semi-structured form was used to interview residents. A semi-structured interview form contains closed and open questions, the latter giving space for the interviewee to describe how he/she interprets a phenomenon[20]. The sociodemographic variables analyzed were: age, education, place of birth, and origin before living in the settlement.

The identification of the resident's link to the settlement was made through questions that examined their origin and time of residence in the settlement.

The questions on the topic of access to healthcare were about which health service was used, how long and how far it takes to reach it, how they evaluate the health service used, citing positive and negative points, and making suggestions for improvement of this service.

The questions about the residents' health assessment were asked about how they would classify their own health, whether or not they had chronic diseases, if so, what would they be and, finally, if they were being treated and monitored for this health condition.

Three visits were made to the settlements for data collection. 24 residents of the settlements answered the interview questionnaire. All interviews were recorded using a digital recorder and later transcribed in full.

To analyze the responses of residents to the open questions of the questionnaire, Bardin's Content Analysis[22] was used. This is comprised of five stages: pre-analysis, material exploration, treatment of results, inference, and interpretation. Initially, the transcripts of the responses were read briefly, obtaining initial impressions about the material. Subsequently, the material was explored, highlighting, in the reports of residents and leaders, the excerpts that are relevant to the study. At the end, there was an interpretation of the data regarding the objective and interests of the discussion, with the help of the scientific literature.

For statistical analysis of quantitative data, SPSS software, version 20 was used. For statistical analysis of non-parametric independent variables, Pearson's chi-squared test ($\chi 2$) was used. On the other hand, for ordinal independent non-parametric variables, Spearman's Rank Correlation Coefficient was used. To define the degree of strength correlation between the variables, the following criterion was established: weak if $0 < r < 0.4$; moderate if $0.4 < r < 0.7$; and strong if $0.7 < r < 1.023$. Correlations and associations with statistical significance were determined as those that resulted in a p-value ≤ 0.05 and moderate or strong degree of correction.

The construction of the tables was done in Microsoft Office Excel 2016 software.

This research project described herein was approved by the Research Ethics Committee (CEP) registered under the number CAAE: 80446617.7.0000.5152. The interviews were carried out only after the interviewee signed the Informed Consent Form (ICF). The conduct of this study sought to respect the guidelines of Resolutions No. 466, published on December 12, 2012, and No. 510 of April 7, 2016, of the National Health Council[24].

RESULTS

Statistical analysis of the quantitative data obtained in the interviews did not identify statistically significant correlations and associations in any of the questions.

The characteristics of the sample interviewed are shown in Table 1.

It is highlighted in Table 1 that of the interviewed residents, 54.2% (n=13) have chronic diseases. In this group, 7 (53.85%) undergo health treatment to control the disease and 6 (46.15%) do not. Of these chronic diseases, 7 (53.85%) are systemic arterial hypertension (SAH) and the others are subdivided into smaller groups among which were: arthritis, arthrosis, diabetes, leprosy, asthma, bronchitis, and dyslipidemia.

In the analyzed sample, of the 7 residents who have SAH, 4 (57.14%) undergo health treatment to control the disease and 3 (42.86%) do not.

In addition, 66.7% of respondents use the Integrated Care Center (UCC) when seeking care in health services. The UCC are composed of secondary and tertiary health care services.

It is also observed that 58.4% of the population (n=14) interviewed, travel more than 30 kilometers to reach the health service. 41.6% (n=10) reported that it took more than 1.8 hours to reach this service.

The self-classifications of health according to the health service used by the settlement residents are shown in Table 2.

The qualitative analysis of the speeches revealed that, when asked about their main difficulties in accessing the health service, the responses of the residents of the settlement were very similar. They pointed out problems such as the lack of medication available at the health centers, the low number of doctors or even their absence from services, and delays in being seen at the city's emergency services.

When asked about how they evaluated the distance traveled to reach the nearest health unit, the satisfaction of settlement residents was low. Most of them said they were dissatisfied with the distance, as they had difficulty overcoming it. In addition, they reported that, when they arrived at the health service, this problem was added to others, such as lack of attention from the health professional who attends them and the physician's poor connection with them.

Suggestions for improving the quality of health care provided to the population of the settlement were: having health centers closer to the settlement; access to better quality care that comes with more attention given from the professional to the residents' complaints and doctor-patient relationship building.

In this sense, the conductors of this study consider the most important findings of this investigation to be that most of the residents interviewed have chronic diseases. Of these, 46.15% were not followed up and treated for this clinical condition. Most of them used some UCC, a service with a level of secondary and tertiary health care, as a referral health service center. 41.7% of residents in the settlement traveled between 30-39 kilometers to reach the health service. 33.3% of them take between 1.8 and 2.5 hours to reach the health service. The analysis of the interviewees' speeches revealed dissatisfaction with the access to health and the quality of the services used. Suggestions for improving the quality of access to health were to implement health centers closer to the settlement and that more attention be given from the health professional during the service.

Table 1 – Characterization of the sample of residents of rural settlements. Uberlândia, Minas Gerais, Brazil, 2018 (n = 24).

Variable	n	%	95%CI
Sex			
Male	12	50	32.2-75.6
Female	10	41.7	24.4-67.8
Age Groups			
18-44	6	25	9.8-40.7
45-59	10	41.6	22.1-63.4
60-85	8	33.3	15.6-55.3
Education			
Illiterate	4	16.6	5.7-43.7
Incomplete Elementary School	9	37.5	23.1-68.5
Complete Elementary School	1	4.16	0.1-20.5
Complete High School	6	25	11.9-54.3
Time living in settlement (in years)			
5-9.9	11	45.8	25.6-67.2
10-15	13	54.2	32.8-74.4
Possesses Chronic Diseases			
Yes	13	54.2	32.8-74.4
No	11	45.8	25.6-67.2
Birthplace (Brazilian State)			
Minas Gerais	15	45.8	40.6-81.2
Goias	6	25	9.8-46.7
Other	3	12.5	2.7-32.4
Health Service Used			
Primary Care Center (PFCC)	6	25	9.8-40.7
Integrated Care Center (ICC)	16	66.7	44.7-84.4
National Reference Center for Sanitary Dermatology and Leprosy (CREDESH)	2	8.3	1.1-27
Distance traveled to reach health service (km)			
20-29	8	33.3	17.2-59.3
30-39	10	41.7	24.4-67.8
41-50	4	16.7	5.2-40.3
Time taken to travel to health service (hours)			
0-0.8	7	29.2	13.9-54.9
0.9-1.7	7	29.2	13.9-54.9
1.8-2.5	8	33.3	15.6-55.3
>2.6	2	8.3	1.1-27
Rate your own health			
Weak or Reasonable	11	45.8	25.6-67.2
Good	11	45.8	25.6-67.2
Very good or Excellent	2	8.3	1.1-27

* Differences in absolute frequency values refer to loss of information.
95%CI: 95% confidence interval

Table 2 – Health services used by residents of rural settlements in the city of Uberlândia, Minas Gerais, according to their self-classification of health (n = 24).

Rate your own health	Health Service Used		
	PFCC[a] (n=6)	UCC[b] (N=16)	CREDESH[c] (N=2)
Weak or Reasonable; n (%)	1 (16,7)	9 (56,25)	1 (50)
Good; n (%)	5 (83,3)	5 (31,5)	1 (50)
Very good or Excellent; n (%)	0	2 (12,5)	0

[a] Unidade Básica de Saúde da Família.
[b] Unidade de Atendimento Integrado.
[c] Centro de Referência Nacional em Hanseníase e Dermatologia Sanitária.

DISCUSSION

The results of this study indicated that residents of rural settlements are dissatisfied with their conditions of access to health care. Respondents reported difficulties in accessing the health service, such as distance and commuting time. Moreover, most residents do not periodically show to their medical appointments at the PFCC.

Similar research conducted with settlers in Rio de Janeiro indicated that complaints about the displacement to reach health services were also reported by these people[25].

A scarcity of recent surveys that have assessed access to health services by residents of rural settlements was identified. However, a literature review that evaluated 108 works on the subject, published between 2007 and 2015, concluded that 10 studies explicitly indicated difficulties in accessing health services for people living in settlements[26]. Therefore, it is possible that there is poor coverage of Primary Health Care (PHC) in rural settlements and their surroundings, which has been reported in the scientific literature since 2007.

54.2% of respondents in this survey reported having chronic diseases. Of this group, 53.85% do not have any follow-up or treatment for the disease. The most reported chronic disease was SAH. A similar study, also conducted in the Triângulo Mineiro, indicated that 82% of the settlers had morbidities. Of these, 18% reported having SAH and 8% Diabetes Mellitus[25]. SAH is an important risk factor for the development of cardiovascular diseases (CVD)[28]. In this sense, it is suggested that these interviewees diagnosed with chronic diseases are likely to develop CVD in the future.

66.7% of respondents in this survey reported using a Secondary Health Care Service as their reference health center. In addition, the analysis of the answers to the open questions of the questionnaire revealed low satisfaction of settlers with the distance to be covered to reach the health services. Furthermore, they suggested improving the quality of access to their health care and implementing a PFCC closer to the settlement. Research conducted in rural parts of Brazil confirmed the already known low coverage of PHC services in rural areas of the country. This is especially true when compared with the offer of these services in the urban area[29]. Moreover, some Family Health Teams of health services located in rural areas have difficulties in implementing, in their work units, actions that optimize

the health care provided to residents of this region who have a low connection with the service. One examples of these actions is seeking to assist residents who travel long distances to arrive at the service on the same day they schedule their appointment[29]. Considering the assessment of the distance traveled by residents to the health services, as well as the percentage of those who use PHC services as a reference, we consider that the settlers analyzed in this study live in places with low coverage of PHC services. In addition, these PHC services do not use effective strategies, in their operation, focused on reducing the difficulties of access of this population to health care.

In this investigation, the residents of the settlement demanded improvements to the quality of access to health and more attention from the health professional during the service. Literature reviews that sought to analyze investigations that evaluated, quantitatively and qualitatively, the doctor-patient relationship, indicated the existence of a possible lack of empathy of health professionals with them during care[30]. In addition, other studies considered herein indicated that if the health professional pays attention to improving emotional aspects of the doctor-patient relationship during the consultation, the subsequent assessment made by the patients about the quality of the consultation can improve. Thus, we suggest that the settlers questioned in this study can improve their perception of the quality of the health service they access if the professionals who work on them seek to improve and appreciate affection during care.

CONCLUSION

It was identified in this study that approximately half of the interviewed rural settlement residents reported having chronic diseases. However, a similar portion of respondents self-evaluated their health as good. Most residents did not positively evaluate the health services used nor their access to them.

It is likely that there is low coverage of PHC services in the vicinity of the settlement and that this contributes to the maintenance of chronic disease rates found in this population. One way to reverse this disease trend would be through the implementation of strategies that seek to improve the quality of these services provided.

This investigation has limitations. Among them, a previous sample calculation was not performed using data from the National Institute of Colonization and Agrarian Reform (NICAR) with the number of settlers in the *Triângulo Mineiro*, Minas Gerais.

As strengths of this study, we highlight that this was a rarer type of investigation in the recent scientific literature, as well as the use of a semi-structured questionnaire to obtain data.

It is suggested that more studies be conducted to assess larger samples of residents of rural settlements in Minas Gerais; thus, providing a better understanding of health conditions and access to public services by this population.

REFERENCES

1. União das Repúblicas Soviéticas Socialistas. Conferência Internacional Sobre Cuidados Primários De Saúde. Declaração de Alma-Ata. Alma-Ata (URSS) [Internet] 1978 [citado 7 março de 2020]. Disponível em: http://cmdss2011.org/site/wp-content/uploads/2011/07/Declara%C3%A7%C3%A3o-Alma-Ata.pdf
2. Dantas ACMTV, Martelli PJL, Albuquerque PC, Sá RMPF. Relatos e reflexões sobre a Atenção Primária à Saúde em assentamentos da Reforma Agrária. Physis [Internet]. 2019 [citado 7 março de 2020]; 29 (02):1-19. Disponível em: <https://www.scielo.br/j/physis/a/4LmRGDZFHdmmCMnpZwSNhSD/?lang=pt>. doi: 10.1590/S0103-73312019290211.
3. Brasil [Internet]. Lei Nº 4.504, de 30 de novembro de 1964. Dispõe sobre o Estatuto da Terra, e dá outras providências. [atualizado em 1964; acesso em 3 mar 2020]. Disponível em: <http://www.planalto.gov.br/ccivil_03/leis/l4504.htm>.
4. Maywald PG, Marcial Junior O. Estrutura de áreas protegidas dos assentamentos de reforma agrária no município de Uberlândia-MG, Brasil: um estudo de ecologia de paisagem. Soc Nat. [Internet]. 2013 [citado 7 março de 2020]; 25(01):75-90. Disponível em: <https://www.scielo.br/j/sn/a/3KgFjdnBZDMbfQLvk4DqCzw/?lang=pt>. doi: 10.1590/S1982-45132013000100007.
5. Celuppi IC, Geremia DS, Ferreira J, Pereira AMM, Souza JB de. 30 anos de SUS: relação público-privada e os impasses para o direito universal à saúde. Saúde Debate [Internet]. 2019 [citado 7 março de 2020]; 43(121):302-313. Disponível em: <https://www.scielo.br/scielo.php?script=sci_abstract&pid=S0103-11042019000200302&lng=en&nrm=iso&tlng=pt>. doi: 10.1590/0103-1104201912101.
6. Andrade EF de. A Estratégia de Saúde da Família (ESF) em Assentamento de Reforma Agrária: o caso da Unidade Básica de Saúde do Assentamento Bela Vista do Chibarro [dissertação]. Uberlândia (MG): Universidade Federal de Uberlândia; 2017.
7. Gaudioso CE, Souza JCRP, Criado FS, Monteiro BH, Barbosa DA. Saúde do trabalhador rural: uma revisão bibliográfica. Rev Ciênc Trabalho [Internet]. 2018 [citado 7 março de 2020]; (11). Disponível em: <https://rct.dieese.org.br/index.php/rct/article/view/166>.
8. Rocha LP, Cezar-Vaz MR, Almeida MCV, Borges AM, Silva MS, Sena-Castanheira J. Workloads and occupational accidents in a rural environment. Texto Contexto Enferm. [Internet]. 2015 [citado 7 março de 2020]; 24(2):325-35. Disponível em: <https://www.scielo.br/j/tce/a/RS7CC8PB8CQf5gR4yfN9dMv/?lang=en>. doi: 10.1590/0104-07072015000480014.
9. Andrade MV, Noronha KVMS, Menezes RM, Souza MN, Reis CB, Martins DR et al. Desigualdade socioeconômica no acesso aos serviços de saúde no Brasil: um estudo comparativo entre as regiões brasileiras em 1998 e 2008. Econ Apl. [Internet]. 2013 [citado 7 março de 2020]; 17:623-45. Disponível em: <https://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-80502013000400005&lng=en&nrm=iso>. doi: 10.1590/S1413-80502013000400005.
10. Costa MC da, Silva EB, Soares JSF, Borth LC, Honnef F. Mulheres rurais e situações de violência: fatores que limitam o acesso e a acessibilidade à rede de atenção à saúde. Rev Gaúcha Enferm. [Internet]. 2017 [citado 7 março de 2020]; 38(2). Disponível em: <https://www.scielo.br/j/rgenf/a/PDhWVNzrq5R7vYjjWT9Dkmg/abstract/?lang=pt>. doi: 10.1590/1983- 1447.2017.02.59553.
11. Merriam-Webster [Internet]. An Encyclopedia Britannica Company. [acesso em 3 set 2021]. Disponível em: <https://www.merriam-webster.com/dictionary/self-classification>.
12. Silva KA; Bartholomeu MAN, Claus MMK. Auto-avaliação: uma alternativa contemporânea do processo avaliativo. Rev Bras Linguist Apl. [Internet]. 2007; 7(1): 89-115. Disponível em: <https://www.scielo.br/j/rbla/a/7trGtMHc6mNFdF4QqFDG4YD/abstract/?lang=pt>. doi 10.1590/S1984-63982007000100006.
13. Apollinário F. Dicionário de metodologia científica: um guia para a produção do conhecimento científico. São Paulo: Atlas; 2004.
14. Brasil [Internet]. Instituto Brasileiro de Geografia e Estatística. Uberlândia. [atualizado em 2020; acesso em 3 mar 2020]. Disponível em: <https://cidades.ibge.gov.br/brasil/mg/uberlandia/panorama>.
15. Secretaria Municipal de Planejamento Urbano de Uberlândia [Internet]. Banco de dados integrados. [atualizado em 2016; acesso em 3 mar 2020]. Disponível em: <http://servicos.uberlandia.mg.gov.br/uploads/cms_b_arquivos/17811.pdf>.
16. Prefeitura Municipal de Uberlândia [Internet]. Unidades de Atendimento: endereços das unidades. 2020 [atualizado em 2020; acesso em 3 mar 2020]. Disponível em: <https://www.uberlandia.mg.gov.br/prefeitura/secretarias/saude/unidades-de-atendimento-em-saude/>.
17. Brasil [Internet]. Sistema de Informação de Atenção Básica - Cadastramento Familiar- Brasil. [atualizado em 2020; acesso em 3 mar 2020]. Disponível em: <http://tabnet.datasus.gov.br/cgi/deftohtm.exe?siab/cnv/SIABFbr.def>.
18. Pereira AM. Experimentação Agroecológica: descrição de práticas visando a sustentabilidade rural e ambiental [dissertação]. Uberlândia (MG): Universidade Federal de Uberlândia; 2017.
19. Mahaluça F. Noções de amostragem. Moçambique; 2016.
20. Manzini EJ. Entrevista semi-estruturada: análise de objetivos e de roteiros. Marília; 2004.
21. Belizário TL. A influência da qualidade da água para a saúde dos moradores do projeto de assentamento de reforma agrária Dom José Mauro, Uberlândia-MG [dissertação]. Uberlândia (MG): Universidade Federal de Uberlândia; 2015.
22. Bardin, L. Análise de Conteúdo. Tradução de Luís A. Reto e Augusto Pinheiro. Lisboa: Edições 70; 2009.
23. Siqueira AL, Tibúrcio JD. Estatística na área da saúde: conceitos, metodologia, aplicações e prática computacional. Belo Horizonte (MG). Coopmed; 2011.
24. Brasil [Internet]. Conselho Nacional de Saúde. Resolução nº. 510 de 07 de abril de 2016. Dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais. Diário Oficial da União, 24 de maio 2016; Seção 1, 2016 [atualizado em 2016; acesso em 3 mar 2020]. Disponível em: <https://bvsms.saude.gov.br/bvs/saudelegis/cns/2016/res0510_07_04_2016.html>.
25. Santos JCB, Hennington EA. Aqui ninguém domina ninguém: sentidos do trabalho e produção de saúde para trabalhadores de assentamento do Movimento dos Trabalhadores Rurais Sem Terra. Cad Saúde Pública [Internet]. 2013 [citado 7 março de 2020]; 29(8):1595-1604, Disponível em: <https://www.scielo.br/j/csp/a/4TqkCwbYLYnmkYBcxsDWyLM/abstract/?lang=pt>. doi: 10.1590/0102-311X00096612.
26. Barros LDV, Teixeira CF. Movimento dos Trabalhadores Rurais Sem Terra e saúde do campo: revisão integrativa do estado da arte. Saúde Debate [Internet]. 2018 [citado 7 março de 2020]; 42(2):394-406. Disponível em: <https://www.scielo.br/scielo.php?script=sci_

abstract&pid=S0103-11042018000600394&lng=en&nrm=iso&tlng=pt>. doi: 10.1590/0103-11042018S227.
27. Lima NS, Calábria LK, Melo JV, Rodrigues NBC, Lopes PD, Borges AC et al. Prevalência de doenças crônicas não transmissíveis em população no assentamento da reforma agrária no Pontal do Triângulo Mineiro. Rev Med Saúde Brasília [Internet]. 2018 [citado 7 março de 2020]; 7(1):5-23. Disponível em: <https://portalrevistas.ucb.br/index.php/rmsbr/article/view/8977/5731>.
28. Malachias MVB, Plavnik FL, Machado CA, Malta D, Scala LCN, Fuchs S. 7ª Diretriz Brasileira de Hipertensão Arterial. Arq Bras Cardiol. [Internet]. 2016 [citado 7 março de 2020]; v. 107, n. 3, supl. 3, p. 1-6. Disponível em: <https://www.scielo.br/scielo.php?script=sci_arttext&pid=S0066-782X2016004800002>. doi: 10.5935/abc.20160151.
29. Garnelo L, Lima JG, Rocha ESC, Herkrath FJ. Acesso e cobertura da Atenção Primária à Saúde para populações rurais e urbanas na região norte do Brasil. Saúde Debate [Internet]. 2018 [citado 7 março de 2020]; 42(1):81-99. Disponível em: <https://www.scielo.br/j/sdeb/a/3tZ6QRxxTsPJNj9XwDftbgS/abstract/?lang=pt>. doi: 10.1590/0103-11042018S106.
30. Sposito CVA, Silveira FC, Uechi FAA, Crevelim KR, Silva MAD Análise de questionários de satisfação sobre relação médico-paciente: uma revisão bibliográfica. Rev Ágape [Internet]. 2018 [citado 7 março de 2020]; 1(1):1-11. Disponível em: <http://revistaagape.com.br/index.php/revistaagape/article/view/17/11>.

Received in november 2020.
Accepted in september 2021.