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Perception of the Women of the Mandacaru Settlement about Health Care

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Abstract

This article aims to discuss the understanding of the perception of health care of women living in the Mandacaru Settlement. It consists of a qualitative research, with an ethnographic approach, and analyzed from the interpretative analysis. The field study was carried out in the Mandacaru Settlement, in Petrolina, Pernambuco, from March to June 2019 and 17 women participated in the research. This study was submitted to and approved by the Ethics Committee of the University of São Paulo School of Nursing. These women were between 22 and 79 years old, were rural workers, artisans, confectioners, and many of them were migrants, and this is a common characteristic in the Submedio São Francisco Region, and among the main results found are the impact of the transition from conventional agriculture to agroecology and the understanding, or perception, of health care in the context in which they live. Thus, they perceive it as a space of diverse health care practices rich in popular knowledge and with a strong relationship with rural work.

Keywords: Health Care; Rural Settlements; Rural Women's Health

Abbreviations: INCRA: National Institute of Colonization and Agrarian Reform; EEUSP; Ethics Committee of the School of Nursing of the University of São Paulo; ICF: Informed Consent Form.

Introduction

In the context of rural agrarian reform settlements, which consist of sets of agricultural units installed by the National Institute of Colonization and Agrarian Reform (INCRA) in a rural property [1], landless rural women farmers find diverse and beneficial spaces that go beyond land ownership. They offer a wide range of products, strengthen family farming, agroecology and are considered reference spaces in social participation and health care practices [1].

They are structures where there is the possibility of adding values, building a consolidated identity and encompassing their ways of life. In addition, settled women have a very strong representation in the preservation of skills needed in different productions, which can range from basic food crops to the raising of animal species [2].

Women who live in rural settlements can be important references in their communities due to their important representativeness in family farming, in the process of agroecological transition, for seeking their own livelihood, but also for building their identities as settled women in the

search for autonomy and rights and it is within the context in which they live that they develop their health care practices based on their knowledge and experiences full of meaning.

When it comes to care, it is discussed that it involves an attitude about one's own life, a way of looking at or establishing relationships with the world, and the construction of a set of practices that would serve as support for the elaboration and modification of one's knowledge of oneself and of the other [3]. In other words, care is born from a relationship between oneself and with the other, based on a construction of care practices and, for the author, caring for the other consists of also taking care of oneself.

In the common sense, care can be attributed to a meaning of "a set of procedures technically oriented to the success of a certain treatment" Ayres JRCM [4], but health care practices are produced from several aspects that involve experiences and actions, going beyond sets and technical knowledge.

Therefore, the main objective of this research was to understand the perception of health care of women living in the Mandacaru Settlement, seeking to understand its codes and meanings in the sociocultural context in which they are inserted.

Method

Type of Study

This article consists of a qualitative research with an ethnographic approach and was produced from the Doctoral Thesis entitled "'*When I stay still, I get sick*': meanings about the body and health care practices of women in the Mandacaru Settlement, Petrolina – PE" defended and approved in May 2021.

Qualitative research is concerned with a sociocultural dimension, beliefs, values, opinions, representations, forms of relationship, uses, customs, and behaviors [5]. This process helps us to understand these relationships generated by human beings that leads us to interpret such realities.

Thinking about the group of settled women, the collectivity and experience of health care practices, the ethnographic approach was fundamental, as it aims to observe and understand the relationship between discourses and practices about the body, care, rural work, living in settlements, related to the sociocultural codes specific to the context in which women are inserted.

Ethnography, on the other hand, is a traditional procedure of Anthropology, constituting a set of conceptions and procedures used with the objective of scientifically understanding a given sociocultural reality [6]. In this sense, anthropology and its ethnographic method of investigation become powerful instruments Gualda DMR [7], insofar as it highlights the limits of the biomedical model by revealing that the health practices of a population are directly linked to their way of life within a sociocultural context. Therefore, it was essential to apprehend the point of view of these women from the understanding of the meanings of certain social practices they experience.

Place of Study

The research was carried out in the Mandacaru Settlement located in the municipality of Petrolina, in the semi-arid region of Pernambuco. The settlement is located 18 km from the center of the city of Petrolina and has a total area of 482 hectares where approximately 65 families are settled.

The Mandacaru Settlement began with the occupation of a farm in 1999 and was regularized by INCRA in 2001, making its creation official. Thus, it was chosen for its history and already established structure. In its more than twenty years of foundation, it already has direct public transportation to the community, electricity network, piped water, public lighting, community garden, residents' association, that is, it has traveled a historical path and life experience that has led to the construction of sociocultural codes and meanings about its experiences.

The research began at the end of 2016 through bibliographic research and data collection took place between February 2019 and June 2019 and, as it is a qualitative research with an ethnographic approach, there was no search for statistical representativeness. But, as an inclusion criterion, women had to be 18 (eighteen) years of age or older and reside in the settlement.

In qualitative research, there is no sense in the search for statistical representativeness, but for social representativeness, and not even a probabilistic number makes much sense[11]. Therefore, for this study, a number of participants was not defined. Thus, the snowball sampling technique was applied, based on a subject (seed), widely used in qualitative research to study groups that are difficult to access.

Upon arriving at the Settlement, the one who became the seed in this process was one of the community leaders who introduced some women, taking them to meet the Community Health Agent (CHA) who lives in the settlement and she led the other women. To characterize this research,

empirical saturation was followed, in which the data being collected no longer bring new or different information that justifies an increase in the collection of material [8].

To construct the research, the instruments of participant observation and semi-structured interview were applied, in addition to a field diary. Participant observation was applied in order to gather a qualitative corpus of information that is based on communicational rationality and can be obtained through direct contact of the researcher with the observed phenomenon Minayo MCS [9,10], in order to collect the actions of the actors in their natural context, from their perspective and their points of view.

Semi-structured interviews were conducted in places of the women's choice in order to make them feel comfortable for the activity. The interviews were audio-recorded and photographs were recorded. Seventeen (17) women aged between 22 and 79 years who live in the settlement participated in the interviews and, to replace their original names, names from the biodiversity of the Caatinga and very present in the territory in which they are located were chosen.

Data Analysis

For analysis, the audios were transcribed and organized into documents that are still stored following confidentiality and preserving the identity of the women. After transcription, the data were analyzed using the technique of interpretation of meanings, based on the encounter with the facts that emerged in the investigation. The categories were highlighted based on an exhaustive reading and followed the operational steps proposed by Minayo MCS [5]: data ordering; data classification; analysis itself, articulating the information.

Ethical Aspects

Based on Resolutions No. 466/2012 of the National Health Council [11] and No. 510/2016 [12], which deal with research involving human beings, the research project was submitted to and approved by the Research Ethics Committee of the School of Nursing of the University of São Paulo (EEUSP).

The participation of the women settlers was conditioned to the signing of the Free and Informed Consent Form (ICF) requesting authorization for the use of the narratives, as well as the images of the place and the women for research purposes and scientific publications. The terms were signed in two copies in which the objectives and methodological procedures of the investigation were presented, ensuring that the information would be treated anonymously and exclusively for scientific purposes.

Findings

Profile of the Women of the Mandacaru Settlement: From the first day of occupation of the territory to the present day, the women of the Mandacaru Settlement play an important role in the construction of local history and their own autonomy within the context in which they live. Table 1 describes the profile of the women participating in the research who were named after plants of important representativeness in the Caatinga.

Name	Age	Naturality	Profession	Income	Marital Status	Schooling	Religion	Child No.
Quixaba	79	Eshu - PE	Retired farmer	1 minimum wage	Married woman	Illiterate	Catholic	12
Pot-bellied	51	Exu-PE	Farmer and day laborer	No fixed income	Single	3rd year of Fundamental	Catholic	0
Aroeira vermelha	45	Salgueiro-PE	Farmer and trader	>1 minimum wage	Stable union	Middle school	Catholic	3
Catingueira	40	Cabrobó-PE	Farmer	Bolsa Família	Divorce	4th year foundation	Catholic	6
Angico	22	Juazeiro-BA	Agricultural technician	No fixed income	Single	Agricultural Technical High School	No religion	0
Bromeliad	49	Triunfo-PE	Farmer and artisan	1 minimum wage	Married woman	4th year foundation	Catholic	8
Cactus	68	Orocó-PE	Retired farmer and confectioner	1 minimum wage	Divorce	Illiterate	Catholic	2

Palm	63	Parnami-rim-PE	Housewife and Widowhood Benefit	1 minimum wage	Widow	4th year foundation	Evangelical	4
Jurema	53	Trindade-PE	Farmer	1 minimum wage + Bolsa Família	Married woman	3rd year foundation	Catholic	4
Juazeiro	74	Petrolina-PE	Retired farmer	1 minimum wage	Widow	4th year foundation	Catholic	15
Jericho	45	Irecê-BA	Farmer and confectioner	1 minimum wage	Separate	Grade 5	Evangelical	3
Xique-xique	64	Cabrobó-PE	Farmer and confectioner	>1 minimum wage	Single	8th and 9th year in progress (EJA*)	Catholic	4
Umbuzeiro	33	Trindade-PE	General services (unemployed)	Bolsa Família	Widow	3rd Grade Elementary	Evangelical	2
Faveleira	52	Exu-PE	Farmer and marketer	>1 minimum wage	Married woman	3rd year foundation	Evangelical	3
Facheiro	50	Ouricuri-PE	Farmer and marketer	>1 minimum wage	Divorced	4th year foundation	Catholic	2
Mandacaru	39	Cabrobó-PE	Agricultural technique	>1 minimum wage	Stable union	Completed higher education	Catholic	2
Friar's Wreath	49	Araripina-PE	Farmer, nursing technician and Community Health Agent	>1 minimum wage	Married woman	Completed higher education	Catholic	3

Table 1: Profile of the women from the Mandacaru Settlement who participated in the interviews.
Source: Prepared by the author (2020).
***EJA** – Youth and Adult Education.

The 17 interviewees signed the informed consent form and were instructed on all the procedures and objectives of the interview, agreeing to participate spontaneously and very collaboratively.

Table 1 shows that most of these women are not from the municipality of Petrolina, but are migrants from other cities in search of the work offered in the irrigation projects that exist in the region focused on fruit growing. Only Juazeiro was born in Petrolina. Due to being known for irrigated fruit growing, Petrolina attracts families in search of improvements through work in this sector.

This migration process, the need to work from an early age, to take care of the children led most of these women to leave school very early [13]. This group had a number of eight women still of reproductive age, but even those who are older have spent their lives working hard in agriculture. As the rural economic dynamics of the region is increasing, priority is given to the implementation of irrigated fruit growing perimeters, it is in these spaces that rural workers are joining and rebuilding their lives and those of their families. Despite the difficulty during the process, it was through migration that many women participating in this research arrived in Petrolina and followed a trajectory that led them to the settlement.

When it comes to profession, or occupation, most are farmers, but they can carry out other activities such as women confectioners, day laborers and artisans. Most of them are salaried and three of them receive the benefit of Bolsa Família, a social support program for people without income in Brazil. Two of them took an agricultural technician course and one took a nursing technician course. Of those who attended higher education, one graduated in environmental management and the other in pedagogy. These are women who had to reconcile rural work, family care and studies, and rural work and family required a lot of time and effort.

Cactus and Quixaba only sign their own names because they did not have the opportunity to study, as they had to deal with the fields and their children from a very early age. Among these women, the predominant level of education was not beyond elementary school. In these cases, work and home care led them down a path they didn't have much choice about. They had to stop studying and Xique-xique was one of those women who had to abandon her studies to work and take care of her children, but now she is proud to be able to study again and, even at the age of 64, she is attending Youth and Adult Education (EJA) and said that she will finish high school and dreams of attending college.

As for religion, we have a Catholic majority (twelve), four evangelicals and one with no religion at all. Angico affirms that he believes in God, that he does not follow any religion, but that his belief is present in everyday life.

The Transition from Conventional Agriculture to Agroecology and Its Relationship with Health

The farmers of the settlement had to go through a process of transition from conventional agriculture to agroecological production. This process presented several obstacles to be overcome and the main difficulties faced were: lack of technical assistance, lack of scientific references, isolation of farmers and lack of practice in organization and associativism [14].

The so-called conventional agriculture consists of the use of management techniques that involve the use of chemical fertilizers and pesticides and is widely used in monocultures [15]. Agroecology involves the use of natural methods to combat pests and protect vegetables such as: syrups, pepper, natural fertilizers, and compost products.

Agroecology has an important meaning for these women of the settlement with regard to health care practices, in view of objectivity in the construction of healthy eating, care for the environment and the community. This activity has been expanding the orientations in these practices, leading to a search for a better quality of life, as stated in Bromelia's narrative, when asked about what health is: "*First of all, food!*". Throughout our conversation, I emphasized this relationship between food and health as a means of care for a better good life.

Two agroecological activities of great importance to the community are the Community Garden and the Sweet Group, the first group being composed of 60% women and the second is 100% female. In both activities, women work and experience a complex way of life, with multiple activities and working hours, which demands a lot of health. Agroecology is important and impacts the lives of these women in a way that they strongly associate with health care, both for healthy eating, without the application of pesticides, and for mental health, as this offers them security, autonomy and they feel reassured for being able to work, because the body that works is healthy.

This transition process was remarkable in the community, especially for those women who had some allergy or sequelae due to the excessive use of pesticides. "*My neck was this thick, swollen, my face, my hands [...] I harmed myself and became allergic and 'a' can enter an area that has poison*" (Facheiro, 50); "*I can't work in the fields, no. I have a problem with my eyesight because of the poison. I got this problem and I can't even work*" (Umbuzeiro, 33). Both narratives express the relationship between work, pesticide use and health, leading these women to present limitations in their work activities.

The group was accustomed to agricultural activities that involved the use of pesticides on large farms, the use of certain techniques and inputs that they could not afford and needed to implement new activities, acquire new technical knowledge that could subsidize and diversify the production culture.

Harmful chemicals killed about 193,000 people per year until 2018 and those who work in this area are subject to poisoning, allergies, even deeper problems such as deformities, congenital malformations, endocrine, neurological, mental disorders and the development of tumors. It is important to highlight that both women refer to pesticides as "poison", emphasizing their harmfulness to health, but it was something that also affected the financial and social lives of both.

For Facheiro, the transition process was relevant, as it gave her the opportunity to continue working as a farmer. However, Umbuzeiro's life was totally harmed, because the main sequelae caused by the pesticide was glaucoma, and the strong sun of the hinterland prevents her from working in agriculture. Thus, she started to maintain herself with the Bolsa Família and with some cleaning activities in the surroundings and neighboring villages.

Discussion

Health care involves a complex network of interactions that "*encompasses different forms of knowledge, values, beliefs and meanings that shape health practices within a sociocultural context*. Reflecting on the relationship between health care and the women of the Mandacaru Settlement, it is understood that health results from care practices that are cultivated from their experiences and relationships with the community and the health system.

For the women of the Mandacaru Settlement, these experiences and relationships also involve the process of

illness, which can guide the way they experience their care practices. The representation of diseases, popular beliefs, cognitive models, culturally constituted realities can be considered the main paradigms related to the health-disease process that guide various health care practices.

"*Be careful with that so you don't let the disease arrive. It is for one to be on the safe side*" (Jericho, 45). Jericho brings a perception in her narrative to express that, for her, health care has to do with prevention, but it is a relationship that goes beyond that. For the women of the Mandacaru Settlement, it is also a relationship with work.

"*I think it has everything to do with the work, because our work is very heavy. For those who have back problems, a certain time will come... Just like a doctor once said to me, he said I wouldn't be able to pick up the weight of a needle. And that the time would come when I would be in a wheelchair, if I didn't take care of myself. Then I said, 'Mercy!' But even so, I didn't go into his conversation and I keep working. But now, I'm feeling (pain) more constant, right? I took injections, I spent more than six 'months'... Six 'months' like this, just shaking*, not feeling much. But now, unfortunately, it's more frequent (the pain)." (COACH, 50)

For the community, the risk at work is imminent and daily. These risks can directly affect your health, but on closer reflection, there is a cultural logic permeated in this life trajectory. Everyone deals with daily risk in a natural way, as it is part of their routines.

Such risks are part of the deep-rooted culture that in the hinterland it is normal, it is common to face high temperatures, the possibility of encountering a venomous animal and this coexistence can lead to a fragility in health care practices in terms of prevention, protection, but for the community it is something natural. It is something that can be seen as vulnerability from the point of view of health professionals, but it is a situation that they demonstrate mastery and knowledge of the main problems faced are caused by excessive sun exposure among this class, according to several studies, and may include the appearance of melasmas and skin cancer. Thus, it is argued that many farmers in the semi-arid region of the Northeast avoid the use of Individual Protective Equipment (PPE), under various allegations such as the high cost of materials and the discomfort at work due to the weather.

When asked about the lack of use of PPE, she said that they are used to it, that clothing is already a form of protection, but recognizes that they should protect themselves better. Few have access to sunscreen and Faveleira said he does not use it due to a strong allergy to the product. Crown-of-friar, Mandacaru and Bromeliad claimed to use it constantly, but it has not been a practice for all.

In addition to the relevant relationship with work, the concern with access to health units permeates the health care of these women. The Mandacaru Settlement depends on the health units located in the urban area, but most often uses the Basic Health Unit (UBS) that is located in the rural village at a distance of about seven kilometers from the community. To get to the city, it can take an average of forty minutes. To go to any of the services, it is necessary to use transportation, whether collective or private, which becomes a barrier, as many do not have the financial conditions to pay for transportation.

The nearby UBS is composed of CHA, nurse, physician, nursing technicians, receptionists, offices, vaccination room and blood collection. In the city, the most accessed places are the Emergency Care Unit (UPAE), the University Hospital and the Polyclinic, in addition to the Dom Malan Hospital for obstetric urgencies and emergencies. These services are used in cases of greater urgency and for services of greater complexity. At the UBS they manage to solve most of the problems, but they complain that the number of tickets that are distributed daily for medical appointments is insufficient.

One of the main complaints of these women is the delay in consultations, the difficulty in accessing vaccination and referral for exams or surgeries. According to Coroa-de-frade, vaccination at the UBS which, because there is no refrigerator, there is no vaccine on a daily basis. Many mothers take their children to the city or even get appointments in the urban area due to the long wait and, in order to get these services, they use strategies such as third-party addresses in order to register in these central units.

Studies show that most health services are located in urban areas of municipalities and do not cover settlement areas. To meet these needs, the women of the settlements use strategies similar to the women of the Mandacaru Settlement, when using other addresses, considering the economic and geographical difficulties to access services.

The services most sought by women in the professional health system are usually related to reproductive health, such as the use of contraceptives, prenatal care, pediatric consultations, vaccination, as well as preventive cytopathological and breast exams. They still seek to perform laboratory tests to monitor chronic diseases such as hypertension and diabetes *mellitus*. The ACS always assists with guidance, with information about the days of appointments and vaccinations, informs about the scheduling of exams and tries to help in some more specific and more time-consuming exams.

Studies show that there is an important difference between the care offered to women in urban and rural areas, especially with regard to obstetrics and gynecology, that is, women of reproductive age [13]. Among the women of the Mandacaru Settlement, it is common for them to seek care in the city, even though it is more distant, while they are of reproductive age. However, the nearest UBS provides prenatal care, cytopathological and laboratory tests and other needs through the Family Health Strategy (FHS) program in Primary Health Care. This program offers a follow-up structure for the mother-baby binomial from the diagnosis of pregnancy to the birth and growth of the child through childcare consultations with medical professionals and nurses.

For the climacteric and menopause periods, the UBS also offers follow-up services through the FHS, but these women very often resort to popular knowledge through the use of herbs and medicinal plants that they learned from their ancestors. Younger women prefer to use industrialized medicines and rarely, if ever, resort to natural products for their health care.

In the field of Public Health, the scientific and popular knowledge produced by consumers, health workers and the general population is considered for the organization of the care strategies and practices of the public health system. Thus, the care practices of the women of the Mandacaru Settlement follow a logic that organizes, guides and leads to the development of their own practices, many of which are passed down from generation to generation.

The sociocultural context in which a group is inserted shapes the therapeutic itineraries experienced by individuals. These experiences guide health practices, reflecting the patterns of certain social groups, such as settled women.

These experiences have a depth and complexity that is particular to the settled women, and this complexity establishes the meanings that construct this health care. Groups like this can offer their members many benefits, such as sharing lifestyle advice or coping strategies, or acting as a refuge for isolated individuals.

These women articulate health care practices that go beyond the public and private spheres, in addition to being shared both with other women and with the health professionals with whom they relate. The production of health involves understanding how health care practices are inserted in an ever-changing scenario. That is, it is not something constant, fixed or inflexible. On the contrary, there are exchanges, lived experiences and socio-cultural relations that permeate such productions.

Health for these women is intrinsically related to rural work and the opportunity to work with agroecology, that is, without the use of pesticides, is something of paramount importance for this population in view of the great damage to health that these harmful chemicals can cause to health, including leading to death. The World Health Organization (WHO) has published several publications discussing the use of pesticides in food and their impact on 300,000 deaths per year [14]. In addition, several other studies discuss the impacts of pesticides on women's health, from poisoning to infertility [15].

The diversity of these women's daily practices showed a constant and daily exercise of care in its multiple dimensions. Their health care practices include concern with food, the use of natural products from the region for the production of teas, sitz baths and, among others, with water treatment, with the hygiene of both the body and the environment in which they live. There is also a care that involves spiritual, social and financial life.

In this sense, health care practices can be understood as socially organized responses. They reflect the interactive complex between social groups, institutions, relationship patterns, and a specific body of knowledge. They show the diversity in the forms of care in different groups and can be understood as social conditions for such practices.

The Health Care System is constituted by the interaction of three different sectors: the traditional, the popular and the professional, so that each sector conveys specific beliefs and norms, legitimizing different health care practices. Each sector has its own ways of explaining and treating the lack of health, defining who is the person who heals and who is the patient, and specifying how they should interact during the therapeutic encounter. The traditional sector is the lay, non-professional and non-specialized domain of society, in which the lack of health is first recognized and defined. It is in this sector that primary health care is provided.

The logic that guides this care practice is based on beliefs about the structure of the body, the origin and nature of diseases. In fact, the main sphere of care is the family, so that it is in the family environment that complaints are identified and dealt with. In these groups, women are the main providers of health care, usually mothers and grandmothers, who diagnose most of the diseases and treat them with the available resources.

The folk sector is one in which certain individuals specialize in sacred or secular forms of healing. In other words, they are care practices that do not belong to the official medical system and occupy an intermediate position

between the traditional and professional sectors.

In this sector, it operates with a holistic understanding of health and disease, involving all aspects of the patient's life: relationships with other people, the natural environment or supernatural forces. Thus, the popular sector operates within a relational logic, so that health care involves the entire network of relationships of which the patient is a part.

On the other hand, the professional sector is dominant and hegemonic in our society, in health care it comprises the health treatment professions that are organized and legally sanctioned, as is the case of biomedicine. In this sector, most health professionals orient their health care practices within a logic specific to the biomedical model, based on an anatomical and physiological understanding of the body, health and disease.

Studies argue that half of the world's population lives in areas considered rural, with only 38% of nurses and less than 25% of doctors working in these areas. This context of health services reveals the lack of quality of care in rural communities. Thus, this settled population needs to resort to a set of practices to take care of their health, including seeking care in the services located in the surroundings.

In the face of the struggle for the health of the settled population and the expansion of health services implemented in settlements or in the surrounding areas, the difficulty of access is still great and the care models often do not take into account their particularities.

Conclusion

During this trajectory, the paths of these women around the health care systems are discussed, but it is evident that the theme does not end here. Quite the opposite. There is much to know and deepen about these women who seek popular, scientific or professional knowledge and reflect this life experience in their daily lives.

In the midst of all this complexity, they develop their health care practices that carry diverse meanings permeated by cultural, social, political and historical contexts. This care involves rites, relationships with nature, social relationships, with work and with themselves. [16-18].

Therefore, in order to think about the health care of settled women, we must look at the totality of the sociocultural context in which they are inserted, so that I hope that this research will be an incentive for new studies in order to expand the scientific knowledge of these women and their experiences about the body and health.

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