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State of the art of the brazilian nursing stricto sensu production on rural population health

Estado da arte da produção stricto sensu da enfermagem brasileira sobre saúde da população rural

Estado del arte de la producción stricto sensu de la enfermería brasileña sobre la salud de la población rural

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Abstract

Objective: to characterize the *Stricto sensu* production of Brazilian post-graduate Nursing courses on the theme of rural population health. **Method**: comprehensive review carried out through the Sucupira Platform. The sample consisted of masters and doctoral dissertations and theses from which information was extracted to form two databases subjected to descriptive and textual statistical analysis. **Results**: A total of 118 research reports comprised the sample. We identified a higher number of studies produced in the form of master's dissertations, from the South region of Brazil, published between 2015 and 2016, and that used quantitative approaches. The exploratory analysis found that the research developed focused on three central themes: public policies and health care services, cultural care in the family context, and health of the rural elderly. **Conclusions and implications for practice**: the production on rural health at the *Stricto sensu* post-graduate level in Nursing in Brazil points to a new range of possibilities for research and may contribute to the care practices that rural nurses perform.

Keywords: Rural Health; Nursing; Rural Population; Rural Areas; Education, Nursing, Graduate.

Resumo

Objetivo: caracterizar a produção *Stricto sensu* da pós-graduação brasileira em Enfermagem sobre a temática saúde da população rural. **Método**: revisão compreensiva realizada por meio da Plataforma Sucupira. Estabeleceram-se, como amostra, dissertações e teses de mestrado e doutorado das quais foram extraídas informações que constituíram dois bancos de dados submetidos à análise estatística descritiva e textual. **Resultados**: 118 relatórios de pesquisa compuseram a amostra. Identificou-se maior quantitativo de estudos produzidos do tipo dissertação de mestrado, provenientes da região Sul do Brasil, publicados entre 2015 e 2016 e que utilizaram abordagens quantitativas. A análise exploratória permitiu constatar que as pesquisas desenvolvidas versavam sobre três temáticas centrais: políticas públicas e serviços de atenção à saúde, cuidado cultural no contexto familiar e saúde do idoso rural. **Conclusões e implicações para a prática**: a produção sobre a saúde rural em nível de pós-graduação *Stricto sensu* em Enfermagem no Brasil aponta para um novo leque de possibilidades de investigação e poderá contribuir para as práticas de cuidado que os enfermeiros rurais realizam.

Palavras-chave: Saúde da População Rural; Enfermagem; População Rural; Zona Rural; Educação de Pós-Graduação em Enfermagem.

Resumen

Objetivo: caracterizar la producción *Stricto sensu* de los cursos brasileños de posgrado en enfermería sobre la salud de la población rural. **Método:** revisión comprensiva realizada a través de la Plataforma Sucupira. Se establecieron como muestra las disertaciones y tesis de maestría y doctorado, de las cuales se extrajo informaciones que constituyeron dos bases de datos sometidas al análisis estadístico descriptivo y textual. **Resultados:** 118 informes de investigación conformaron la muestra. Se identificó un mayor número de estudios producidos en el tipo de tesis de maestría, del Sur de Btrasil, publicados entre 2015 y 2016 y que utilizaron enfoques cuantitativos. El análisis exploratorio mostró que la investigación desarrollada abordó tres temas centrales: políticas públicas y servicios de salud, cuidado cultural en el contexto familiar y salud del anciano rural. **Conclusiones e implicaciones para la práctica:** la producción sobre salud rural a nivel de posgrado *Stricto sensu* en Enfermería en Brasil apunta a un nuevo abanico de posibilidades de investigación y puede contribuir a las prácticas de cuidado que realizan los enfermeros rurales.

Palabras clave: Salud rural; Enfermería; Población Rural; Medio Rural; Educación de Postgrado en Enfermería.

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INTRODUCTION

Rural populations are inserted in the scope of rural populations, defined by the National Policy for the Integral Health of Farm and Forest Populations (NPIHFFP) as those whose ways of life, production, and social reproduction are mostly related to the countryside, the forest, aquatic environments, extractivism, and agriculture and cattle raising.[1]

The populations that (re)exist in rural areas face inequities related both to the difficult accessibility to services and the low availability of health professionals to meet their demands and to differentiated patterns of illness, with the persistence of endemic patterns and quality of life indices that are poorer than those of the general population.[2]

The work of nursing in rural areas is marked by specificities, as it involves the development of a work process that professionals generally did not experience during their academic training, which is generalist, does not contemplate the rural reality and does not contribute to break the cycle of invisibility of this population.[3,4]

From this perspective, rural health research emerges as a foundation capable of helping to understand rural health and has gradually gained space and solidity on a path that presents itself as an instrument of social justice. It is conceived through methods of knowledge dialogue that aim to promote the empowerment and emancipation of individuals.[5] However, despite the advances that have been made, the development of studies on the health of the rural population is still not very expressive in Brazil, especially in the Nursing area.[6-8]

The recognition of rural health, however, is urgent to intervene in the health-disease process in the context of Primary Health Care (PHC), the health care modality most closely related to rural health care, and the Unified Health System (UHS), because the rural universe has particularities that condition the organization of health services and health and social practices.[5] To develop adequate public policies and achieve effective health interventions, it is necessary to know the rural populations, considering their sociocultural and environmental particularities.[9]

From this point of view, investigating the knowledge produced in graduate studies, a scenario closely related to the production of studies that directly contribute to the development of interventions and public policies that can culminate in the improvement of health and quality of life of the community, collaborates to apprehend these particularities that can subsidize the construction of these public policies aimed at the rural population.

Thus, the relevance of this study is highlighted, which aims to characterize the *Stricto sensu* production of Brazilian Nursing graduate studies on the health of the rural population with a view to delimiting its state of the art. The study also makes it possible to contribute to the advancement of knowledge of Nursing as a science, profession and academic discipline.

METHOD

This is a comprehensive review study, of a documental and systematized nature. Its operationalization was based on the selection of descriptors, literature searches, the selection of research reports for the constitution of the sample, the constitution of two databases from the sample, and descriptive and textual statistical analysis of these.

The descriptors, listed from consultations with the Descriptors in Health Sciences (DeCS), were: "rural population", "health of the rural population", and "rural area". The searches in the chosen database were carried out between January and March 2020 by two independent researchers. The Sucupira Platform was used and the Catalog of Dissertations and Theses of the Coordination for the Improvement of Higher Level Personnel (CAPES) was consulted, which presents the panorama of research reports (dissertations and theses) of the *Stricto sensu* graduate programs in Brazil. In the search, the descriptors were used in isolation, without associations.

After entering the descriptors, the following filters were applied: academic degree - master's, doctorate, professional masters and professional doctorate, and area of knowledge - Nursing. To select the studies that made up the sample, the research reports that were available for full access or those that, despite the year of defense having occurred before the creation of the Sucupira Platform, were fully available for free access in the online repositories of universities.

As an exclusion criterion, research reports that dealt with indigenous health were excluded due to the understanding that, despite the fact that some peoples inhabit rural territories, they have differentiated specificities that constitute a specific research field in the Nursing area itself. No time cut was established in the searches, given the nature of the objective of this study.

After the initial searches, eligible studies were selected for the sample based on a thorough reading of the titles, followed by reading the abstracts and the full text of the research reports. These steps allowed the inclusion or exclusion of studies based on the selection criteria listed. Once the selection was completed, two databases were created to process the quantitative and qualitative information present in the research reports.

The first database consisted of quantitative information extracted from dissertations and theses, which represented the variables: State, Region and Higher Education Institution (HEI) where the research report was produced, year of defense, academic level, approach, method for data collection and theoretical framework used by the authors. The information was entered into Microsoft Excel 2016® spreadsheets and subjected to descriptive statistical analysis, with calculation of absolute and relative frequencies and subsequent presentation by means of graphs and tables.

The second database was built by extracting the results sections and the conclusion of the abstracts of the research reports that comprised the sample. The Writer tool of the LibreOfficePortable® software was used, which gave rise to a text corpus, which was later exported for processing by the software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* – IRAMUTEQ® for textual statistical analysis.

IRAMUTEQ® was used to perform Descending Hierarchical Classification (DHC) and Correspondence Factor Analysis (CFA)

analysis. The DHC conducts quantitative analysis of textual data and constructs contextual content classes according to the similarity of the vocabularies. In turn, the CFA allows us to visualize, by means of a Cartesian plan, how the words that make up the classes are close or in opposition to each other, which contributes to the delimitation of thematic axes of analysis.[10]

Thus, integrating the steps of the DHC and the CFA, the corpus analysis was presented based on comprehensive thematic axes that allowed delimiting the field of research on the health of the rural population in the *Stricto sensu* post-graduation course in Nursing in Brazil and highlighting the main themes researched. In the presentation of each axis, excerpts extracted from the corpus were shown for the purpose of illustrating the semantic content that led to its origins.

It is noteworthy that this study, by using exclusively scientific texts for the literature review, waives ethical review, according to the assumptions of Resolution 510/2016 of the National Health Council of Brazil. On the occasions when text segments from the consulted reports were used, they were identified with the letter D (dissertation) or T (thesis), followed by a random Arabic number.

RESULTS

Initially, the search strategy used resulted in 22,878 research reports. After initial refinement based on reading the titles, 304 were pre-selected and submitted to reading the abstracts, leaving 137 research reports, submitted to full analysis, which allowed establishing 118 dissertations and theses as the sample. The remaining studies were excluded for not meeting the selection criteria. Figure 1 schematizes this process.

As for the time interval, 44.1% (n=52) of the studies were published in the interval of years between 2012 and 2015, as can be seen in the historical series represented in Figure 2.

About 47.5% (n=55) of the studies were developed in graduate programs located in the South region of the country, followed by the Southeast region, with 33.1% (n=38). The university with the largest number of studies was the Federal University of Minas Gerais. Figure 3 shows the number of studies developed by region of Brazil and university.

Regarding the academic level, there was a predominance of master's dissertations, which represented 68.6% (n=82) of the sample. As for the methodological aspects, the approaches used were similar, with a slight predilection for the quantitative approach, corresponding to 50.8% (n=57). About 95% (n=112) used interviews as one of the forms of data collection (we emphasize the use of more than one method of data collection in most studies). Regarding the theoretical framework used, although 63.5% (n=75) did not specify it, the cross-cultural theory was used by 7.6% (n=9), as shown in Table 1.

Regarding the processing of the text corpus, 15,454 words were found, with 3,253 distinct forms and 430 text segments (TSs - partitions that the software makes in the corpus to perform the analyses, usually three lines long), with an average of 4.75 occurrences for each word form (average value used to define the words to be included in the dendrogram classes built by the DHC method). About 1,844 words appeared only once (hápax). The lexicographic analysis of the corpus obtained a retention of 89.77% (corresponding to 386 of 430 TSs), considered satisfactory for analysis purposes.

The DHC considered, for the construction of the classes, the following criteria: words whose frequency was greater than twice the average occurrence in the corpus (F>9.5); words with a chi-square value (χ^2) greater than or equal to 3.84 (95% significance) and that presented statistical significance (p-value≤0.05).

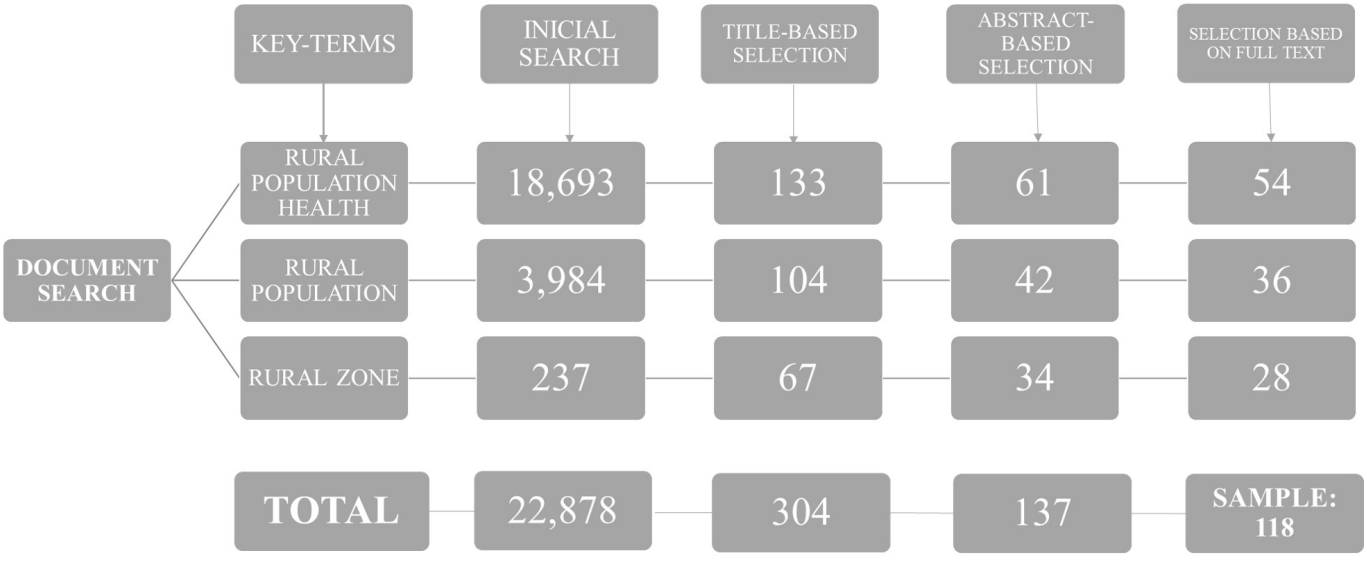

Figure 1. Steps taken for the constitution of the study sample. Natal (RN), 2020.
Source: research data, 2020.

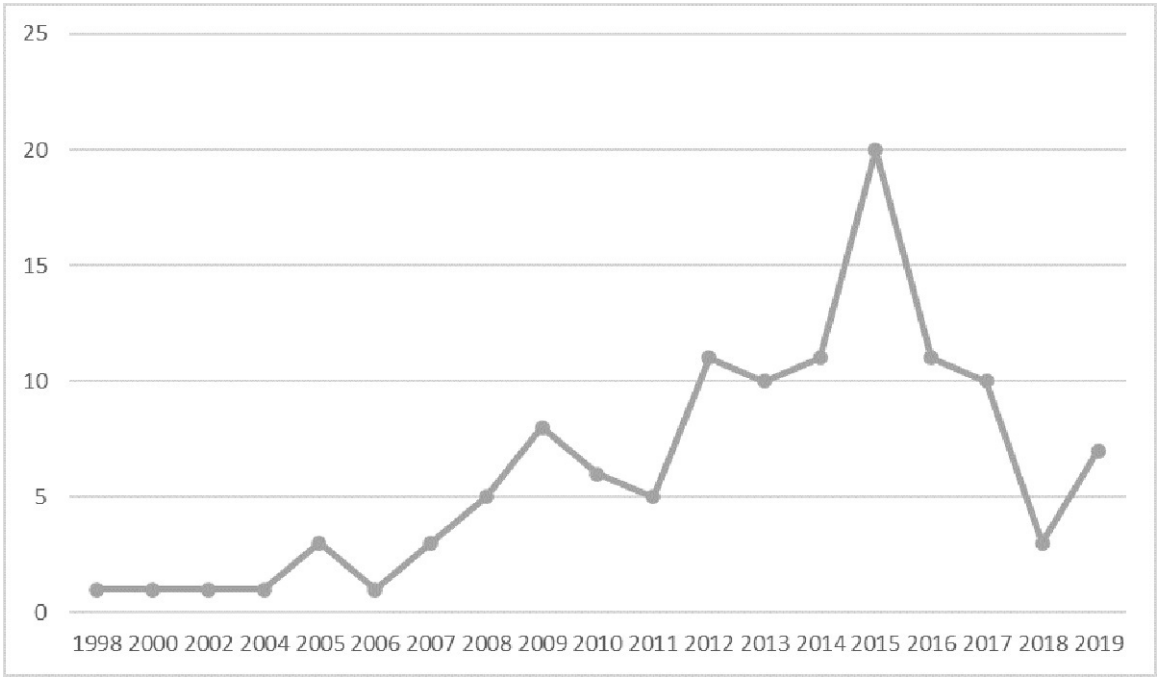

Figure 2. Time interval of publication of the dissertations and theses in Nursing on the health of the rural population that composed the sample. Natal, RN, 2020.
Source: survey data, 2020.

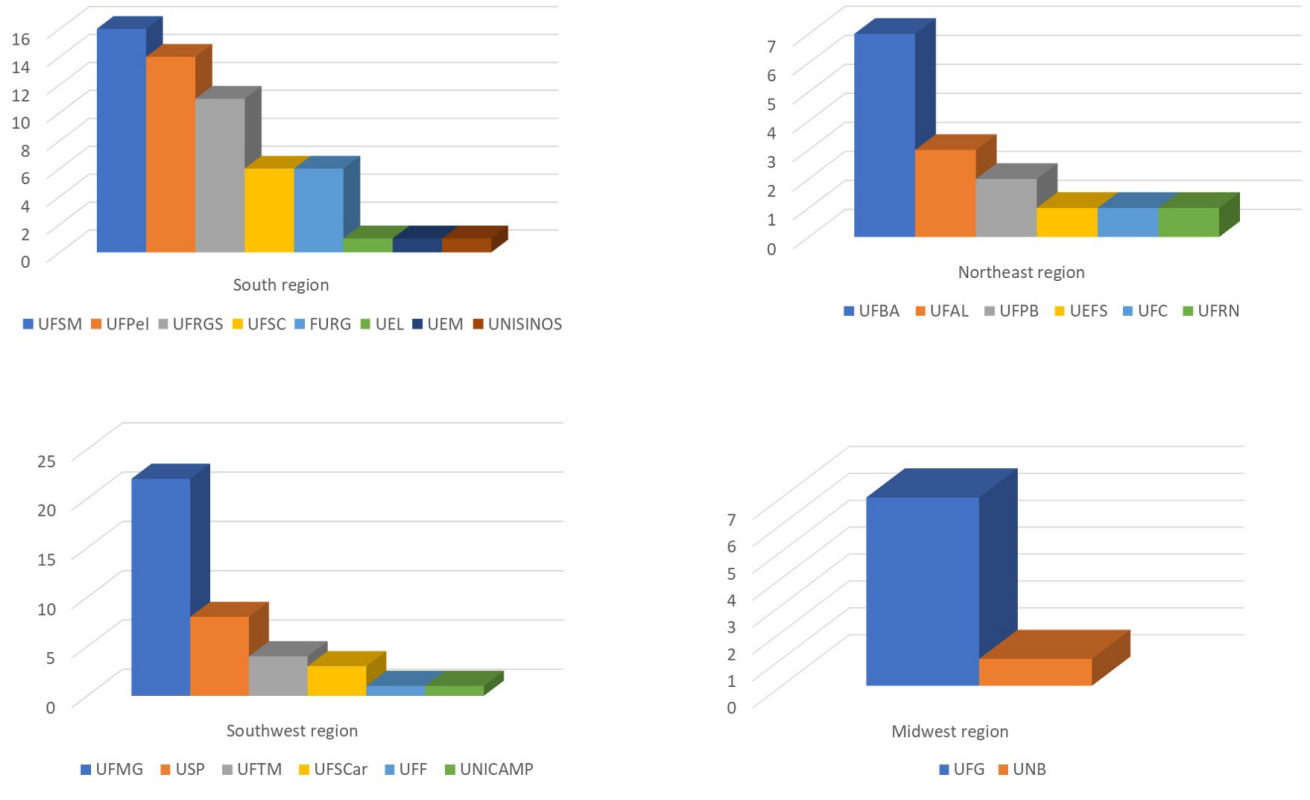

Figure 3. production of dissertations and thesis on rural population health according to university and region of Brazil. Natal, RN, 2020.
Source: survey data, 2020.

Table 1. Characterization of the variables selected from the research reports that made up the sample. Natal, RN, 2020. (n=118).

Variable	N	%
Academic level		
Master	81	68.6
Doctorate	36	30.5
Professional masters	1	0.8
Approach		
Quantitative	60	50.8
Qualitative	50	42.3
Mixed	8	6.8
Data collection method		
Interview	115	97.5
Observation	26	22.0
Clinical Examination	15	12.7
Laboratory Examination	13	11.0
Documental	7	5.9
Genogram	6	5.1
Focus group	4	3.4
Field diary	4	3.4
Photography	4	3.4
Oral history	3	2.5
Household survey	2	1.7
Ecomap	2	1.7
Free evocation of words	2	1.7
Culture Circles	1	0.8
Body Map	1	0.8
Comic	1	0.8
Ethnobotanical survey	1	0.8
Photovoice	1	0.8
Critical incident technique	1	0.8
Relationship network	1	0.8
Theoretical framework used		
Not specified	77	65.3
Cross-cultural theory	9	7.6
Ethnoenergetics	6	5.1
Symbolic interactionism	4	3.4
Critical liberating education	3	2.5
Social Determinants of Health	2	1.7
Interpretive Anthropology	2	1.7
Social Representations Theory	2	1.7
Bioecological theory	2	1.7
Family development theory	2	1.7
General Systems Theory	2	1.7
Nursing care philosophy	1	0.8
Gender theories	1	0.8
Cultural rationality	1	0.8
Popular health education	1	0.8
Risk society	1	0.8
Food social space	1	0.8
Phenomenology	1	0.8
TOTAL	**118**	**100**

Source: survey data, 2020.

As can be seen in Figure 4, during the DHC, the corpus was initially subdivided into two subcorpora, one of them giving rise to Class 5, composed of 55 TSs. Subsequently, the corpus on the right was divided in two, constituting Classes 3, with 88 TSs, and 4, with 86 TSs. In a last step, as opposed to Classes 3 and 4, a last partition occurred in the corpus, giving rise to Classes 1, with 98 TSs, and 2, with 59 TSs.

Each semantic set of words that made up each lexical class indicated by the DHC was analyzed and, with the support of the CFS, a similarity of content and the close relationship between Classes 1 and 2 and between Classes 3 and 4 were perceived. It was also found that the words that made up Class 5 were more distant from the other classes, while the words in Classes 1 and 2 and those in Classes 3 and 4 were closely associated.

The analysis of the dendrogram from the DHC, together with the oppositions and similarities visualized in the CFA, allowed us to verify that the combination of Classes 1 and 2 made it possible to formulate the first thematic axis, entitled Public policies and rural health care services. Classes 3 and 4, in turn, made it possible to elaborate a second thematic axis called Cultural care in the context of the rural family. Finally, Class 5, separately, gave rise to a third axis called Health of the rural elderly.

These axes made it possible to delimit the state of the art of rural health research conducted by Nursing in Brazil, identifying, in a generalist way, the thematic panorama of the *Stricto sensu* production in this area of knowledge.

The first thematic axis examines the public policies for the rural population developed in Brazil, highlighting their late and incipient development, and the invisibilization of this population before the government; it also discusses the barriers faced by rural communities in access and accessibility to health services and the role of PHC in rural health care. The following excerpts illustrate these analyses.

> *[...]in Brazil, policies have been created to reduce health inequalities of the various groups of rural populations in the country, but these policies have not been fully implemented, and the rural population has precarious living and health conditions [...].* (T01)

> *[...] the health of rural populations is a broad phenomenon, with its specificities, and the challenge of public policies is to recognize the rural setting as a care space that demands unique interventions [...].* (T02)

> *[...] access is impaired in two ways: the long geographic distance from the micro areas to the health unit, linked to insufficient vehicle for the team, and by the limitation of medical consultations [...].* (T03)

> *[...] the conditions necessary to achieve a healthier life for the rural population involves improvements in Primary Health Care and the professionals involved [...].* (D01)

The second thematic axis delimited the cultural care in the context of rural families developed by Nursing, which encompasses

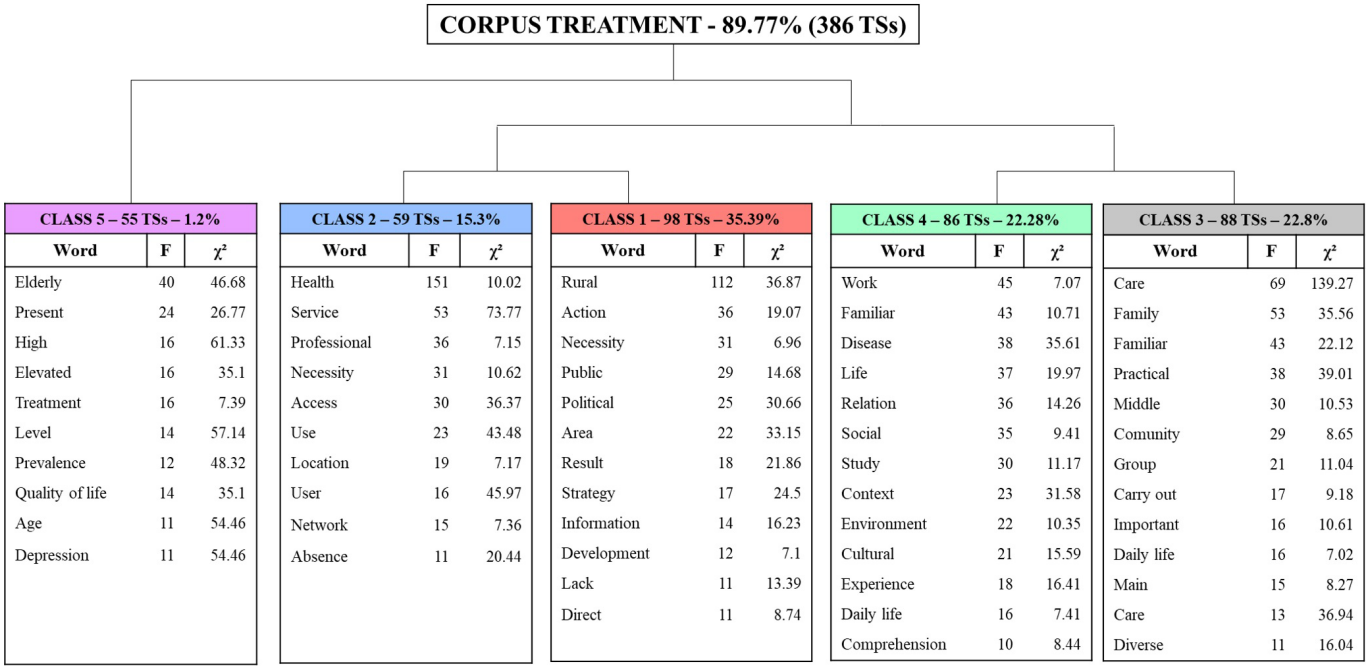

Figure 4. Dendrogram from the DHC performed by IRAMUTEQ on the text corpus of the study. Natal, RN, 2020.
Source: own elaboration, 2020.

the nurse's ability to incorporate the culture of rural subjects in the development of their practice, aligning popular and scientific knowledge, which is permeated by obstacles that are related to the deficiency in the nurse's training process for working in rural areas, as can be seen in the following excerpts.

> *[...]nursing needs to promote care that considers the values and beliefs of the subjects based on the understanding of the disease not only as a biological process, but also as a social, cultural and political process [...].* (D02)

> *[...] the formal preparation received in the undergraduate course provided an opportunity for generic learning to work with people, but the way of life of these (rural) populations was not contextualized [...].* (T04)

The third thematic axis analyzes the health of the rural elderly and highlights the accessibility of the rural elderly to health services, as well as the prevalence of relevant diseases in the rural elderly. The following excerpts illustrate these inferences.

> *[...]the main reasons for the elderly not using health services even in case of need are related to insufficient financial resources, delay in care, lack of transportation, use of self-medication and lack of medical professionals [...].* (D03)

> *[...] the pre-fragility and fragility conditions presented high percentage of occurrence associated with greater chances for adverse health outcomes and negative repercussions on the quality of life of the elderly.* (D04)

> *[...]there is a higher number of elderly men than women in rural areas and, in general, a precarious socioeconomic insertion, low education, reduced family income, and segregation in rural spaces delimited by large estates.* (D05)

DISCUSSION

In the health area, there are few studies that evaluate the general conditions or more than one health indicator of rural populations in regional or national scenarios, and the existing studies focus on investigations of specific aspects of rural worker health.[9] This fact is also corroborated in the Nursing field.[3]

This study showed that the number of studies developed had an advance in 2015, which may be related to the fact that in 2013 the NPIHFFP was published by the Ministry of Health,[1] taking into consideration that most master's degree researches, which were the most conducted, take about two years to be completed.

Despite the progress achieved, the development of studies on rural populations within the scope of Nursing in Brazil is still little expressive. The gap, however, emerges as a new possibility for research due to the need to expand knowledge on the subject, which can contribute to advances in the performance of rural nurses and to the establishment of their professional identity in Brazil,[6] since studies on this identity are still scarce.

Furthermore, the characterization of Nursing knowledge on rural health can boost the advancement of the practice and the profession, opening windows for interfaces with Advanced Nursing Practice, an innovative instrument that can contribute to the improvement of health care for population groups with

greater vulnerability or difficult access, as in the case of the rural population.[11]

As for the characterization of the identified studies, the approaches used emphasize the existence of quantifiable and non-quantifiable or qualifiable domains and that the phenomenon of interest (in this case, the health of the rural population) sometimes needs to be decomposed, sometimes needs to be recomposed into a whole and that, in this process, there are pretensions that are measurable, descriptive, comprehensive, analytical, classificatory, among others, which explains the almost equalization between the approaches.[12] The predilection for the quantitative approach, however, may also have been influenced by the more post-positivist conception of researchers.[13]

Regarding data collection procedures, the use of the interview stands out in almost the totality of the sample, explained due to its operationalization being adequate for both qualitative and quantitative studies, as well as due to its more formal connection with the data collection phase.[12]

As for the theoretical references used in the studies, although most of them did not specify them, the Transcultural Theory stands out, representing one of the specific references of Nursing itself that has been used the most by researchers.[14]

The thematic delimitation evidenced little variability in the themes of the studies developed by Nursing on its own performance regarding the health of the rural population, with the studies being more related to general themes in the area of public health. This fact has been reiterated by other authors.[6]

Regarding the findings framed in the first thematic axis, it is known that in Brazil, health policies have evolved along with political and economic trends, following, above all, the development of capitalism, which put the perspective of public health in the background. Rural populations, in this context, were invisible to the eyes of health policies.[15]

However, it is public knowledge that this population has long required the attention of these policies, especially UHS, due to the existing health inequities and to collaborate with the overcoming of the current care model, which does not consider the specificities of rural subjects.[16] Such policies, not necessarily specific to the health sector, establish connections with aspects intrinsic to the life of the subjects and widely implicate the health-disease process.[17]

The historical evolution of public policies in rural areas shows that the labor and health rights of this population were belatedly recognized. With the creation of the Fund for Assistance and Welfare to the Rural Worker (FUNRURAL) in 1963 (later incorporated into INAMPS in 1974), through the Rural Worker Statute Law, the offer of health care to rural workers through social security contributions was formalized. Universal access to health care for these individuals, however, only occurred with the creation of the UHS and was intensified with investments in PHC and Family Health teams.[18,19]

In Brazil, there is no PHC policy specifically aimed at the rural territory, even though this is the predominant care model that assists individuals in it. Despite the existence of NPIHFFP, in practice, this policy is not articulated with the country's National Primary Care Policy, which is generically applied to urban and rural populations.[20] As an aggravating factor, there is the fact of the rural population's incipient participation in the formulation of these public policies.[21]

The inefficiency and insufficiency of these policies reflect the situation of rural health care services in Brazil. The provision of health care is based on the work of Family Health Care teams that, despite their potential to reorganize the curative care model, operate based on prioritization of spontaneous demand, grant little autonomy to users and end up becoming bureaucratic places that act as "bridges" for the individual to access other levels of care.[16,22,23]

Other characteristics of these services are the difficulty of access by users who do not have their own transportation, the insufficiency of basic supplies, the precariousness of the physical structure of existing health care facilities, and the low availability of professionals. There is also a limitation of shifts, which causes gaps in care and compromises the integrality of care.[20,22,24-26]

Although, with the advent of the UHS, important advances have been achieved and, in recent years, there has been recognition of the rural population before public policies, the full reach of these rights is not guaranteed, since there are care gaps and great distances to be covered in the search for supply and access to health services.[18]

From this perspective, the organization of the work of Nursing in the Family Health Strategy (FHS) should be organized in such a way as to stimulate popular participation in councils, debates, and local meetings in order to allow the rural population to participate in the elaboration, programming, and supervision of public policies and to contribute to the increase of effectiveness and comprehensiveness of health actions.[3]

The second thematic axis examines cultural care in the context of the rural family. The studies developed by Nursing on this theme are approached through ecological and ethnographic perspectives, which make it possible to unveil the construction of a reality about the health and illness of rural families,[27] which includes the establishment of relationships between dying and illness with the lifestyle and type of work, which are directly influenced by cultural factors.[24]

Rural families take care of themselves through beliefs, values and habits built from the process of interaction among their own members and among the entire rural community, which crystallize and are transmitted among the subjects according to the context through which they individually pass.[28] Thus, the care present in the lives of rural families is conceived as cultural care, since the sociocultural structure and appropriate worldviews influence their health care practices.[29]

In this perspective, from the rural family's point of view, health does not mean only the absence of pain, but is related to daily practices, and health care is associated mainly with food and family care, which is mostly the responsibility of the women who make up these families, and their care rituals involve the use of prescribed drugs as well as medicinal plants and practices focused on religiosity.[30]

Therefore, in order to provide care to rural families, nurses need to understand the cultural context of the community they accompany, understand and value local knowledge, along with their behaviors, practices and care dynamics that integrate their health care system. It is also necessary to encompass their work in different manifestations of knowledge beyond the biologicist knowledge, in order to confluence the empirical knowledge of the family members with the scientific knowledge, and seek a point of balance that allows overcoming the obstacles and building an effective rural health model.[3,30-32]

In addition, nurses must view rural families with an emphasis on the changes in their life cycle and focus on health education during home visits and in the community itself, promoting a closer relationship with families in order to enable shared care that takes into account the potentials and weaknesses of family care.[27]

However, even though rural family care is a field of action for Nursing, especially in the context of the FHS, nurses who work in rural health care face difficulties related to insufficient academic training to work in these scenarios, considering that Nursing schools focus their practical classes and internships in urban settings and, thus, nurses cannot capture, during their training, the modes of care based on the cultural diversity of the subjects.[3,27]

Facing these challenges, countries such as Australia, the United States of America, and Canada have driven the organization of rural nursing practice through changes in legislation and the expansion of nurses' activities with the integration of education, research, management, and care practice.[4]

Thus, it is important that Brazil follows these examples and adopts measures such as offering nursing students the opportunity to experience, during their training, experiences in the rural FHS, which allows them to exercise reflective thinking, symbolic expression, improve the communication process and develop creative skills, playing a transformative role that will contribute to working in rural areas after training.[4]

Finally, the third thematic axis delimits the production on the health of the rural elderly by Nursing. The rural elderly are susceptible to aggravating clinical conditions different from those of those who live in urban areas and this occurs mainly due to the environmental factors to which they are exposed and because access to health care is more difficult and less of a priority in their perception, since most of them need to work in the field during the day to survive.[33]

The fact that the elderly live in rural areas naturally accentuates the vulnerabilities they experience, and studies show that there are common characteristics between developing and developed countries, such as lower average income and greater severity in health problems.[34]

Researchers argue that the regular use of health services was higher among the urban elderly when compared to the rural elderly, indicating the disadvantageous situation in the access and use of health services by the rural population, for example.[35]

It is estimated that the provision of health services to the elderly living in rural areas is difficult due to characteristics related to access (insufficient transportation, poor road conditions or lack of them, location far from health services, social isolation), income and the elderly's own habit of seeking curative/therapeutic care rather than preventive care.[33,36]

The geographical barriers in rural areas, especially, constitute an impeditive factor for greater access to health services for this population. This factor hinders the proper monitoring of existing health problems, leading to the occurrence of complications, which, in turn, have a negative impact on the quality of life of the elderly,[37] which, despite the imposed barriers, has shown higher rates than among the elderly living in urban areas,[38] but is influenced by the presence of morbidities and/or functional disability.[39,40]

Among the morbidities that affect the rural elderly, depression, whose prevalence of 8.1% has already been detected by a population-based study, Diabetes Mellitus, whose prevalence of 16.9% has already been evidenced in the state of Rio Grande do Sul, for example, and the frailty syndrome of the rural elderly, which has a prevalence found in the literature of about 43%, stand out. Among the factors that contributed to these diseases, the low education was common.[41-43]

It is noteworthy that the elderly age group is the one with the lowest level of schooling in Brazil, which is accentuated in rural regions, and points to the need for educational policies that culminate in the empowerment of this population, both for self-care and for the promotion of their health.[44]

In this perspective, it is highlighted that the demands of the aging process in the Brazilian rural environment are characterized by a set of specific demands, which require special attention from different sectors, especially health.[35]

Therefore, it is necessary to establish a health plan for the elderly who live in these areas. In this sense, the introduction and implementation of care for this population must be guaranteed based on comprehensive care, health promotion, and prevention of diseases, as mentioned in the various health policies that guide the UHS.[45]

Thus, the importance of the nurse's role in the care of the elderly is reinforced, which corroborates the elucidation of the profile and lifestyle of the rural elderly, with a view to intervening in the problems associated with frailty and acting to prevent and delay adverse and undesirable outcomes.[43,46]

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The analysis of the research reports revealed that the health of the rural population is still a field of studies that has been little explored in the *Stricto sensu* post-graduation level in Nursing in Brazil. The state of the art in this field of research showed little variability of the themes, which were generically concentrated in studies about public policies and care services, cultural care in the family context, and the health of the rural elderly.

However, it is emphasized the importance of the development, by Nursing, of studies that address the health of the rural

population, both due to the existing gap about its performance in these contexts and because their particularities and vulnerabilities require attention, which points to a range of possibilities for researchers due to the need for expansion of knowledge in this field of studies.

It also highlights the need for these studies for professional nursing practice in rural areas, since exploring the studies that nursing develops on this theme, as well as the care practices that rural nurses perform, contributes to guide the nurses' actions, as well as to increase the body of knowledge of nursing science.

As for the limitations of this study, we highlight the impossibility of retrieving some research reports via the Sucupira Platform or the Institutional Repositories.

AUTHOR'S CONTRIBUTIONS

Study design. Bruno Neves da Silva. Erika Simone Galvão Pinto.

Data collection or production. Bruno Neves da Silva. Vitória Keller Gregório de Araújo. Erika Simone Galvão Pinto.

Data analysis. Bruno Neves da Silva. Vitória Keller Gregório de Araújo. Rayane Saraiva Felix. Erika Simone Galvão Pinto.

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