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Health care for Family Health Strategy in the northeast sea and hinterland territories

Cuidado em saúde pela Estratégia Saúde da Família nos territórios do mar e sertão

Cuidado en salud por la Estrategia Salud de la Familia en los territorios del mar y sertón

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ABSTRACT

Objective: To identify the health practices carried out by family health team professionals working in rural and water territories. **Method:** This was a qualitative exploratory study, using thematic analysis to process and interpret the empirical material. A total of 29 semi-structured interviews were conducted with Family Health Strategy professionals from the municipalities of Apodi-RN, Fortim-CE, Icapuí-CE, Novo Oriente-CE, from June to August 2019. **Results:** The endemic disease control agents proved to be involved beyond surveillance and zoonosis control, and should be considered mandatory in Family Health Strategy teams in this territory. Professionals' actions involving environmental and workers' health remain focused on the care axis, but should include health promotion, prevention and education, with a view to equity and comprehensive care. **Conclusion:** The way of life of the rural and water population, with a health-environment-work link, should be the guiding principle in all health care practices carried out by rural Family Health Strategy professionalsm, and still, the possibility of expanding the number of professionals rural should be considered.

Descriptors: Health Knowledge, attitudes, practice; Primary Health Care, Health Equity; Qualitative Research; Rural Health

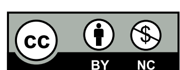
RESUMO

Objetivo: *Identificar as práticas de saúde realizadas por profissionais de equipe de saúde da família que atuam em territórios do campo e das águas.* ***Método:*** *Tratou-se de um estudo qualitativo do tipo exploratório, cuja análise temática foi utilizada para o processamento e interpretação do material empírico. Foram realizadas 29 entrevistas semiestruturadas com profissionais da Estratégia Saúde da Família dos municípios de Apodi-RN, Fortim-CE, Icapuí-CE, Novo Oriente-CE, no período de junho a agosto de 2019.* ***Resultados:*** *Os agentes de combate de endemias mostraram-se envolvidos para além de vigilância e controle de zoonoses, devendo ser considerado sua obrigatoriedade em equipes da ESF deste território. Ações dos profissionais que envolvam saúde ambiental e do trabalhador permanecem focadas no eixo assistencial, mas devem atravessar promoção, prevenção e educação em saúde, visando à equidade e o cuidado integral.* ***Conclusão:*** *O modo de vida da população de campo e das águas, com articulação saúde-ambiente-trabalho, deve ser norteador em todas as práticas de cuidado em saúde realizadas pelos profissionais da Estratégia Saúde da Família e, ainda, a possibilidade de ampliação de profissionais nas equipes rurais deve ser considerado.*

Descritores: *Conhecimentos, atitudes e prática em Saúde; Atenção Primária à Saúde; Equidade em Saúde; Pesquisa qualitativa; Saúde da População Rural.*

RESUMEN

Objetivo: *Identificar las prácticas de salud realizadas por profesionales de equipo de salud de la familia que actúan en territorios del campo y de las aguas.* ***Método:*** *Se trató de un estudio cualitativo de tipo exploratorio, cuyo análisis temático fue utilizado para el procesamiento e interpretación del material empírico. Fueron realizadas 29 entrevistas semiestructuradas con profesionales de la Estrategia Salud de la Familia de los municipios de Apodi-RN, Fortim-CE, Icapuí-CE, Novo Oriente-CE, en el período de junio a agosto de 2019.* ***Resultados:*** *Los agentes de combate a las endemias se mostraron involucrados para allá de la*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vigilancia y control de zoonosis, debiendo ser considerado su obligatoriedad en equipos de la ESF de este territorio. Acciones de los profesionales que envuelvan salud ambiental y del trabajador siguen centradas en el eje asistencial, pero deben atravessar promoción, prevención y educación en salud, objetivando la equidad y el cuidado integral. ***Conclusión:*** *El modo de vida de la población del campo y de las aguas, con articulación salud-ambiente-trabajo, debe ser orientador en todas las prácticas de cuidado en salud realizados por los profesionales de la Estrategia Salud de la Familia y, aún, debe ser considerada la posibilidad de ampliación de profesionales en los equipos rurales.*

Descriptores: *Conocimiento, actitudes y práctica en Salud; Atención Primaria de Salud; Equidad en Salud; Investigación cualitativa; Salud Rural.*

INTRODUCTION

The global historical context of Primary Health Care (PHC) begins with a selective and assistance model, already defined programs and service portfolios in emerging countries, and advances towards a comprehensive and integral model proposed at the Alma-Ata Conference, through clinical and health promotion actions, as well as social participation strategies[1].

In Brazil, the Unified Health System (SUS) has as its principles the universality of access, comprehensive care and equity, which must be consolidated, initially, at the gateway to the SUS, which is PHC. Even with difficulties, the implementation of SUS principles and guidelines were favored by policies to strengthen PHC[1].

In 2011, a movement to change the National Primary Care Policy (PNAB) began, largely based on tackling critical issues such as: infrastructure, work process, quality of care, work management and financing. In 2017, in the midst of political and economic crises, its reformulation was considered as favoring the economy to the detriment of the improvement and qualification of PHC, in which, with a view to its improvement, the Family Health Strategy (ESF) has been adopted as the main model of care[2].

The ESF's work process is based on: definition of territory and territorialization; longitudinal link; be a preferred gateway to the SUS; clientele registration; health accountability; reception and access, with the aim of producing comprehensive care, which has been achieved through the decentralization/municipalization of health care[2].

Along with the PNAB, the National Health Promotion Policy (PNPS) is mentioned, which has as principles and values to recognize the subjectivity of people and groups in the process of attention and care in defense of health and life, and adopts as principles equity, social participation, autonomy, empowerment, intersectionality, intrasectorality, sustainability, integrality and territoriality[3].

There are still gaps in guaranteeing access to healthcare for the population. It is known that those who live in remote and rural areas are known worldwide for suffering important inequities, generating worse social and health conditions such as: low education and salary income, difficult access for their residents to social, health and commercial services, due to territorial distances and lack of public transport(4-8). Furthermore, studies in several countries have found that residents of rural areas have a worse self-reported health status compared to residents of urban areas, and the main determinant of health standards appears to be the territory itself and its challenges in accessing care services.[8].

In rural, forest and water areas, such limitations in access and quality in health services remain challenges to be overcome worldwide. In Brazil, it is in small counties that the SUS is most fragile in terms of equipment, human resources, among other factors, deficiency in the area of environmental sanitation[9-11].

In this sense, the National Policy for Comprehensive Health of Rural, Forest and Water Populations (PNSIPCFA), a health promotion and equity policy, provides for the reduction of health risks arising from work processes and agricultural technological innovations, as well as improving health indicators and their quality of life through sanitation actions and access to water resources, the construction of healthy and sustainable environments, the need to value the knowledge and traditional health practices of these populations, considered, therefore, a policy of decolonial contribution[10] .

The PNSIPCFA aims to strengthen and coordinate health surveillance actions with a focus on the rural, forest and water working population and the expansion of Rural Workers' Health Reference Centers. In its operational plan for the period 2017-2019 within the scope of the SUS, its axes included: access for rural, forest and water populations

to comprehensive health care, health promotion and surveillance; and monitoring and evaluation of health actions for rural, forest and water populations[10,11].

Given the specificities of this population, this article aims to identify the health practices carried out by family health team professionals who work in rural and water areas.

METHOD

This is a study with a qualitative approach of an exploratory type, clarifying concepts and ideas brought by the interviewees, that is, within the scope of this approach, the construction of the narratives took place through the perceptions of health professionals, which were then further specified.[12,13].

Three counties were selected, two in Ceará and one in Rio Grande do Norte, considering the presence of research institutions and demands from popular movements to carry out health studies of the rural and water population. The following criteria were considered in the selection: being small, rural population above 35% of the total population; variation in the extremely poor population; exclusive use of SUS greater than 95%; presence of population from the countryside and waters; presence of fishermen's associations in municipalities where artisanal fishing predominates, and rural workers' unions in counties where family farming predominates.

Given the articulation between research institutions and popular movements, the counties selected were Fortim, Icapuí and Novo Oriente, in Ceará and Apodi, in Rio Grande do Norte, which have some heterogeneities and similarities.

The heterogeneities are more related to extreme poverty and income, in which the counties of Ceará have worse indicators in relation to the county of Rio Grande do Norte[14]. With regard to similarities, there is the use of the SUS, where it is observed that less than 3% of the population of each county has a private health plan, that is, they mostly need public healthcare, with the poorest county, Novo Oriente, in the backlands of Ceará, with 99.5% of the population dependent on the SUS[14]. All of them have a Human Development Index (HDI) below the national level and the state itself, which reinforces the context of vulnerability of the population of the counties surveyed.

In each county, an ESF team was selected, with the following characteristics: complete, operating in rural or "rurban" areas (transition areas between rural and urban), and serving rural and water communities/popular movements . If there was more than one team with these characteristics, a recommendation was requested from the municipality's Municipal Health Department (SMS).

Through the coordination of SMS, research participants were mobilized, which totaled 29 professionals, distributed as follows: four nurses, four doctors, four dental surgeons, four nursing technicians (TE), four oral health technicians (TSB) , five community health agents (ACS) and four agents to combat endemic diseases (ACE), all belonging to the respective family health teams in the territory.

As an investigation technique, a semi-structured interview was used, in which the script had around 10 questions, with the following guiding themes: health and work; health and environment; occupations of rural and water populations (PCA); occupational risks and worker health; access and equity in PCA health; among others. To preserve the identity of the participants, we listed the interviews by professional category, and identified them in the excerpts indicated in the research.

Data collection in the field was carried out from June to August 2019, by researchers with expertise in qualitative research. The interviews were recorded, transcribed and processed for subsequent analysis, using the Thematic Analysis technique, which, according to Minayo[15], "consists of discovering the cores of meaning that make up a communication".

This research was submitted for consideration and authorized by the Research Ethics Committee of the School of Public Health of Ceará, through consolidated opinion no. 3,372,478, and all participants signed an Informed Consent Form.

RESULTS AND DISCUSSION

For the field of collective health, the national and international scenarios have been spaces of crisis regarding changes in public policies and ways of conceiving the population's rights. For health practices, bridges of dialogue must be anchored between the biomedical paradigm, the social determination of health and decolonial contributions, to ensure advances and achievements in public health, through the SUS[16].

A decolonial approach at the SUS level requires promoting the autonomy of communities in managing their own health, as well as incorporating the knowledge of traditional peoples in the formulation and implementation of health policies.

The SUS advances as a universal political proposal and promotes policies against decolonial practices, however, by broadening the look at the different segments that concern the system (workforce and deprotection mechanisms, financing, care model, public regulation, private), there is still a set of population groups, such as the rural population, forests and waters, the black population, LGBTQIA+ and those deprived of liberty, with health conditions outside the guarantee of equity[17].

Health care must be based on comprehensiveness and has three large sets of meanings: attributes of health professionals; attributes of the health service organization; political responses to health problems[18].

It is expected that, in rural territories, there will be greater sensitivity to health conditions due to low education and salary income, difficult access for residents to social, health and commercial services, understanding the influence of culture, thinking and acting , of the user in favor of their quality of life and recognizing the impact of social determination on the health of the population[19].

From the perspective of PHC and the attributes of health professionals, one of its guidelines is the longitudinal link([20]), which is characterized by:

> *[...] a construct of a complex and systemic nature, related to relational dimensions, as well as collective and organizational ones, which are expressed in a primary care model, with repercussions on the team's work process, on the organization of the service[20] (p.4).*

That said, when correlating attributes of PHC and health care, the bond was identified as an interpersonal relationship in the subjects' speeches, resulting in improvements in the care of the population in a collective manner. The following speeches carry this meaning:

> *"We create more than a bond, you know, between professional and patient, we almost create a bond of friendship [...] and we even talk about other things outside of that (health) condition, and that makes it easier [...] we can reach our goal." (Doctor 03).*

> *"I'm friends with everyone... I like to give advice, to guide - especially because I've had a very difficult life, so I like to always guide children's mothers to take care of their children... so as not to lose their teeth [...] we guide you, we talk, – I'm a friend, here, to everyone". (TSB 02).*

> *"There's that bond, the important thing is that we have the bond. [...] Every day we are in the field working, collecting data, carrying out a survey and trying to come up with strategies to improve life in this locality in terms of health". (ACE 01).*

The different professional categories recognize that the bond is not only capable of building a therapeutic relationship between professional and user, but can also guarantee user empowerment in self-care and making them seek services according to their health needs[20]. Therefore, health professionals must be able to meet the demands of the population, also guaranteeing the resolution of PHC, as seen below:

> *"I would say five percent, ten percent of the patients we receive here that we refer. We can solve a lot of things here, a lot. And, when we forward it, the county can also solve a large part of this, right? It rarely goes to other counties." (Doctor 03).*

> *"When they come to us, we try to serve them in a fully integrated way to try to resolve the problem quickly, especially because this type of worker doesn't have much time, so we try to resolve everything quickly, give extra attention, right? ". (CD 01).*

> *"We work as a team, I work a lot with the health agent, we form a partnership, I pass it on to the nurse, the nurse passes it on to the doctor, so we already have full coverage. We can handle the entire population." (TE 01).*

In rural or remote territories, the need for the ESF, as a team, to assume greater protagonism and resoluteness is reinforced, based on the main health needs of the population due to socioeconomic weaknesses and health vulnerability already identified in studies[5,6].

Still from the perspective of creating bonds, the field and water context seems to have the ACS as an essential focus of care coordination. In rural settings, where communities are geographically spaced, such a professional is

fundamental in bringing the community closer to the team[21]. It is not uncommon for several reports from professionals other than the ACS themselves to talk about their link between community and service:

> *"The search is for the ACS in their visit and when the family contacts the ACS to see the nurse or the doctor, we go and visit, but, of course there is also a priority, you understand why we don't have one, As the demand is great here at UBS, there is not much availability [...] to visit everyone. At least I try to do it this way, I'm always making an appointment to visit a hypertensive patient or a group of… these people with controlled prescriptions are always going, you understand?" (Nurse 02).*

> *"There is also the issue of health agents, who we guide, we talk to because they are the link, right, between the UBS, between the health center, primary care, and the population, they are the ones who work every day. We try to discuss with them [...] any need for assistance, [...] we tell the health agents the days we will be here, the hours, the services offered, what we can do, right, and they are there, always alert, looking for some change that he, you know... looked around and saw [...] 'something is wrong, let's schedule a visit for that person who can't'". (Doctor 03).*

> *"Such a person, when going through such a situation, has a health agent and then the health agent comes and contacts us to talk about someone when they cannot come to the unit, so that the team, the doctor, the nurse can go to this person, so we can provide assistance." (Nurse 04).*

The highlight for the ACS in this article is because this professional was identified in the last reformulation of the PNAB as capable of assuming nursing and ACE functions, which would greatly increase their duties, demonstrating the possibility of expanding the scope of practices, mainly with the population residing in rural areas and, on the other hand, could mischaracterize the nature of their educational work, weakening the bond between the community and the healthcare team[2,22,23]. Furthermore, in the same reformulation, the possibility was raised of there being ESF teams responsible for an average of 3000 people without this professional, a situation that would leave the rural and water population even more vulnerable and with less access to health services.

Continuing, the role of ACE must also be highlighted in this research. The PNAB([2]) of 2017 considers this professional category as possible to be part of a Family Health team, however, aiming for equity, this professional must be considered mandatory in teams in the field and water territories. Thus, the care evidenced in the speeches below involves a community approach that goes beyond epidemiological surveillance itself.

> *"We reach out to community leaders to set up a meeting with the community and warn them about these risks, what they are so exposed to. This is our work, this is our day to day life, collecting data, guiding the owner of the house, property in the locality, taking health promotion into these communities, doing prevention work, wherever it is cheaper, in this case, and even taking it." (ACE 01).*

> *"Our demand [...] takes trachoma, which is an exam that is carried out in the eye, I don't know if you know it, it is [...] are [...] there are agents trained for this, it is an exam which is done in the eye [...] then we also take up the issue of canine vaccines [...] exams [...] to diagnose kala-azar in animals [...] visits to community homes, distribution of fish screens in the case of those houses where there is exposed, open water, we use fish and screen, depending on the deposit we decide which is best". (ACE 02).*

All ACEs interviewed were part of family health teams. It is known that the educational practices carried out by professionals present obstacles due to precarious and fragmented work, the lack of investment in their training and the organization of the routine to the detriment of production. It is also observed that one of the ACEs above reported the ability to perform trachoma screening tests, while their role, generally, is to explain and clarify how to avoid this condition.[23].

It is reinforced that an agreement between ACE and ACS for intersectoral actions that guarantee comprehensive care is fundamental, and not the unification of an overworked professional for so many demands, as proposed by the new PNAB. The importance of both professionals, collaborating and actively participating in activities to promote, prevent and control diseases, especially in rural areas, is clear.

The fact of being away from the influences of urban centers, with medicine based on hard technology, allows healthcare practiced in rural areas to have the potential to expand and develop practices that value quaternary prevention – avoiding overmedicalization and iatrogenic procedures and actions – directing care for health needs, from a systemic perspective, also based on the social determination of health[25].

It is observed that there is a search for comprehensive care among professional categories, carrying out practices of prevention, promotion, education and treatment in health, as provided by PNAB 2017, which considers programmatic actions and spontaneous demands to be common attributions([10]). The speeches below are about:

“Here we do vaccines, we give lectures, we provide home care, prenatal care, collective health, women’s health, we do a lot, guidance too, in relation to everything, the issue of cleaning, the issue of nutrition, the importance of taking medications, the correct times and not self-medicating. The importance of vaccines too. We try to guide them when they do it correctly.” (Nurse 04).

> *“We work a lot with lectures here, like, we come with a nutritionist, we come with a pharmacist, like you today we have a doctor, we work a lot like that, but, like, when someone comes here with some problems by looking for us to solve them, we try to solve them or just solve these problems”. (TSB 03).*
>
> *“What we have tried to do is this agenda that addresses this issue of health promotion, so we have night care aimed at fishermen to try to serve... the men’s health public is already complicated to come to the health center and the public fishermen even more so because they leave early in the morning and return almost at night [...] at this time we try to schedule appointments and offer other things, nutritional guidance, dental care...”. (Nurse 03).*
>
> *“In relation to women’s health there is also some work, not only for women, but for the general public, we try to use the devices we have in the community, which is the sea, so thalassotherapy is carried out here, which is this therapeutic moment even with sea bathing [...] this therapy [...] of rehabilitation, therapeutic, but it is a character much more [...] directed towards popular health education”. (Nurse 01).*

In the last speech mentioned above, there was mention of popular health education which, in addition to transmitting information about changes in habits to avoid a set of diseases, aims to exchange knowledge, whose starting point is the student, or that is, the population. Furthermore, the use of integrative and complementary practices (PICs) such as auriculotherapy was mentioned, albeit in an embryonic way, as shown in the excerpt below:

> *“There are some resident professionals who work here and we offer other integrative practices, for example, auriculotherapy...”. (Nurse 03)*

From the perspective of comprehensive care and attributes of the service organization([16]), it was possible to observe, in the present study, the professionals’ attempt to adapt the service according to demand, through actions and practices, in addition to direct assistance, paths proposed by the PNPS([3]).

It is understood that there is mobilization of professionals to go beyond the biomedical and curative model, but that there are still challenges in the process of transforming the way of working:

> *“We try to create an agenda that includes not only the direct clinic itself, although people still tend to look for this biomedical model, even though we have a menu of offerings that I consider diverse, but there is still a strong presence of the doctor, right, but what we have tried to do is really promote health education, it is… promotion, prevention, so we work a lot with groups…” (Nurse 01) .*
>
> *“We do more educational and preventive work. If the population doesn’t help, doesn’t contribute to us, unfortunately [...] it won’t work [...] then the clinic will be super crowded, the doctor will be super busy”. (ACE 02).*
>
> *“Most people should value their health more. Look more for the issue of prevention, – coming for prevention beforehand, no – it comes more for the sake of, sometimes, when you have that pathology, with that disease, with that pain and you already want to get better from here, and. .. doesn’t invest much in prevention, very little.” (Doctor 01).*

The professionals’ mention of the need for health education activities and the implementation of integrative and complementary practices through residents (health professionals in training) seem to be part of the advancement of health practices, however the proposed formats for educational actions present contradictions when it comes to incorporating decolonial approaches.

Lectures and guidelines may reflect colonial paradigms, such as the hierarchization of knowledge and the detention of knowledge only by the professional, not necessarily guaranteeing the participation, protagonism and autonomy of service users. Furthermore, in some speeches, the interviewees seem to blame the population for a possible lack of interest in the actions of the teams that would go beyond medical consultations, without considering that, for the effectiveness of these actions, social participation and the autonomy of the user, the empowerment of the population in health care practices([17,26]).

In his study, Esmeraldo[27] describes that changing the care model involves both the perception of professionals and users. In agreement with this same study, the reports mention some health workers trying to organize the team's schedule without necessarily going to medical appointments. However, based on the report of one of them, the user's search is described, mainly in urgent demand, due to the culture of the immediate, seeking only the resolution of a complaint, making it difficult to organize and plan a reception that involves other factors in addition to assistance.

Still from the perspective of service organization and the team's agenda, one of the ways to guarantee access and equity is through advanced access, reconciling scheduled appointments and spontaneous demands, as well as being able to double the number of appointments in the units and promote an agenda based on health needs, that is, the team's work process is now scaled by the territory and the enrolled population[28].

Among those interviewed, practices to improve access were mentioned through night care, shared care, home visits with the presence of the oral health team and provision of services in the community. Being attentive to the demands of the community are points described in the interviews:

> *"I try to act a lot in this sense with other professionals, when possible, the doctor works with the nurse, the nurse works with dentistry, the pediatrician comes here once a month, you know, he comes to all the units, we try to reconcile these moments , [...] not so much in the consultation, but in the waiting room to be more professional together [...] here we have a very good partnership with the ACS, [...] to request something and they respond, be aware of the demands of the community". (Nurse 01).*
>
> *"We are assisting them, there are home visits, a day is scheduled, the health agent comes here, sets a day, we go to the community and assist them. The dentist also goes... then we offer all the services [...] we check blood pressure, test blood sugar, weight, height, we answer questions, deliver medicines...". (TE 02).*
>
> *"We know that not all people have the means to come, you know, physical conditions, sometimes due to the distance. We also organize ourselves to make home visits to those most in need, so to speak, [...] we try to look for this demand that is, in a way, forgotten [...] Everyone who needs care comes, demands and we try to organize it according to our service offering, let's say, our service hours in these situations: we try to organize ourselves so that everyone who comes to the UBS is attended to [...] We do it here once a month night care which is for precisely those people who are unable to come during the day, they come at night, you know, workers who [...] cannot afford to be here during the day for medical, dental care and so on". (Doctor 03).*

Although some actions carried out by the team are described, it must be taken into account that the PCA has specificities with regard to health, work and the environment, topics that are necessary to be included in PHC practices, as established in the PNSIPCFA operational plan.[10]. However, little was mentioned about activities related to worker health or environmental health, with only reports being provided in situations of work accidents or brief guidance on sun exposure in the work context, as the following speeches point out:

> *"Thus, the main focus of these patients, who are from rural areas, is more guidance on the type of care with the use of sunscreen, right [...] the PSF professional, in this case, with other services, normal free of charge demand, ends up leaving this part of guidance, right, about the use of sunscreen, the importance of care, right, like the skin and ends up missing this and many people don't have this knowledge". (Dental surgeon 03).*
>
> *"The issue of workplace accidents that can be resolved here, we can resolve. If you need sutures, things like that, we can sort it out. But, sometimes, we need x-rays, things like that, and then we send them to the county." (Nurse 03).*
>
> *"Yes, sometimes you get cut, sometimes in the bush, in agriculture you get cut, you stay at home, you have to do the dressing and we have to cover everyone". (ACS 04).*

Studies[29,30] show the need to implement specific programs for rural workers, with regard to environmental health and worker health, from the perspective of promoting comprehensive health, in addition to the discussion of basic sanitation, collection of garbage and lack of water supply, social determinants that have already been shown to be precarious among the counties studied[31]. Difficulty for the population in accessing information about the harm caused by pesticides, interest in knowing about proper packaging management after their use, the need to use personal protective equipment have already been topics raised as being of interest to the population, promoting emancipatory health practices that consider the plurality of unique PCA subjects in the attention-care process.

The interviews noted the need to expand the scope of practice of professionals, aiming to ensure greater resolution of the demands brought by the population, seeking other forms of care that go beyond the minimum responsibilities of each professional, especially in rural areas.

Regarding limitations of the study, the time taken to carry out the interviews and demands to return to health services are considered, as it is not possible for the interview instruments to be able to explore all perspectives as responsibilities of PHC and professionals working in the ESF.

FINAL CONSIDERATIONS

The role of ACE in a rural context and its need to be an essential member in the composition of family health teams in rural territories linked to ACS must be taken into account, a subject considered by all interviewees in this research as essential in education, promotion, prevention in health, being the link between the community and the team.

Progress was observed in health care practices for the rural and water population by identifying health education activities, implementation of integrative and complementary practices, use of advanced access to manage the team's agenda, and the rural territory as a space of health training, strengthening the expansion of the PNPS.

However, the health education models used still fit a colonial perspective. Furthermore, little was mentioned about actions involving worker health and environmental health, areas of action that are extremely necessary for these people whose way of life, personal, family and professional, has a direct relationship with the environment and the territory.

The decolonization of health involves fighting social inequalities that affect access and quality of health services, ensuring comprehensive culturally sensitive and quality health care for the entire population. In the case of the rural and water population, it is through policies such as PNPS, PNAB and PNSIPCA that health professionals must base their care practices, guaranteeing social participation and promoting community autonomy.

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CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest.

CONTRIBUTIONS

The authors contributed to the design, preparation, collection, analysis and interpretation of data, as well as writing, reviewing and approving the final version. Furthermore, they agree that they are responsible for the accuracy and integrity of all work.

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