

Original Article

Occupational therapy practice with rural populations from the perspective of primary health care

Atuação da terapia ocupacional com a população do campo na perspectiva da atenção primária à saúde

Maria Eduarda Pachêco Silva^a , Marília Meyer Bregalda^a , Ana Carolina de Moraes Teixeira Vilela Dantas^b 

^aUniversidade Federal da Paraíba – UFPB, João Pessoa, PB, Brasil.

^bInstituto René Rachou, Fundação Oswaldo Cruz – Fiocruz Minas, Belo Horizonte, MG, Brasil.

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Abstract

Introduction: The Multidisciplinary Residency Program in Family and Community Health, with an emphasis on the health of rural populations, seeks to ensure comprehensive health care for this population, which is marked by inequities in access to social rights. **Objectives:** To identify the interventions developed by occupational therapists participating in the program and their theoretical foundations, and to characterize the demands of the population served. **Method:** This was a qualitative, descriptive, and exploratory study conducted virtually through semi-structured interviews with seven occupational therapists. **Results:** Professional practice within a logic different from that of care productivism contrasts with barriers to access to services and with the scarcity of resources for practice. Population demands are related to work-related illness, mental disorders, conditions resulting from chronic diseases, alcoholism, and violence against women. The main interventions developed by the occupational therapists are group activities, home visits, and health promotion and disease prevention actions, with emphasis on valuing the knowledge and ways of life of rural peoples in the construction of health care. The participants reported that the health of rural populations was scarcely addressed in undergraduate education, in addition to the difficulty of finding publications in the profession to support these interventions. **Conclusion:** Funding and the creation of projects for the insertion of professionals in rural areas, the inclusion of rural population health in undergraduate education, and encouragement of research on the topic may qualify the practice of occupational therapists and other health professionals

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in this context, toward practice that is effective, collective, contextualized, and comprehensive.

Keywords: Occupational Therapy, Rural Health, Primary Health Care, Internship - Nonmedical.

Resumo

Introdução: O Programa de Residência Multiprofissional em Saúde da Família e Comunidade com ênfase em saúde da população do campo busca garantir a atenção integral à saúde dessa população, marcada por iniquidades no acesso a direitos sociais. **Objetivos:** Identificar as intervenções desenvolvidas por terapeutas ocupacionais integrantes do programa e seu embasamento teórico, e caracterizar as demandas da população atendida. **Método:** Pesquisa qualitativa de caráter descritivo e exploratório, realizada virtualmente através de entrevistas semiestruturadas com sete terapeutas ocupacionais. **Resultados:** O exercício profissional em uma lógica diversa do produtivismo assistencial contrasta com barreiras no acesso aos serviços e escassez de recursos para a atuação. As demandas populacionais se relacionam com o adoecimento pelo trabalho, transtornos mentais, agravos decorrentes de doenças crônicas, alcoolismo e violência contra a mulher. As principais intervenções desenvolvidas pelas terapeutas ocupacionais são atividades grupais, atendimentos domiciliares e ações de promoção de saúde e prevenção de doenças, destacando-se a valorização dos conhecimentos e modos de vida do campesinato na construção do cuidado em saúde. As participantes referiram que a saúde da população do campo foi pouco abordada na graduação, além da dificuldade em encontrar publicações da profissão para embasar essas intervenções. **Conclusão:** O financiamento e a criação de projetos para inserção de profissionais no campo, a inclusão da saúde da população do campo na formação graduada e o incentivo à pesquisa sobre o tema podem qualificar a atuação de terapeutas ocupacionais e outros profissionais da saúde nesse contexto, na direção de uma atuação resolutive, coletiva, contextualizada e integral.

Palavras-chave: Terapia Ocupacional, Saúde da População Rural, Atenção Primária à Saúde, Residência não Médica não Odontológica.

Introduction

Brazil is a country of vast territorial extension and presents different territorial contexts. According to data from the 2022 Demographic Census, of the 203.1 million people living in the country, 177.5 million (87.4%) lived in urban areas and 25.6 million (12.6%) in rural areas (Instituto Brasileiro de Geografia e Estatística, 2024).

The rural population consists of peoples and communities whose ways of life, production, and reproduction are connected to the land. Peasants are family farmers, settled or encamped rural workers, wage earners, and temporary workers, whether or not they live in rural areas (Brasil, 2013).

This population is characterized by biodiversity and by racial, ethnic, religious, cultural, social, and production-system and production-technology diversity. Historically, it has been marked by inequities in access to health care, the exploitation of natural wealth by large landowners, cultural oppression, and different forms of violence committed mainly against peasant women (Brasil, 2013).

The concentration of public and private resources and services in large cities makes this population dependent on the conditions imposed by the urban way of life, affecting

its autonomy and causing social disadvantages shaped by lack of access (Wanderley, 1997 as cited in Silva et al., 2023).

In Brazil, coverage of basic sanitation, an important social determinant of health, is also lower in rural areas. In 2020, 93.4% of the urban population had access to water supply services, 63.2% to sewage services, and 98.7% to household solid waste collection. In rural areas, only 55.6% of households had access to water supply, 37% to sewage services, and 44.8% to solid waste management (Brasil, 2022).

Arruda et al. (2018) indicate that residents of rural communities perceive their health as worse than that of the urban population and seek health services less often.

The lower availability of nearby health services in rural areas and the difficulties in access, which result in higher transportation costs for people, could be highlighted. These difficulties were more evident among older adults and low-income individuals in rural areas, who showed significantly lower probabilities of access than their urban peers (Arruda et al., 2018, p. 9).

Considering that the social determinants of health, which directly influence the quality of life of different population groups, include economic, social, cultural, and environmental aspects, and considering the Brazilian rural context, it can be stated that the Unified Health System (Sistema Único de Saúde, SUS) faces challenges in promoting the health of this population segment (Brasil, 2013).

In recognition of the specificities of rural areas, Ordinance No. 2.866, of 2 December 2011, established the National Policy for the Comprehensive Health of Rural, Forest, and Water Populations. Its objectives, guidelines, and strategies address both the conditions and social determinants of health in these territories within the health-disease process and the need to improve the quality of life of rural, forest, and water populations through actions and initiatives that consider their ways of life and work. To put these purposes into practice, effort is required from public authorities, society, and SUS services (Brasil, 2013).

To guarantee health care for the entire Brazilian population, Primary Health Care (PHC) constitutes the first level of care and is characterized by a set of actions that include health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, and health maintenance. It is the gateway to the SUS, and its principles are accessibility, accountability, comprehensiveness, universality, equity, humanization, and continuity of care (Brasil, 2017).

The main way PHC operates is through the Family Health Strategy (ESF), whose actions are developed by multiprofessional teams in Family Health Units (USFs), which should be located as close as possible to individuals in the territories where they perform their everyday activities (Brasil, 2017).

With Ordinance GM No. 154, of January 2008, occupational therapists became more prominently integrated into PHC nationwide through the creation of the Family Health Support Centers (NASF), composed of teams with professionals from different fields to expand the effectiveness of care for users (Brasil, 2008). With the enactment of Ordinance GM No. 635, of May 22, 2023, NASF was replaced by Multiprofessional Teams in Primary Health Care (eMulti), which maintain the role of supporting family health teams and qualifying and expanding the effectiveness of the teams' work (Brasil, 2023).

In June 2005, Law No. 11,129 established Residency in the Professional Area of Health with the purpose of working in an integrated manner with all health professions, especially from the perspective of family and community health (Brasil, 2005). To incorporate education, health care, SUS management, and social participation and oversight into everyday work with a view to producing changes in this context, Ordinance GM/MS No. 1,996, of August 20, 2007, set forth the guidelines for implementing the National Policy for Permanent Education in Health (PNEPS). Thus, the expansion of Multiprofessional Residency Programs in Family Health and Integrated Residencies in Health qualifies as a strategy for implementing PNEPS to address the shortcomings and demands of the SUS (Brasil, 2009).

The Multiprofessional Residency Program in Family and Community Health (RMSFC), with an emphasis on the health of the rural population, was created in 2015 through an articulation between the University of Pernambuco (UPE), the Landless Rural Workers' Movement (MST), and the Grão Collective, Rural Health. This residency is supported by the National Policy for the Comprehensive Health of Rural, Forest, and Water Populations and aims to qualify health professionals to understand the historical inequities affecting the rural population and address its demands. Residents in this program are assigned to the municipalities of Caruaru, Pernambuco, where they work with settled and encamped MST families, and Garanhuns, Pernambuco, where they serve quilombola communities. Thus, as a way to guarantee and implement the principles of the SUS in a rural territory, this model of practice represents one of the only offers of expanded multiprofessional care for this population within its coverage area (Lima et al., 2023).

As occupational therapy is a profession that uses resources and technologies to promote the emancipation and autonomy of people who, for specific reasons, experience difficulty with social insertion and participation (Barros et al., 2002), its integration into health teams working in rural areas should be grounded in addressing inequalities in this population segment's access to health care. In this sense, occupational therapists can work in different settings with this population, considering their everyday life spaces, singularities, and identity characteristics (Paiva et al., 2013).

In a search for scientific productions aligning the work of occupational therapists with the rural population, Silva et al. (2023) report that knowledge on the subject is not widely disseminated and that professional support for practice in this context remains insufficient. These authors also note that:

Various possibilities for action aimed at a collective and socially grounded perspective were identified. However, these dimensions of the work still need to be discussed further, as do issues surrounding the historical-social problems related to collective, social, and cultural vulnerabilities (Silva et al., 2023, p. 12).

As the RMSFC has enabled a group of occupational therapists to obtain professional qualification for practice with the rural population, systematizing the perceptions and experiences of these former residents may add elements that contribute to the production of scientific knowledge on the subject. Moreover, correlating theoretical and practical foundations with the reality of the activities they developed makes it possible to better qualify the profession's specific interventions in territories, contexts, and with subjects from this population segment, since other professionals may benefit from the results obtained. In this sense, this study aims to characterize the main demands

and particularities of the rural population served by these professionals, identify the interventions they developed in the RMSFC, as well as the specificities of this professional practice, and understand the theoretical foundation of this work.

Method

This is a qualitative, descriptive-exploratory study. According to Triviños (1987), in qualitative research, researchers are concerned not only with results and products but also with the processes underlying phenomena, in order to uncover their relationship with the present context.

Descriptive studies seek to analyze facts or phenomena in depth and to describe in detail how they present themselves, considering, among other aspects, the social, economic, and political issues involved, as well as the perceptions of different groups and communities. Exploratory research, in turn, is conducted when the chosen topic has been little explored, with the aim of providing a general explanation of a given subject. This type of study requires a consistent literature review, analysis of document data, and observation of facts or phenomena (Oliveira, 2007).

The data collection instrument was the semi-structured interview, in which the interviewer follows a script with general or topic-based questions, focusing on the central issue of the research while allowing some flexibility to further develop the participant's account (Santos et al., 2021).

The interview script addressed the following central themes: the occupational therapists' motivations for entering a residency program with an emphasis on the health of the rural population; the contributions of undergraduate education to practice in rural territories; the differences between practices developed in rural and urban settings; the populations and demands addressed by the professionals; the actions and resources used; the limiting and enabling aspects in the development of the interventions; and the theoretical foundations supporting their practice.

Regarding ethical aspects, this study complied with the principles of (Resolução No. 466 de 12 de dezembro de 2012), issued by the National Research Ethics Council (Conselho Nacional de Ética em Pesquisa, CONEP), and of (Resolução No. 510, de 7 de abril de 2016) of the National Health Council, which establishes the rules applicable to research in the Human and Social Sciences (Brasil, 2012, 2016). The study was submitted to the Research Ethics Committee of the Center for Health Sciences at the Federal University of Paraíba and was approved under Opinion No. 7.240.393 and CAAE No. 83906724.8.0000.5188. The inclusion criterion was that participants had to be occupational therapists who had completed the RMSFC offered by UPE, from its creation in 2015 through the second semester of 2024.

The professionals' contact information was provided by the tutor of that program to the research co-supervisor, one of the founders of the RMSFC. In December 2024, the ten occupational therapists who met the inclusion criterion were invited by email and WhatsApp to participate in the study, and seven of them agreed to be interviewed.

The interviews were conducted through the Google Meet® platform, upon signing the Informed Consent Form, according to the participants' availability, from December 2024 to February 2025, and were recorded in full for later transcription and systematization of the data. They lasted an average of 58

minutes, and two research assistants, who were occupational therapy students, helped prepare the transcripts.

Data processing and analysis were conducted through the content analysis proposed in Bardin's formulations (2016), which she defines in three stages: I) pre-analysis, related to the organization and systematization of the initial ideas in order to guide the development of the analytical categories; II) exploration of the material, corresponding to the systematization of the data based on the analytical categories defined in the previous stage; and III) treatment of the results obtained and interpretation, in which it is possible to analyze the data, draw inferences, and develop interpretations that align with the research objectives.

Results and Discussion

The seven study participants had a mean age of 32.5 years. Table 1 shows that four of them (57.1%) were from the Northeast region and that, overall, five (71.4%) returned to their hometown after the residency. In addition, there was a clear predominance of cisgender women (85.8%). Regarding race/ethnicity, equal proportions were observed for Brown (28.7%) and Black (28.7%) participants. As for the participants' monthly income at the time of the interview, 14.2% reported earning 1 to 2 Brazilian minimum wages; 42.9%, 3 to 4; 14.2%, 4 to 5; and 28.7%, more than 5 minimum wages.

Table 1. Characterization of the research participants.

Characterization	Hometown	Current city of residence	Age
01	João Pessoa, Paraíba	João Pessoa, Paraíba	30
02	Brasília, Federal District	Garanhuns, Pernambuco	36
03	Maribondo, Alagoas	Maribondo, Alagoas	34
04	Itaquaquetuba, São Paulo	Belo Horizonte, Minas Gerais	31
05	Bezerros, Pernambuco	Bezerros, Pernambuco	27
06	Recife, Pernambuco	Recife, Pernambuco	34
07	Bom Despacho, Minas Gerais	Bom Despacho, Minas Gerais	36
Gender identity		n	%
Cisgender woman		6	85.8
Trans man		1	14.2
Race/ethnicity		n	%
White		3	42.6
Brown		2	28.7
Black		2	28.7

Source: Prepared by the authors, 2025.

Table 1. Continued...

Monthly income	n	%
1 to 2 minimum wages (R\$1,412.00 to R\$2,824.00)	1	14.2
3 to 4 minimum wages (R\$2,824.00 to R\$4,236.00)	3	42.9
4 to 5 minimum wages (R\$5,648.00 to R\$7,060.00)	1	14.2
More than 5 minimum wages(> R\$7,060.00)	2	28.7

Source: Prepared by the authors, 2025.

As shown in Table 2, most of them graduated in states in the Northeast region of the country (57.1%) between 2012 and 2019. There were representatives from five of the eight cohorts that had graduated from the residency program up to the time this study was conducted, with a predominance of participants who worked with quilombola communities in the municipality of Garanhuns (71.3%). An equally proportional distribution of employment ties in the public sector (28.7%) and private sector (28.7%) can also be observed, in addition to one participant having left the occupational therapy profession after completing the residency. Almost all of the professionals (85.8%) held a postgraduate degree in addition to the RMSFC with an emphasis on rural population health.

Table 2. Participants' academic data.

Academic data		
Institution where the participant completed her occupational therapy degree	n	%
Federal University of Pernambuco - Pernambuco	2	28.7
Federal University of Minas Gerais - Minas Gerais	2	28.7
State University of Health Sciences of Alagoas - Alagoas	1	14.2
Federal University of Paraíba - Paraíba	1	14.2
Federal University of Triângulo Mineiro - Minas Gerais	1	14.2
Year of graduation completion	n	%
2012	1	14.2
2013	1	14.2
2015	2	29.0
2016	1	14.2
2017	1	14.2
2019	1	14.2

Source: Prepared by the authors, 2025

Table 2. Continued...

Residency cohort	n	%
T01/2015	2	28.7
T03/2017	1	14.2
T04/2018	1	14.2
T06/2020	2	28.7
T08/2023	1	14.2
Place of practice during the residency	n	%
Garanhuns - Pernambuco	5	71.3
Caruaru - Pernambuco	2	28.7
Current work	n	%
Private sector	2	28.7
Public sector	2	28.7
Public and private sectors	1	14.2
Teaching	1	14.2
Does not work as an occupational therapist	1	14.2
Postgraduate degree in addition to the residency	n	%
Yes	6	85.8
No	1	14.2

Source: Prepared by the authors, 2025

The starting point for the analysis of the interview content was the identification of meaning units (Bardin, 2016), based on the central themes previously defined according to the research objectives and the interview script. These units were then grouped into five thematic categories: 1- The path to the residency and perceptions of occupational therapy education; 2- Practice in rural and urban areas: most evident differences; 3- Populations and demands found in the territory; 4- Interventions, resources, and limiting and enabling aspects in the care process for the rural population; and 5- Theoretical foundations for practice with the rural population. The study participants were identified by the abbreviation OT, followed by the number corresponding to the chronological order in which the interviews were conducted.

The path to the residency and perceptions of occupational therapy education

The focus of this category was to identify the motivations that led the interviewees to enter the RMSFC and whether they considered that their undergraduate education had provided sufficient support for practice with the rural population.

Their main motivations for entering the program were an interest in pursuing a specialization; a previous connection with rural settings, quilombola communities, and social struggles; and prior knowledge of the practices developed in the residency.

I wanted to do something; I did not know what [...] I just wanted to leave undergraduate school with something (OTI).

I have a history in the rural community [...] when I graduated, I had nothing specifically about the rural population, riverside communities, Indigenous people, Black people, quilombola communities, perhaps just a brief mention, and I always felt that was lacking in my education [...] so I kept studying the residency program and following it for four or five years. Then I decided to try (OT4).

This finding is similar to that of a study that analyzed and characterized the factors influencing the choice of area of practice among recently graduated occupational therapists, pointing to cultural, political, and personal aspects in the composition of the motivations behind that choice (Moreno, 2019).

A theoretical essay by Pessoa et al. (2018) showed that coming from a rural area is one of the factors associated with the insertion of professionals into that territory and that, to stimulate higher education students' interest in working with the rural population, undergraduate and graduate curricula need to be revised. In addition, the increasing specialization of the health professions has led to the centralization of services and the concentration of professionals in urban areas, and temporary health team provision programs, such as residency programs, may discourage structural changes in local health systems.

This topic was present in the responses, which indicated how much the place where the educational institution is located interferes with the education process. All respondents completed their undergraduate education on campuses located in Brazilian state capitals. Some of them reflected that, because of this, the discussions and experiences during their university years were directed toward urban settings.

Our field of practice also ends up being shaped by the services with which the institution is able to establish partnerships, right? (OT4).

I know there is an obvious limitation because of where the university is located (OT5).

The expansion of higher education institutions into inland areas and the inclusion in undergraduate curricula of content addressing issues affecting rural areas and their communities would be ways to bring students closer to rural settings, and vice versa. In this way, this context would begin to absorb more professionals with the competencies needed to address the specificities of this population segment and facilitate their access to health care (Pessoa et al., 2018).

One point that deserves emphasis is the role of students in the learning processes about the rural population during undergraduate education. Some occupational therapists, as students from rural backgrounds, recalled that the visibility given to this population segment in class occurred when they themselves brought their own experiences into the discussion.

During the period when I was in undergraduate school, it was not a topic that I saw being discussed very much, right? Because I am from a rural area, because I am from the countryside, I was always there trying [...] it depended much more on my own personal search than necessarily on something that was actually planned, you know? (OT5).

I believe it came from my own personal experience of living on a rural property; that is what made me understand that population (OT3).

Regarding the aspects of their undergraduate education that were relevant to practice in the residency, the main points identified were discussions about the SUS; the history and foundations of occupational therapy, which helped give the profession an identity and explain to the population receiving care what the profession does in different contexts; knowledge about groups and their potential in the care process; and the importance of multiprofessional work.

Understanding group dynamics was very relevant to me (OT1).

Not specifically about rural areas, no, but about populations on the urban periphery, the study of the SUS, communities, right? So yes, my foundation at UFTM was very strongly focused on the SUS and on the complexity of the SUS (OT2).

Two participants stated that they had undergone a generalist education and that, although this had positive aspects, it was not enough to support a specific practice such as that developed in PHC with the rural population.

My education was very good, excellent professors, but I still think something was missing (OT3).

I had a generalist education [...] I went through all fields of knowledge in terms of the life cycles and some specificities, right? But I did receive a fairly broad education, and that was quite valuable (OT7).

Debates about the sociocultural diversity of rural peoples, Brazil's agrarian issues, and actions that can be developed with people with chronic diseases in PHC were the points the participants identified as those they missed most during their occupational therapy education.

Practice in rural and urban areas: most evident differences

As they developed their ideas about the main differences between practices developed in rural and urban areas, the setting of this work was one of the topics highlighted, both with regard to the benefits of contact with nature and because of the perception that there was greater freedom to practice occupational therapy according to a logic different from that of care productivism, inscribed in a productivity that values the processes of improving life more than the number of visits and procedures conducted.

Nature. For me, it was something spectacular, walking through the woods... every landscape was beautiful, there were trees, there were plants... I even get emotional because I liked it so much, and it brought a sense of calm. It was as if buildings suffocated a little of the poetry that existed in everything, and in the countryside they did not [...] I came home with a tired body, but with such a light mind; my work felt very light, even though we encountered very difficult realities, with lack of access to everything (OT6).

I had wings, that was it, I had wings. So I could make occupational therapy happen in a way that was not rigid [...] I see that my work brought me a great deal of joy, which is not different in the clinic. There are positive points, there is progress, but there are also pressures, and I cannot be, uh, 100% (OT1).

The understanding of the territorial dimension in professional practice with the peasantry refers not only to a geographically delimited space and presupposes ways of relating and working that enable a more horizontal articulation with the population and a more participatory practice (Silva et al., 2023).

Rodrigues et al. (2020) state that, in contemporary society, the sociopolitical dimension, considering the capital-labor binomial, is inseparable from and determining in the mode of organization and labor relations, working hours, the work environment, and workers' health.

What can therefore be observed is that the occupational-therapeutic process in Primary Health Care in rural areas, based on the logic of singular, community, and territorial care, with respect for the timing of processes and ways of life, can have positive repercussions on professional practice and on the quality of life of health workers.

The cultural and historical issues of the people and the territory were also mentioned, in the sense that, in the rural context, these aspects tend to stand out more than in urban settings. In addition, one occupational therapist pointed out differences in the perceptions of illness among the population receiving care.

Working in a community, whether rural, as in my experience, involves many variables. It is the climate, the access, the lack of roads, the lack of many resources [...] on the other hand, there is all the potential of that population that is there, of the history of that people (OT3).

It is the way of life, the culture, the way of becoming ill, the social determination of health [...] I would say that the needs, all of that, differ across different peoples. The way of producing health also brings differences. The understanding of health is sometimes different. And it is not a homogeneous difference, right? On the contrary, I think it is very diverse, and that is why it is complex, because there is not one Brazilian countryside; there are Brazilian countrysides, and they are very diverse (OT5).

For Costa and Carvalho (2012), the rural population constitutes a social entity whose historical movement is characterized by its way of being and living, and what distinguishes it from urban cultures and their forms of expression is the importance attributed to everything and everyone found in that space.

Considering their diverse experiences of life, work, and the health-illness process contributes to a broad view of health, not limited to the absence of disease. Through constant dialogue between rural communities, social movements, and health services, as well as interprofessional work and the valuing of comprehensive care for this population segment, health promotion and prevention actions are strengthened (Lima et al., 2019).

Barriers to access to health services because of public neglect and geographic distance were the element highlighted by the research participants as the greatest difference between rural and urban areas. They stated that both the population and professionals had difficulty obtaining transportation to access services in the health care network and also to enable the service to reach the communities.

It was possible to notice, in fact, a difference, the distances to the services. The services are very much in the city center. There is always this transportation difficulty [...] these issues that, if we think about a network in a capital city, are quite different (OT4).

Sometimes the service even existed in the city, but it did not reach that place [...] in the urban setting, even though it is also difficult, we still manage to obtain things at least minimally (OT6).

There is a historical neglect, right? The material conditions for access to rural areas, for the development of activities, the fact that the territories are extensive and do not have concentrations like those in urban settings make things difficult and often require us to create distinct strategies to guarantee some forms of access (OT7).

A case study by Dantas et al. (2019), which analyzed health care for settled families in the interior of Pernambuco, highlighted transportation and mobility difficulties as one of the greatest factors hindering the effectiveness of health actions. Irregular roads, insecurity, poor lighting, and scarcity of public transportation for families who need to travel to the FHUs are among the issues listed in the study.

Pessoa et al. (2018) explain that this phenomenon brings home care to the forefront. If the health team does not travel the long distances in order to reduce or overcome users' barriers to access to FHUs, those distances will be traveled in the opposite direction by the communities when they need care, over extended periods and with whatever means of transportation they have available.

Populations and demands found in the territory

Regarding the populations served during the residency, there was consensus that, because this was Primary Health Care (PHC), people of all age groups, genders, and races/ethnicities benefited from the services provided. Even so, access to health care for adult women, children, and older adults stood out.

Family health has this breadth, right? It means looking at everyone, looking at the community, so it is a much more community-based occupational therapy [...] there are all the issues of everyday life, of this occupational nursery [...] when I was not dealing with the issues of the rural area [territory], I worked a great deal with childhood, adolescence, and the older adult population (OT2).

I think the main groups were women and children. Men were very difficult [...] they spent the whole day working (OT6).

Regarding the demands, one respondent reported that, because the population was unfamiliar with the role of occupational therapy, especially in PHC, one of the ways of identifying people with demands for care by the profession was active outreach, which included actions to publicize the possibilities of professional practice to the population and to the service teams. In addition, she emphasized that many actions were shared among the professionals on the work team, given the program's multiprofessional nature.

People did not know what it meant to have an occupational therapist in the Family Health Unit. It was something unfamiliar, so the demand often did not arrive directly [...] I would go out in pairs with my team and gradually insert myself into the profession-specific demands and into the demands that were not profession-specific. In family health in rural areas, we cannot wait for someone to say, This here is for OT; we have to arrive and say, I can help with this here (OT5).

I wrote a short text, Situations in which occupational therapy can help, and left it with the receptionist at the health post because she knew many people in the community, and people often asked her for help. She brought demands to the team, and there were never any for me, so I gave it to her (OT6).

Among the demands most frequently identified by the interviewees were complications arising from chronic diseases, such as diabetes and hypertension. In addition, situations of inadequate support by the Basic Health Units in monitoring these cases became evident.

There were various demands, many people with disabilities, with chronic health conditions in general [...] hypertension and diabetes were equally frequent (OT1).

There were strokes, there was Parkinson's disease, many heart problems that I discovered through blood pressure measurement, something simple that, unfortunately, they did not have access to (OT2).

Issues specific to the context also became evident among the demands encountered. Illness resulting from activities developed in everyday life, especially intense physical labor, was identified as a determinant in this process. Marriage between relatives, which increases the likelihood of genetic diseases, was also mentioned by one occupational therapist.

Many people have their everyday life affected there in daily life, in the performance of occupational roles, which are different in rural areas. So we see occupations very clearly [...] there are quilombola communities in which people marry cousins. A great deal of consanguineous marriage, you know? [...] there are cases of cerebellar ataxia, neurodegenerative diseases, and many serious health issues linked to consanguinity because these are territories that close in on themselves (OT2).

In terms of demand, for example, I had to deal with the adult population, with work in the fields, with physical wear and tear (OT3).

So I worked with farmers who were working, right? Anyway, in Caruaru there is the issue of sewing, which is very strong and has a major impact on the health-disease process (OT5).

Among the main occupational risks to which rural workers are exposed—constant exposure to pesticides and solar radiation for long hours; activities requiring repetitive, monotonous movements and inadequate posture; an accelerated pace of production; and accidents involving work materials—the demands that this population can most readily identify in themselves are back problems resulting from the physical effort involved in agricultural activities (Santos & Menta, 2016).

With the child population, the need for early stimulation, developmental surveillance, encouragement of play, promotion of social inclusion processes, and various forms of guidance became evident. The respondents stated that many caregivers were unaware of the implications of some of their children's health conditions. If active outreach had previously been the most conventional way for the community to access the services provided by occupational therapists, during the pandemic it became common for caregivers to seek out these professionals.

With children, I think what I followed most was prematurity, cerebral palsy, and autism [...] learning difficulties, Down syndrome [...] cases of cleft palate; the mothers left the hospital without any guidance at all (OT3).

There were mainly demands involving children, groups thinking about prevention, thinking about play in the community, child development, things like that, right? (OT4).

At that time, this process of childhood becoming stronger and more related to occupational therapy was already beginning a little, so it was a demand that came up a great deal, but very differently from today [...] We were able to deal with it in a more democratic way, so to speak, and not simply hand it over to occupational therapy alone (OT5).

Mental illness was also listed by the professionals as something that significantly affects the rural population.

The main demand was mental health; it was very serious, especially among women, issues of anxiety and depression (OT6).

I personally also provided care to people with mental disorders, right? People who were receiving territorial care there (OT7).

For some occupational therapists, alcoholism also gained prominence among the identified demands to be addressed, especially among men in the communities.

The biggest problem was hunger and alcoholism. People were going hungry; it was a situation of extreme poverty in the quilombos, so they turned to alcoholism as an escape valve (OT1).

I followed some men who had issues related to harmful alcohol use (OT4).

These were demands related to autonomy, right? Harm reduction in relation to alcohol and other drug abuse (OT7).

According to Sombra Neto et al. (2022), in addition to disorders related to alcohol use, the so-called common mental disorders, characterized by depressive symptoms, states of anxiety, difficulty concentrating, and somatic complaints, are the most prevalent among peasants. Among the factors contributing to this are environmental and social isolation, violation of civil, political, and cultural rights, scarcity of opportunities for education and income generation, work overload, and loss of physical vitality.

In a study by Santos and Menta (2016) on the interface between rural work and mental illness, the authors point out that, together with the search to feel that one belongs to a group, the cultural practice of harmful alcohol use in this population segment functions as relief from tension and as a defense against the dangers faced and the situations that cause grief. As Bardi (2022) states, this issue results from multiple structural factors within the capitalist logic that marginalizes a significant part of society, precarizing ways of life and access to basic rights. In addition, harmful use can weaken the individual's ties with their support network, which is often already limited, and justify asylum-like care practices that reinforce the process of segregation, blaming, and exclusion of subjects. Discussing these themes in academia is fundamental to understand the aspects that lead to the incidence of mental disorders in these people, the alternatives they adopt to lessen their implications, and the actions that can be developed to deal with this phenomenon.

Another theme present in the occupational therapists' accounts was violence against peasant women, described as something naturalized by the community and neglected by professionals in the Basic Health Units.

There were many cases of domestic violence, and it was something naturalized. For the staff at the unit, it was okay, for the nurse it was okay, for the community health workers it was okay for that to exist because, many times, a woman asked to be beaten because she did not make lunch, did not make dinner, and so she really deserved to be beaten (OT1).

There were many issues of violence against women, and against all women, including very young girls, physical violence [...] (OT2).

Arising from patriarchy, violence against rural women is an expression of male domination. Men in this context have the socially accepted identity of rural workers, whereas women, overburdened with unpaid tasks such as caring for the home and family members and agricultural work itself, are excluded from decision-making regarding property and financial matters, which contributes to their not recognizing themselves as political subjects with rights. This situation, combined with the silencing of cases of violence and the lack of specific public policies to protect peasant women, makes confronting these violations difficult or unfeasible, as well as guaranteeing these women's rights (Stochero & Pinto, 2023).

Interventions, resources, and limiting and enabling aspects in the health care process for the rural population

The objective of this category was to identify the interventions the respondents developed with the rural community, the resources they used, and the limiting and enabling aspects they encountered in this process.

Regarding the interventions, they reported conducting individual and interprofessional care, waiting-room activities, and group activities, the latter carried out mainly for the purpose of providing various forms of guidance related to the needs of the population receiving care.

We conducted a great deal of group work [...] my main intervention took place within the groups; it involved home visits and active outreach (OT1).

Many groups [...] I was the one who provided the guidance in the health center's actions [...] November Blue, I managed to organize a men's group [...] a play group, but a play group to improve nonviolent communication [...] Information as well, such as medical appointments with professionals; they do not understand anything because no one stops to explain it (OT2).

We did waiting-room activities. Generally, in the residency, we were always paired with someone, right? Conducting multiprofessional work, and often even interprofessional work, at the health unit or in the home (OT3).

In their case study, Dantas et al. (2019) indicate that workers situated in this care context conduct preventive educational actions, home care, articulation with the health care network, and intersectoral actions and, because they understand the potential of joint activities, prioritize collective interventions aimed at health promotion, community organization and mobilization, and the strengthening of popular knowledge.

A literature review on occupational therapists' practices in PHC showed that conducting groups, which goes beyond the walls of health institutions, can encompass a greater number of individuals, enabling preventive health education actions and strengthening sociocultural participation networks (Cabral & Bregalda, 2017).

As for the resources used, it was possible to observe their scarcity, as well as the need to resort to creativity to conduct the planned interventions, which meant that the professionals had to use what was available in the territory or cover the cost of the materials themselves.

In family health, even basic supplies were lacking; we did not have water, we did not have access to a phone signal, and often we did not have internet access (OT2).

Materials, poster board, those kinds of things we paid for out of our own pockets. We kept a small fund, and whenever we needed to buy something, we used that fund. We had no support [...] the Health Department provided nothing, the

unit provided nothing, and we managed as best we could. Sometimes we were able to do it; sometimes some of the things we planned stayed only in our minds because they did not move forward for lack of resources (OT1).

Even without the most recommended materials, one alternative found to meet the needs of the people receiving care was the use of low-cost adaptations.

Everyone used to joke that I was the pool-noodle person, because I made everything with pool noodles, and I always had something with me to make a low-cost adaptation, a pencil grip, an adaptation for a spoon, one thing or another [...] I had my little case with things I adapted, I put together some early-stimulation kits, with things, small containers with rice, things so that we could actually provide stimulation, but without high cost. And, in fact, that should have been provided and structured, right? (OT5).

Some occupational therapists reflected on how the work was facilitated when the necessary and appropriate resources were available. Others pointed out that the absence of these resources did not necessarily justify ineffective work, but that, in addition to being regrettable, it should also be questioned.

I used my imagination [...] when we have an arsenal of resources, of course that is good; it facilitates what we do, it facilitates our practice, but it does not limit it. We asked for things, we demanded them [...], but they were not available, so it was mostly with what the environment offered. We have to work with what we have, knowing that we must always question why it is not available (OT3).

Material resources, within the public system, within health care, do have important limitations, you know? But I believe that our technical education and our critical ability to analyze reality are what will make it possible for us to use the resources we have in favor of our work process and the care of our clientele. Because we are workers who move through territories, we cannot carry many different instruments with us. So, I think materiality is necessary, but it is not the only thing that determines the quality of our work process. Our technical ability and our critical analysis of reality will be fundamental tools for the development of practices (OT7).

According to Lancman & Barros (2011), the occupational-therapeutic process is directly influenced by the excess of demands and the lack of resources. Guaranteeing appropriate working conditions is one of the basic premises for occupational therapists and the other members of the health team to be able to conduct the planned interventions. The lack of the resources needed for this process may make the interventions unfeasible, affect the quality of the service provided to users, and generate dissatisfaction at work (Mata et al., 2023).

Regarding the limiting aspects of their practice, the main point mentioned was the distance from other health facilities and the difficulties experienced by both the communities and the professionals themselves in accessing them.

The unit had a vehicle, but the unit vehicle was not always available [...] it was very far away; it was a barrier for us as workers, but even more so for the population. If there was a pregnant woman, she had to have family or someone in the city so that, when she was close to giving birth, she could stay there, because if she stayed in the quilombola community, she would not be able to get there. And besides that, the car to take someone from the quilombo to the city was very expensive (OT1).

What should at least have been guaranteed, which was transportation for the team to get there, was not [...] the ones who saved us were the Community Health Workers, who, after saving their money, bought their own motorcycles, because they also suffered from transportation difficulties, and they gave us rides [...] there were houses we visited that no one had ever visited because they were so far away (OT5).

The precariousness of spaces for conducting activities was also identified as a limiting aspect. Although the rural territory offered a plurality of locations, some interventions required a more private setting.

Sometimes I did not have a room, so I had to wait until one became available, which might be the procedure room, for example; then we just went to the floor with the children and brought a sheet to spread on the floor (OT2).

What we were able to do took place in community spaces [...] those more collective activities, which is also very powerful, but when one thinks about more direct care, that resource was sometimes lacking (OT4).

We were in that format of being much more in the territory than in the health unit itself, right? The units were what they were; the infrastructure was acceptable, but there was always a need for more spacious environments for collective activities and so on [...] we conducted a great deal of home visits, and care under the tree [...] there were obviously difficulties in this process, but that is where the understanding of the levels of complexity comes in, right? Understanding that family health is precisely this place, of low technological density and high complexity (OT5).

Geographic location, accessibility, and the population's use of services characterize PHC as the gateway to the SUS, and, for it to be effective, access to users' demands must be expanded through, for example, integration with the other levels of care in municipal and state health systems. Once this process does not occur, professionals are encouraged to reorganize their own work process and the service itself to ensure the quality of care (Dantas et al., 2019).

Regarding the enabling aspects, the participants' accounts revealed that the main strength of practice in rural areas was the rural territory itself, highlighting the contribution of ways of life and cultural issues to the care process. The exchange of knowledge, habits, and life histories was striking in their accounts.

A great strength was the issue of culture [...] we were able to understand some habits, some practices. For the Family Health Team, it was not; it was simply something to be set aside. I think that was because they did not have the knowledge that culture is health (OT3).

An enabling factor is listening to the ways of care the communities were already practicing and bringing that knowledge together so that we can think about care actions (OT4).

The enabling factor was the fact that I was in a place culturally different from where I came from [...] the strength of exchanges, right? [...] of the sensitivities of contact, right? Of popular health education itself, which means stopping, listening, collectively building responses, and helping to organize those responses (OT7).

Popular Education in Health, one of the foundations of these residency programs, is a pedagogical possibility grounded in the supportive experience of listening to, being with, and learning from the other, prioritizing dialogue and the exchange of knowledge. Thus, valuing the knowledge and experiences of rural populations emerges as a powerful element in the construction of health care, since it fosters the active participation of the rural population in this process and contributes to significant changes consistent with the principles of the SUS in this care setting (Dantas & Falcão, 2014).

Theoretical foundations for practice with the rural population

While discussing the theoretical foundations for practice, the respondents reported difficulty finding materials specific to occupational therapy and the need to seek references in studies from other professions and in the work produced by earlier residency cohorts in order to better develop their activities.

I needed to read a great deal about the diseases affecting the Black population [...] I had to read a great deal of the pharmacological literature because there is medication that cannot be given to the Black population (OT1).

Honestly, I did not use occupational therapy references specifically [...] I think, unfortunately, that our references, at least up to the period of my education and all, were in a very white-centered place (OT4).

Occupational therapy's own references are a major void. We wanted to have them, but they did not exist [...] I had the occupational therapy foundation; I needed the foundation of what the rural context was and to make that interface [...] some residency capstone papers were more specific to occupational therapy [...] from a person's practice, you build your own. So I would say that some of my greatest references were the residency capstone papers from the rural health residency itself (OT5).

Publications on health policies, community issues, social movements, and the country's agrarian issues were also identified as fundamental to the theoretical foundation of these professionals' practice. One participant mentioned the importance of Black authors such as Angela Davis and Nêgo Bispo in shaping the practices developed with the rural population.

The foundations specific to family health, this community issue, which occupational therapy also has as a theoretical reference [...] the struggle, social movements [...] all the studies related to Paulo Freire, Angela Davis, all Black references, right, Nêgo Bispo [...] Alternation Pedagogy, the foundations of the SUS, these studies that involve these populations (OT2).

When we talk about strengthening a community in every respect, I remember very clearly the book Grassroots Work [...] it conveys the importance of the way we can organize ourselves in the search for our rights (OT6).

There is the National Policy for the Health of Rural and Forest Populations, to which water populations were later added, right? That is the main reference; it is what guides the residency itself [...] I greatly strengthened my foundation in understanding the agrarian question, with the movements themselves also serving as major references, the quilombola movement, the MST [...] the foundation of popular health education (OT5).

Regarding the theoretical foundation for the varied issues that fall within the scope of the occupational therapist in the health of the rural population, Silva et al. (2023) state that it remains scarce and insufficient and that, when the Brazilian context is considered, it is necessary to develop a cultural, social, and collective understanding of professional practice with peasants.

A study that aimed to present an overview of the undergraduate occupational therapy programs at Brazil's federal institutions found that most of them, at the level of discourse, are aligned with the National Curricular Guidelines for undergraduate education in the field with respect to proposing a critical, humanistic, reflective, and generalist education. Despite this, in practice, there is a strong emphasis on biological and health sciences content and a disproportionate distribution of social sciences and humanities content (Pan & Lopes, 2016).

Practice in the rural context offers potentialities for care that go beyond the biomedical model, and, to improve the competencies of professionals who work or may come to work with the health of the rural population, it is important to reformulate the pedagogical projects of health-related programs. A balanced approach between biomedical knowledge and the theoretical, philosophical, and political principles concerning this population segment is necessary to materialize an emancipatory pedagogical practice (Dantas & Falcão, 2014; Pessoa et al., 2018).

Conclusion

This study investigated the interventions developed by occupational therapists through the Multiprofessional Residency Program in Family and Community Health

(RMSFC), with an emphasis on the health of the rural population, as well as the specificities and theoretical foundations of this practice. The study contributed to the systematization of knowledge on occupational therapy practice in territories, contexts, and with subjects belonging to this population segment. Because of its exploratory nature, the study has limitations related to the literature review and the comparison of results, given the scarcity of materials addressing the practice of this professional category with Brazil's rural peoples. Thus, future research is recommended to deepen knowledge on the topic and better understand the interventions developed by this professional category in Primary Health Care (PHC) and in other areas of occupational therapy practice with this population segment.

The results showed that coming from a rural area or having a connection with that territory influences both the choice of the program and practice in this context, and that the health of this population segment was not a topic prioritized during undergraduate education. Among the most notable differences found between practice in rural areas and practice in urban areas are the distance from other health services and the difficulty in accessing them. Children, adult women, and older adults were the groups that benefited most from occupational therapy care, and among the most recurrent demands presented by these peoples are context-specific issues, such as complications resulting from the physical effort involved in agricultural work, mental illness, harmful alcohol use, and violence against women.

Group activities, home visits, and health promotion and disease prevention actions stand out as the main interventions developed by occupational therapists with the peasantry. Also, the ability to conduct contextualized assessments and proposals and to adapt to different situations, resulting from a generalist education, emerged as one of the main allies in occupational-therapeutic practice. Aspects related to precarious working conditions, including the scarcity of financial and material resources needed to implement the planned interventions, were identified as factors reducing the quality of the service provided. The study also identified difficulties in building a theoretical foundation for this practice because of gaps in undergraduate education for work with the rural population and the insufficiency of occupational therapy-specific references to support these practices.

Practice in PHC in rural areas requires recognition of the dynamism of the territory and its socioenvironmental vulnerabilities. To stimulate health professionals' interest in the peasantry, higher education institutions need to mobilize toward expanding their campuses into inland areas and including the health of the rural population in their Pedagogical Projects, while also considering the integration of this topic into the curriculum as a way to deepen and enrich occupational therapy education. Public authorities must likewise invest in an attractive and safe work environment to retain professionals who come to work in this context.

To overcome the barriers that hinder this population's access to health care, the transfer of financial resources to these regions must consider geographic and professional isolation, making it possible to fund, acquire, and maintain vehicles that transport health teams to their beneficiaries. Strategies must likewise be developed to reduce the need to refer these peoples to urban centers for specialized care, toward a strengthened and more resolute PHC.

To facilitate the organization of the work process of health professionals working in rural areas and to mitigate harm to this population's quality of life, it is essential to raise awareness among these workers and prepare them to address the problems that most

affect this population through the integration of the knowledge of the team and of PHC users. There is also a need to provide the necessary resources and appropriate spaces for the production of care.

The creation of projects aimed at inserting more professionals into rural areas, support for the development of a network of these workers, and encouragement of research in this area are strategies that can publicize the actions developed with the peasantry, expand the theoretical foundation for practice in this territory, and thus expand services and qualify the interventions developed by professionals working in this context.

Lastly, there are various possibilities for occupational-therapeutic practices with the peasantry, and these actions, when consistent with the sociocultural realities of the individuals and groups followed, can strengthen human occupations, both individually and collectively. The need also stands out to build undergraduate education grounded in the critical perspective of future occupational therapists, toward the production of socially grounded, emancipatory, and transformative practices articulated with the territory and with the everyday lives of the people receiving care, while ensuring respect for their specificities, both in rural and in urban areas. To stimulate the integration of occupational therapy techniques, procedures, and knowledge with the cultural contexts of rural areas, theoretical-practical articulation in this territory must occur from the earliest years of education, together with encouragement of new studies on the topic. Thus, occupational therapists' practice with the rural population will occur in a more resolute, comprehensive, and collective manner, as provided for in the National Policy for the Comprehensive Health of Rural, Forest, and Water Populations.

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Author's Contributions

Maria Eduarda Pachêco Silva: Conceptualization and writing of the text, organization of the sources, collection and analysis of the data. Marília Meyer Bregalda and Ana Carolina de Moraes Teixeira Vilela Dantas: Research supervision and review of the text. All authors approved the final version of the text.

Data Availability

The data supporting the findings of this study are available from the corresponding author upon request.

Corresponding author

Maria Eduarda Pachêco Silva
e-mail: maria.pacheco@academico.ufpb.br

Section editor

Profª. Dra. Roseli Esquerdo Lopes