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HEALTH-DISEASE-CARE PROCESS IN OLDER ADULTS LIVING IN RURAL AREAS: PERSPECTIVE OF CULTURALLY COHERENT CARE

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ABSTRACT

Objective: to understand the health-disease-care process of the older adult living in rural areas.
Method: a qualitative research study from the perspective of Madeleine Leininger's Theory of Diversity and Universality of Cultural Care, carried out with the participation of 19 older adults living in the rural area of a municipality in southern Brazil. Data collection took place in July and August 2018 by means of semi-structured interviews and simple observation. And data analysis was performed following Laurence Bardin's Content Analysis proposal.
Results: the conceptions of health and disease of the older adult living in rural areas are mainly related to the ability and inability to perform the activities of daily living and work, especially with the land and animals. We highlight the care practices of older adults living in rural areas with regard to the use of medications, food consumption and the practice of physical exercise. In addition, the notion about their health condition and the capacity for self-management and adaptation to the challenges of the health-disease-care process.
Conclusion: the health-disease-care process of older adults living in rural areas is influenced by social and cultural factors of the context in which they are inserted. This suggests the planning, implementation, development, evaluation and (re)formulation of health policies, programs and actions focused on providing culturally congruent care, which encompasses more than the singularities of the rural area, in the sense of dichotomy in relation to the urban area.

DESCRIPTORS: Aged. Health of the elderly. Rural area. Rural population. Culture. Nursing. Qualitative research.

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PROCESSO SAÚDE-DOENÇA-CUIDADO DO IDOSO RESIDENTE EM ÁREA RURAL: PERSPECTIVA DE UM CUIDADO CULTURALMENTE CONGRUENTE

RESUMO

Objetivo: compreender o processo saúde-doença-cuidado do idoso residente em área rural.
Método: pesquisa qualitativa na perspectiva da Teoria da Diversidade e Universalidade do Cuidado Cultural de Madeleine Leininger, realizada com a participação de 19 idosos residentes na área rural de um município da Região Sul do Brasil. A coleta de dados se deu nos meses de julho e agosto de 2018 por meio de entrevistas semiestruturadas e observação simples. E a análise de dados, mediante a proposta de Análise de Conteúdo de Laurence Bardin.
Resultados: as concepções de saúde e doença dos idosos residentes em área rural encontram-se, principalmente, relacionadas à capacidade e incapacidade de realização das atividades da vida diária e do trabalho, sobretudo, com a terra e os animais. Destacam-se as práticas de cuidado dos idosos residentes em área rural no que diz respeito ao uso de medicamentos, ao consumo de alimentos e à prática de exercícios físicos. Além, da noção sobre sua condição de saúde e da capacidade de autogestão e adaptação frente aos desafios do processo saúde-doença-cuidado.
Conclusão: o processo-saúde-doença-cuidado dos idosos residentes em área rural é influenciado por fatores sociais e culturais do contexto em que estão inseridos. O que sugere o planejamento, a implementação, o desenvolvimento, a avaliação e a (re)formulação de políticas, programas e ações de saúde com foco na prestação de um cuidado culturalmente congruente, que compreenda mais do que as singularidades da área rural, no sentido da dicotomia em relação à área urbana.

DESCRITORES: Idoso. Saúde do idoso. Zona rural. População rural. Cultura. Enfermagem. Pesquisa qualitativa.

PROCESO DE SALUD-ENFERMEDAD-ATENCIÓN DE ANCIANOS RESIDENTES EN ZONAS RURALES: LA PERSPECTIVA DE UNA ATENCIÓN CULTURALMENTE CONGRUENTE

RESUMEN

Objetivo: comprender el proceso de salud-enfermedad-atención de ancianos residentes en zonas rurales.
Método: investigación cualitativa desde la perspectiva de la Teoría de la Diversidad y Universalidad de la Atención Cultural de Madeleine Leininger, realizada con la participación de 19 ancianos en la zona rural de un municipio de la Región Sur de Brasil. Los datos se recolectaron en los meses de julio y agosto de 2018 por medio de entrevistas semiestructuradas y observación simple. El análisis de los datos se efectuó mediante la propuesta de Análisis de Contenido de Laurence Bardin.
Resultados: las concepciones de salud y enfermedad de los ancianos residentes en zonas rurales están principalmente relacionadas a la capacidad e incapacidad de realizar las actividades de la vida diaria y del trabajo, especialmente, con la tierra y los animales. Las prácticas de atención a ancianos residentes en zonas rurales se destacan con respecto al uso de medicamentos, al consumo de alimentos y a la práctica de ejercicio físico; además de la noción sobre su estado de salud y de la capacidad de autogestión y adaptación frente a los desafíos del proceso de salud-enfermedad-atención.
Conclusión: el proceso de salud-enfermedad-atención para los ancianos residentes en zonas rurales se ve influenciado por factores sociales y culturales del contexto en el que se encuentran. Eso sugiere planificación, implementación, desarrollo, evaluación y (re)formulación de políticas, programas y acciones de salud enfocadas en proporcionar atención culturalmente congruente, que comprenda no solamente las singularidades de la zona rural, en el sentido de la dicotomía en relación con el área urbana.

DESCRIPTORES: Anciano. Salud del anciano. Zona rural. Población rural. Cultura. Enfermería. Investigación cualitativa.

INTRODUCTION

The process of population aging and the consequent increase in life expectancy bring new health needs and expectations of the older adult population in different places of the world, including rural areas of the various Brazilian regions. Such needs and expectations indicate the indispensability of a new care model, in which care practices are not limited to the biomedical care model and, more than that, take into account the conceptions about health and disease of the older adults and the social and cultural factors of the context in which they are inserted.

Age is commonly understood in different societies as synonymous with disabilities, sometimes considered as indicators of health,[1] and exclusion from social life,[2] causing concern about the health-disease-care process with a view to the quality and life satisfaction of those who live this phase of the life cycle, especially when living in rural areas. Because, unlike the urban area, it is characterized by a reality in which low income and low schooling level predominate, precariousness of homes and roads, as well as the lack of public transportation and, consequently, social isolation and difficulty in accessing social and health services, causing social and health inequalities to increase progessively.[3]

Furthermore, based on a literature review regarding research studies that contemplate the health-disease-care process of the older adults living in rural areas, it was identified that these are still incipient, since few scientific publications were found. This gap allows for the justification of the development of new research with the purpose of understanding it in different social and cultural contexts and, therefore, of contributing to the planning, implementation, development, evaluation and (re)formulation of health policies, programs and actions with a view to providing culturally congruent care. In other words, care that adequately and significantly corresponds to the beliefs, cultures and ways of life of people with a view to promoting health and preventing diseases, health problems and deaths.[4]

Based on the above, the concept of the health-disease-care process is also considered as the differentiation from the health-disease process with support in the practical contribution of Nursing as a profession and science on the care process, and not simply the inclusion of care itself.[5] Moreover, even in view of the idea that cultures from different places in the world share common characteristics, it is relevant to consider that, at the same time, these cultures know, understand and practice differentiated care,[4] which should be valued when thinking about the health-disease-care process.

Having said that, the present research aimed to understand the health-disease-care process of the older adults living in rural areas.

METHOD

A qualitative research study from the perspective of Madeleine Leininger's Theory of Diversity and Universality of Cultural Care (TDUCC), since the influence of social and cultural factors, such as religious, kinship, values, ways of life, economic and educational factors contemplated in the same on the object of research is considered.[4]

Data collection was conducted in July and August 2018, through semi-structured interviews and simple observation performed by the author of the research at the participants' homes, on days and times previously scheduled. The participants were drawn from lists of people aged 60 years old or older, during meetings held with the health teams of Basic Health Units organized in the form of Family Health Strategy (FHS) responsible for three areas of coverage subdivided into 19 micro areas located in the rural area of a municipality in the Brazilian South Region, which were determined because

they had the highest number of registered older adults. For each micro area, one participating older adult and two alternate ones were drawn with a view to possible losses due to negative answers, withdrawals or exclusions.

One refusal, one withdrawal, and two exclusions were recorded, for the reason that the older adults drawn did not live since childhood in rural areas, and 19 participations that contemplated the number of areas covered by the BHUs organized in the form of FHS and their respective micro areas in their entirety considering respect with regard to historical, social and cultural characteristics of each city. The inclusion criteria defined were the following: being 60 years of age or older; both genders; living in rural areas since childhood; being registered in the Family Health Strategy; understanding and speaking the Portuguese language or having a family member who performs the translation. And the exclusion criteria were as follows: being absent after three visits made at different times and days; being deprived of liberty by judicial decision, institutionalized or hospitalized. The exact number of participants was defined at the time when research objectives were obtained, because an ideal qualitative sample is the one that reflects, in quantity and intensity, the multiple dimensions of a given phenomenon and seeks the quality of actions and interactions throughout the process.[6]

The data collected through semi-structured interviews were analyzed using Laurence Bardin's content analysis proposal,[7] respecting the stages of pre-analysis, exploration of the material and treatment of the results and interpretation. So that, first, a floating reading of the audios transcribed to a document in Word® format was carried out to understand the collected data. And then, line-by-line reading, from which, based on the discovery of the nuclei of meaning and their frequency of appearance, the following units of registration were identified: social and cultural factors, health, disease, and professional and popular care practices. Therefore, the categories were elaborated. Whereas, from the data collected through simple observation, a field diary was constructed that contributed to a deeper and more reliable reflection about the research object. Many statements of the participants related to the health-disease-care process of the older adults living in rural areas were verified during simple observation.

For the development of the research, the guidelines and regulatory standards of research involving human beings were respected. The invitation to participate sent to the selected older adults was preceded by an explanation about the objectives, relevance, development, risks and benefits of the research, and by a request for the use of a digital voice recorder during the interview. In agreement to participate in the study, two copies of the Free and Informed Consent Form were delivered and signed. For the purpose of anonymity, the participants were identified by codes: "E" for interviewee (*Entrevistado* in Portuguese), followed by the Arabic number corresponding to the interview order, such as: E1, E2, E3, and so on.

RESULTS

All the research participants lived in a rural area since birth or childhood, living and experiencing the health-disease-care process during all phases of life in the social and cultural context, which is characterized by its historical, social and cultural formation from the colonization predominantly of German, Italian and French origin, according to the following statements:

My grandfather was French. My mother is Italian (E1).

[...] *the deceased, my grandfather, came from Germany* (E3).

The research participants were between 63 and 87 years old. Most were women, received rural retirement with a monthly income of one minimum wage and had incomplete elementary school. Regarding the diagnosis of diseases, the 19 participants reported living with at least one chronic

disease, among which the following stood out: systemic arterial hypertension, diabetes mellitus, hypercholesterolemia, arthrosis and herniated disc.

The statements of the older adults living in rural areas allowed coming to the conclusion that their health-disease-care process is influenced by the social and cultural factors of the context in which they are inserted, resulting in health and disease conceptions and in their own care practices, as described in the following categories: health and disease conceptions of the older adults living in rural areas; and care practices of the older adults living in rural areas.

Health and disease conceptions of the older adults living in rural areas

In relation to the health conception of the older adults living in rural areas, it was verified that it is directly related to the ability to perform the activities of daily living and work, especially with the land and animals.

My health was good, but it's still good despite what I have. Because I have leukemia, but I don't take anything. It's never shaken me, because I feel that if I can still work it's a sign that I'm fine (E13).

Health is sleeping well, no headache, no stomachache, no bone pain. Getting up willing in the morning. Spending the day doing the house and taking care of the animals or going to the farm. It's working all day (E19).

The concept of health was also reported as the ability for social participation in entertainment moments with family and community members, in the context in which they were inserted, as well as good interpersonal relationships.

Health is walking. Going to a party and a soccer game in the community, I like it a lot. It's barbecues at home, relatives who come to visit. It's always having people around (E1).

I think I'm healthy. I'm always cool. I don't have any problem with anything, with nobody (E3).

In contrast, for the older adults living in rural areas, the diagnosis of a disease does not necessarily mean being sick. This is probably because health problems are naturalized in the aging process, as observed in the following statement:

When I don't feel anything, it's because I'm fine. But, of course, due to age, I always have some or other thing. It's the same thing as an old car, you put on one piece and you spoil the other. It's hard to say I'm sick. I'm fine (E2).

Thus, with regard to the disease conception of these older adults, it was verified that it was focused on the moments of life in which there is impossibility or limitation to maintain their daily routine, mainly due to health problems, in view of the need to rest in bed and of pain, respectively.

I think the day I say I'm sick will be because I'm going to die. I tell them [referring to daughters and neighbors] *that the day this old woman stays in bed and says she is sick; she can tell that she is sick* (E7).

I considered myself sick only when I get a sciatic attack, because of pain. I couldn't help people. There was no way to do anything and it still bothered those who were working (E16).

Finally, the disease conception of the older adults living in rural areas also refers to feelings of fear and sadness towards the acutization of health problems. Such feelings are caused by the unknown, which makes them have the feeling of imminent death.

I felt sick when the ulcer burst. At first it was gastritis, but when the ulcer broke, I thought I was sick. Since, as they say in slang, I thought I would pack [referring to dying] (E11).

Being sick is when it's sad. Today the doctors don't hide anything and I like it. But when the doctor said: 'You have a stomach infection and is bleeding.' it was a shock. I almost cried. He said:

'*Don't panic, stay calm we'll do the biopsy'.* [...] *then when the result came said, 'It's nothing'. This sadness is due to fear, because we think we will die and want to live more with the family* (E15).

In the next category, the care practices are described in the health-disease-care process of the older adults living in rural areas. Knowing them is the starting point for reflection and discussion on the construction of culturally congruent care, focusing on improving life quality and satisfaction in this population.

Care practices for the older adults living in rural areas

The older adults living in rural areas have knowledge and care practices in the health-disease-care process, especially with regard to the use of medications, food consumption, and the practice of physical exercises. However, the aforementioned knowledge and care practices are due to guidelines from health professionals on lifestyle changes in the face of the diagnosis of chronic diseases, focusing on controlling them and preventing problems.

It's just the same drug treatment and nothing else [referring to prescription drugs]. *I don't buy anything else; my class uses from time-to-time other little customers who buy in the pharmacy and supermarket. I don't do that* (E1).

It's not like eating, eating. I can't eat almost right. Because of diabetes I can't use sugar and bread has to be with that black flour. After I started consulting and found that I was a diabetic, I started taking care of food (E12).

Not now in winter, but before I walked half an hour every day in the morning. Not now, because it's dark at 6:30, seven o'clock, and it rains a lot. When it rains, I don't walk, or I walk every day for half an hour. It hasn't been that long since I've been on my way. The doctor who said it was good, since we are hypertensive [also referring to the spouse] (E4).

On the other, the care practices related to sun exposure most present in the statements of the research participants were the use of long clothes and wide-brimmed hats. These practices were focused on popular knowledge passed on from generation to generation, more than on guidelines from health professionals.

I'll take care of the sun. I put on a good hat and don't go to the sun too hot (E3).

I feel good, I just don't go out and I don't sit in the sun with nothing on my head, it's always the custom. I always put on a cap or a hat, anywhere I may be (E4).

In addition, the older adults living in rural areas showed a notion about their health conditions by recognizing signs and symptoms of possible diseases and health problems, as well as limitations and restrictions related to the aging or health-disease-care processes.

I do a little walking, fifteen minutes a day. But I don't risk it because of my knee, anything seems to unbalance me (E6).

*I had cardiac arrhythmia and the doctor asked me not to make too much effort, so what I can do I do. Sometimes I take a walk, but if I feel like it's not going to do me any good, I stop. The cardiologist told me: '*You *walk, but when you feel what looks like a grip on the chest region, you stop'. Then, I just walk more around the house. When I walk further, I do not go alone* (E15).

Another relevant issue is the ability for self-management and adaptation to the challenges of the health-disease-care process in relation to the care practices of the older adults living in rural areas, also expressed in E7's report, who required intermittent bladder catheterization daily, due to the sequel of cerebral vascular ischemia.

One day I went up to bed and said, I'm not going to be bothering you, whatever God wants. [...] *there's a big mirror that I put on the bed, I straightened up and did my hygiene all right. I said: God almighty, you'll find me this little hole and I'll learn. My lord, I want to learn. Jesus put me in my head and I went slowly looking in the mirror, pulling right with the little glass and put. To this day I'm taking my pee, thank God* (E7).

This is verified, in the statements of these older adults, who used to attend the FHS of the places in which they lived and other health services with the purpose of preventing diseases and problems. For this, they went to medical appointments, performed routine tests, such as blood tests, urine tests; when women, screening for cervical and breast cancer and, when men, prostate cancer screening. However, health education activities have rarely been reported.

Routine is pre-cancer and mammography, these things that we do every six months, every year, as the doctor advises us to do. So, every six months, every year, you have to take a test to make sure everything's okay (E4).

The last time was here on the little center, when I made the flu shot in May. She [referring to the doctor] *set up to do tests and I did and took them to her, who said what I had, how I was. If I had cholesterol, if I had this, if I had that* (E17).

In this context, a historical evolution of the care practices of the population living in rural areas is observed, including people aged 60 or over. Since, when asked about health care in the past, the research participants reported that they did not have health services close to their homes, such as basic health units organized in the form of the Family Health Strategy existing today, and the care practices were based, above all, on popular knowledge, since they attended health services only in cases of diseases considered serious, due to difficulties in access and to the insufficiency of individual and collective means of motor transport.

My mother made tea for us because she didn't have much resource back then. We lost a lot of brothers due to lack of resources. I didn't have the resources; I didn't have any doctors. There were ladies who blessed, gave tea and sent away (E4).

At that time there was no health post, it was more complicated. Thank God, in my family I had no health problem. Only after my parents went to the hospital. But consultation at that time we didn't use to do, because it was very difficult to access (E9).

However, in most of the interviews, professional care practices were observed in which the health-disease-care trinomial predominated in terms of biological factors, without taking into account the values, beliefs, norms and ways of life of these older adults, with the purpose that old age is lived and experienced with autonomy, independence and social participation, consequently, with more quality of life and satisfaction. And culturally congruent care was identified in the statements of only two participants of the research.

I deal a lot with the doctor at the health center, he's a good doctor. When I was consulting with the private doctor who specializes in urine and kidney problems, he told me 'Mrs. E7, you buy the drugs and sometimes you have them here [referring to the BHU]. *You don't want to pass your treatment here and I do?' Then I said: Excuse me sir. But you're not from that urine and kidney problem like the other doctor. And he said: 'But the treatment he does for the lady I can also do'. I agreed and continued with him years ago already* (E7).

It's already [referring to the diagnosis of leukemia] *almost three years that I'm with the doctor, but I don't take anything. It never shook me, because if I can still work, it's a sign that I'm fine* (E13).

In addition, it was noticed that, although the older adults living in rural areas attended the FHS at various times, they denied the use of this health service. This contradiction is seen, for example, in the statements of participant E1, in which, at first, he stated using only private health service and then reported situations in which he sought the FHS.

All private. I was at the health center with the doctor when the pressure problem came up. [...] *and she sent me to another doctor because she didn't get my blood pressure right. So, I picked it up with the private doctor in the city* (E1).

I go to the health center to make the flu vaccine (E1).

The doctor gave me the points at the very health center (E1).

Finally, but not less important, it is noteworthy that the research participants rarely mentioned the nurse as the protagonist of care during the interviews conducted, even when they mentioned the competence functions of this professional. As the example of E3, who reported that he went monthly to see the BHU physician for blood glucose control, but, when asked about how care occurred, he reported that he only went through the Nursing team to perform the hemoglycotest and the appropriate orientations.

DISCUSSION

Regarding the characteristics of the participants, with regard to age, gender, income and schooling, they were similar to the research conducted with older adults living in the Southern Triangle of Minas Gerais.[8] However, it is stressed that, when thinking about the health-disease-care process from a homogeneity perspective, it is unsatisfactory for the planning, implementation and development of a culturally congruent care model that makes sense to the older adults living in rural areas. Since their health and disease conceptions are directly related to the social and cultural factors of the context in which they live and that understanding them makes it possible to approach individual and collective health needs and expectations with a view to improving the care practices. It is necessary that managers and health professionals have an expanded view that encompasses beyond epidemiological data focused on biological factors.[9]

Similarly, to the results of this research, recent findings in the literature report negative or positive self-perception of the older adults living in rural areas about their health condition with the (in)ability to perform activities of daily living and work. Certainly, due to the fact that functionality in the aging and health-disease-care processes basically refers to the maintenance of autonomy and independence of old age individuals and, consequently, to the representativeness they have both in the family, because of the extra income from work as a complement to retirement, and in society, because they feel elated by the fulfillment of their responsibilities.[9–10]

In view of this, it is stressed that, regardless of retirement and of the profession that the research participants exercised in the past, in its entirety had a way of life marked by the continuity of the activities of daily life and work, especially with the land and animals. Thus, preserving its social and culturally respected productive responsibility and valued in the rural area and, at the same time, self-managing and adapting to the challenges of the aging and health-disease-care processes; thus, meeting the results of the research conducted on predictors of subjective quality of life in older adults living in urban and rural areas of the Province of Guayas in Ecuador, which confirms the influence of economy, among other social and cultural factors, on quality of life and, at the same time, the health conception of older adults living in rural areas. In a way that, differently than for those living in urban areas, continuity of work, even when retired, represents an additional income, and also the maintenance of autonomy and independence of this population.[11]

Other findings in the literature corroborate the concept of health described as the ability to participate in entertainment and social interaction moments and the quality of interpersonal relationships with family and community members. A research study developed in Sri Lanka on social participation among older adults living in rural areas highlights, from its results, how fundamental it is for maintaining the health, quality and life satisfaction of this population. In addition, it reinforces the importance of approaching the reality of each social and cultural context, in the sense that people aged 60 years old or older feel motivated with regard to participation in these entertainment and social interaction moments and, therefore, to face problems.[12] After all, these activities suffer social and cultural influence that varies from region to region, according to the ways of life of the local population, as well as from age to age, according to the changes that occur over the years in the different dimensions of human life.[13]

Interpersonal relationships stand out as an important support mechanism for an old age with health, as they contribute to old individuals feeling recognized for their experiences, safe and participative in the community to which they belong.[14] When social participation is non-existent, consequently, it becomes impaired, and a cycle of negative impact on the lives of those in the most advanced stage of life is formed.[2] This refers to the importance of maintaining the feeling of being and belonging socially and culturally representative of the ways of life of people living in rural areas, mainly aged 60 or more, through the evidence of interpersonal relationships of trust, cooperation and reciprocity between family members, friends and neighbors identified in this research.

Health promotion goes beyond care with a focus on diseases and health problem and expands to the broader concept of health that Nursing demands, such as care science, the mobilization of available individual, collective and institutional resources.[15] It is essential that the formal social networks are recognized as a support mechanism in the health-disease-care process of the older adults living in rural areas by the different people involved in self-care and the care of others, that is, the older adults themselves and other members of society, including health professionals.[2] However, following the example of a research study developed on the vulnerabilities of rural old age, the entertainment and social interaction moments of this population are most often the result of their mobilization of individual and collective resources because, usually, it is unassisted by social and health services with regard to the subject matter.[16]

In agreement with the disease conception described as the presence of pain and negative feelings and fear of death in this research, a survey on self-perceived health among older adults living in rural areas shows that body pain influences the quality of life of the older adults, contributing to the intensification of functional impairment, and, therefore, to increase dependence on the performance of activities of daily living and negative feelings and, referring to the fear of death, concomitantly, causing dissatisfaction with their health conditions and life itself.[17] Thus, the fact that the older adult continues working after retirement also corresponds to a mechanism of coping with negative feelings and fear of death,[13] because, as already discussed, work allows for the preservation of their family and social representativeness.

According to the results of the research, the care practices related to the health-disease-care process of the older adults living in rural areas revealed the need to strengthen the Unified Health System (*Sistema Único de Saúde*, SUS) in the sense of (re)organizing health services with a view to a culturally congruent care model, in fact directed to health promotion and prevention of diseases and health problems in this population. For, when it comes to social and cultural factors, problems and health solutions, there is non-conformity between the world view of people living in rural areas and that of the State and science, resulting in the visibility of the context in which they are inserted and the invisibility of the rural.[18]

So much so that, even with the implementation of Basic Health Units organized in the form of a Family Health Strategy in the research locations, the biomedical care model predominates, focusing on health in terms of biological factors, disregarding the influence of social and cultural factors in the health-disease-care process of the older adults living in rural areas. Similarly, a research study on the responsiveness index of the Rural Family Health Strategy, developed in the Federal District, explains the need for care models that break with the biomedical care model, in other words, curative and physician-centered, and that reduce health inequities. As well as it emphasizes the lack of public policies for rural care which think about health, disease and care issues in a culturally congruent manner.[19] This is possibly because, historically, and still today, they are mainly directed to the economic interests of rural development projects that depend on a healthy workforce and, consequently, punctual, fragmented and excluding in relation to the singularities of this population.[18]

Although with the expansion of the number of Family Health Strategy units in geographically isolated locations, such as rural ones and, this said, with the reduction of the difficulty in accessing health services, there was certainly no timely reorientation of the biomedical care model.[20] Thus, making immediate the need for dynamic and constant planning of health actions based on epidemiological data, in line with the social and cultural context of the area covered by the Family Health Strategy and, equally, with the health needs and expectations that are revealed from the individual and collective daily experiences.[21]

For this, a possibility of change consists in the reconstruction of the perspective and professional posture based on knowledge almost exclusively of biological factors towards the (re)knowledge of pluralities of rural areas, with a view to the inclusion of social and cultural factors in the care practices through a relationship of equals between the population to be cared for and the health professionals and other sectors, such as environmental and rural development, in search of the identification of the weaknesses and potentialities of the health-disease-care process.[22]

Based on this, the suggestion that the National Comprehensive Health Policy of rural and forest populations[23] and the National Health Policy of the Older Adult[24] are (re)thought jointly, considering the diversity and cultural universality of care in each Brazilian region. Having as one of its purposes the incentive to provide culturally congruent care, which respects the different ways of life and allows the older adults living in rural areas to live and experience old age with quality of life and satisfaction.

As expressed in the National Policy for the Integral Health of rural and forest populations, to improve quality of care and access to the SUS, it is crucial to take into account the differences and similarities of these population groups and their processes of social and cultural production and reproduction. As well as the sharing of knowledge and experiences with public programs and policies from different sectors, with a view to the principles of equality, universality and integrality.[23] Moreover, for the construction of a dignified life for the older adults living in rural areas, it is essential to propose health education activities aimed at overcoming their weaknesses and recognizing their potentialities, as well as the development of the ability to (re)formulate their life possibilities in the face of the health-disease-care process in the quality of the critical and reflective subjects that they are.[25]

Finally, it is emphasized that, although Nursing is essential for the Family Health Strategy in the reorientation of the health care model in the various Brazilian regions, since it represents a possibility of producing a care model from the context in which people are inserted;[26] in other words, culturally congruent, it is perceived in the statements of the research participants that the physician has the main role, and the nurse, nursing technicians and other health professionals who make up

the family health teams have an adjunct role with regard to the care practices for the older adults living in rural areas, which can be related to the preponderance of the biomedical view, considered an impasse for the efficacy and effectiveness of care provided to the older adult.[27] As well as the fact that, among the competences of the nurse's professional practice, coordination and management of the team stands out. In this way, actions for health promotion and prevention of diseases and health problems are not commonly developed based on the identification of the expectations and needs of the population. This points to the indispensability of the construction of new knowledge and professional, political and social empowerment with a view to improving the exercise of the profession in this field of activity.[26]

The importance of the nurses' role in the care of older adults living in rural areas is well-known, and it is considered essential to advance towards their growth and recognition as protagonists of care, through a more active and close action of this population. This is because the presence of nurses in the health-disease-care process raises patient-professional confidence and curiosity and interest in care practices, contributing to health promotion and prevention of diseases and health problems and, therefore, to active and healthy aging.[27]

Similarly, a research study aimed at understanding the practice of comprehensive care for the older adults, under the eyes of professionals from the FHS and from the Expanded Center for Family Health and Primary Care (*Núcleo Ampliado de Saúde da Família e Atenção Básica*, NASF-AB), verified the need to move towards a new model of organization of the health services, because care practices are still focused on the curative and physician-centered model; therefore, far from the reality lived and experienced by the older adults.[28] Awareness, training and instrumentalization of nurses and other health professionals are fundamental to identify and meet the health needs and expectations of the population in question, considering their singularities and respecting primary care and protection focused mainly on older adult living in areas with social vulnerability,[28–29] among them the rural ones.

It is considered that the limitation of this research consists in the regional cut, with specific characteristics of a municipality located in the Southern Region of Rio Grande do Sul; so that the results, given the Brazilian Regional diversities, including social, cultural, environmental and rural development, cannot be generalized nationwide. Therefore, it is expected that further research studies will be carried out and complement this gap in knowledge about the health-disease-care process of the older adults living in rural areas. This is because the reality lived and experienced daily in their social and cultural context is not entirely contemplated by national health actions, programs and policies directed to the rural population, in which the growing number of older adults stands out. Furthermore, it is expected that this research will serve as a comparison with future data.

In relation to the contribution to the Nursing sector, it is thought that knowing the health-disease-care process of the older adults living in rural areas under the light of Madeleine Leininger's Theory of Diversity and Universality of Cultural Care (TDUCC) contributed to the construction of the body of knowledge and the motivation of new research studies with a view to the state of the art with regard to culturally congruent care, provided by nurses and other health professionals. The movement carried out with the research enables evidence-based reflection and discussion on the relevance of professional care practices that take into account the social and cultural context in which people live and, more than that, that the it constitutes them as individual and collective human beings, with unparalleled health needs and expectations, in coping with social and health inequalities.

CONCLUSION

The health-disease-care process for the older adults living in rural areas is influenced by social and cultural factors. This suggests the planning, implementation, development, evaluation and (re)formulation of health policies, programs and actions focused on providing culturally congruent care that encompasses more than the singularities of the rural area, in the sense of the dichotomy in relation to the urban area, often generalized.

That is, focusing on the provision of a culturally congruent care that understands the diversity and cultural universality of care in rural areas of the various Brazilian regions, respecting the ways of life produced and reproduced over time and permeated by individual and collective subjectivities, such as beliefs and values. Therefore, providing that the older adults living in rural areas live with more autonomy and independence through the construction of knowledge and empowerment regarding their duties and rights in the democratization of public policies, from the valorization of the demands brought and translated by them and awareness about the seriousness of popular participation, respectively.

The importance of the Theory of Diversity and Universality of Cultural Care is also noteworthy for the orientation of new professional care practices, with the purpose of health promotion and prevention of diseases and health problems in these older adults. This is because there is diversity and cultural universality of care that needs to be known and recognized by nurses and other health professionals, meeting a culturally congruent care model really directed to the health needs and expectations of the older adults living in rural areas, in an integral and humanized manner.

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