Rural context and professional rehabilitation in a region of the Ribeira Valley

Contexto rural e a reabilitação profissional em uma região do Vale do Ribeira

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ABSTRACT Aim: To investigate the sociodemographic profile, of work and health, of workers from a region of Registro (SP), locate in Ribeira Valley, and to identify the barriers and facilitators in the professional rehabilitation process of the National Institute of Social Security (INSS), of insured persons workers of this region. Methods: Two steps: (1) A list of workers was obtained from the Family Health Strategy of rural neighborhoods in the city of Registro (SP), and a questionnaire with sociodemographic data, of work and health, was applied, under the form of an interview. (2) Subsequently, two reference professionals of the INSS, who worked at the headquarters of this region were identified and, in addition, individual interviews were conducted to analyze thematic content. Results: Regarding the profile of the subjects, most workers worked on banana plantations, lived on farms, had low schooling; all reported musculoskeletal symptoms, among others. In interviews with reference professionals of the INSS, it was possible to observe, among the main barriers found to professional rehabilitation: the profile of insured rural people with low schooling, with difficulties in transportation, few courses offered, and the evaluation of the medical expert based on the biomedical model, with suffering and injustice. Among the facilitators: the welcome of the social workers reference professionals, the bond established and the empathy. Conclusion: There is a need for public policies that can guarantee the rights of workers and promote improvements in the current model of professional rehabilitation.

KEYWORDS Occupational health. Rural health. Rehabilitation.

RESUMO *Objetivo: Investigar o perfil sociodemográfico, de trabalho e saúde, de trabalhadores de uma região de Registro (SP), localizada no Vale do Ribeira, e identificar as barreiras e os facilitadores no processo de reabilitação profissional do Instituto Nacional de Seguridade Social (INSS), de segurados dessa região. Métodos: Duas etapas: (1) Foi obtida uma listagem de trabalhadores junto à Estratégia Saúde da Família de bairros rurais do município de Registro (SP), e aplicou-se, sob forma de entrevista, um questionário com dados sociodemográficos, de trabalho e saúde. (2) Posteriormente, foram identificados dois profissionais de referência do INSS, que atuavam na sede dessa região e, ainda, foram realizadas entrevistas individuais para análise de conteúdo temático. Resultados: Com relação ao perfil dos sujeitos, a maioria dos trabalhadores atuava em plantações de banana, morava nas fazendas, tinha baixa escolaridade; todos refeririam sintomas osteomusculares, entre outros. Nas entrevistas com os profissionais de referência do INSS, foi possível observar, entre as principais barreiras para a reabilitação profissional encontradas: o perfil dos segurados da região rural com baixa escolaridade, com dificuldades em transporte, poucos cursos ofertados, e a avaliação do médico perito com base no modelo biomédico, com sofrimento e injustiças. Entre os facilitadores: o acolhimento dos profissionais de referência assistentes sociais, o vínculo estabelecido e a empatia. Conclusão: Há necessidade de políticas públicas que possam garantir os direitos dos trabalhadores e promovam melhorias no modelo atual de reabilitação profissional.*

PALAVRAS-CHAVE *Saúde do trabalhador. Saúde da população rural. Reabilitação.*

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Introduction

Rural workers experience, by and large, an intense process of social deprotection, as they often perform work activities in the informal sector, and in precarious housing and work conditions. And when they become ill and unable to perform work activities, they also suffer from the existing barriers to returning to work through the Professional Rehabilitation Program[1]. In the rural context, there are several different factors in relation to this population, which, in general, has low education and low financial income, difficulties in accessing social, health and trade goods and services[2]. It is worth mentioning that the rural population is larger than the urban population in approximately 30% of Brazilian municipalities, reaching 40% in municipalities with less than 20 thousand inhabitants, and it is estimated that in Brazil, there are about 30 million rural workers, demarcating around 20% of the economically active population[3]. However, only after 1988, rural workers (men and women) started to have the same rights as urban workers[4]. Thus, the rural worker also has the right to exercise his/her functions in a healthy and safe environment, and it is the employer's responsibility to take the necessary measures in order to reduce the health and safety risks of that worker[5].

Changes in the world of work imposed a different way of life for the rural population, influencing the aggravation of the health-disease process and workloads[6]. In agriculture, there are dangerous occupations for workers, not only due to the use of tools, machines and pesticides, but especially due to the requirement of great physical efforts in general in the performance of activities[7]. Furthermore, agricultural work has high rates of accidental death, injuries and work-related illnesses[8]. Rural workers, with less purchasing power, have few resources to organize their work processes and few have the technologies that facilitate or replace manual labor[9]. Thus, exhausting working hours, carrying excessive weight, inadequate postures and other ergonomic characteristics cause them to develop musculoskeletal disorders, especially lumbar spine problems[10]. Many of these diseases lead to withdrawal from work activities, with some workers referred to the Professional Rehabilitation Program (PRP) of the National Social Security Institute (INSS).

Officially, the PRP is a service provided by the INSS to Social Security (SS) taxpayers, provided for in Law nº 8.213/91. It is a (re)educational and professional (re)adaptation assistance, which aims to provide insured workers, partially or totally incapacitated for work, and of a mandatory nature, the means indicated for reentering the labor market and in the context in which live[11]. The PRP was created in response to the growing number of people unable to work as a result of work accidents and occupational diseases during the Vargas government, at the time of the dictatorial regime, and today, it can be understood as a subprogram of medical expertise, which has an assistance character under the compensatory logic[12].

Thus, the provision of Professional Rehabilitation (PR) services linked to SS systems has a dual role: on the one hand, it corresponds to forms of intervention to reduce and overcome the disadvantages produced by disabilities, and, on the other, to strategies of economic regulation of systems in order to reduce the time for granting social security benefits[13]. The PRP is an option for workers, most of whom are SS contributors, who are receiving accident or social security sickness benefits, who are unable to perform their original jobs, and whose disabilities and work restrictions are stabilized and are long-term. duration[14]. The procedures that guide the INSS workers involved with the PR are based on the document 'Technical Manual of Procedures in the Professional

Rehabilitation Area', updated in 2018[15].

The referral to the PRP is carried out by the medical expertise of the INSS, and the service is provided by the PR team, which should preferably be multidisciplinary, composed of INSS medical experts and Social Security analysts trained in the areas of Social Work, Psychology, Occupational Therapy, Sociology, Physiotherapy or areas related to the process, called Responsible for Professional Guidance (ROP)[15].

In 2016, there was an expansion of the concept of disability based on the biopsychosocial model of health, and territorial approaches were introduced, but efforts to introduce these changes were not able to break with the hierarchical and cultural and historical macro-politics of INSS[16]. In the 2018 version of the 'Technical Manual of Procedures in the Professional Rehabilitation Area', biomedical actions based on an insufficient and precarious assistance logic were reinforced16. For Pereira and Nogueira[17], the PRP is an 'safety valve' that allows the insured to leave without receiving INSS benefits.

The medical professional is responsible for assessing the incapacity for work, for granting or denying a social security benefit and for referring the insured person to the PRP. Thus, the evaluation of the medical legal expert is influenced by his/her training focused on clinical reasoning and diagnostic performance. In addition, it is often also based on personal and out-of-context criteria, and the socio-political issues of disability are not assessed, since only physical aggravations are considered[14]. In this sense, one of the challenges to be overcome concerns the construction of a consensus on the concepts of health, disability, psychosocial and professional rehabilitation. And these concepts must also take into account the rural work context.

The PR itself is the reinsertion, in the employment company, in a new work activity. When this is not possible, professional courses offered by INSS[18] are offered. However, in many cases, it is necessary to increase schooling for inclusion in such courses. The PR ceases with the issuance of a certificate that indicates the function for which the rehabilitating person was professionally trained[19]. And the homologation of the insured's rehabilitation, regardless of the actual conditions of effective reintegration into the work environment, is the responsibility of the company, with little State interference[20].

The scenario of social public policies, in the Country, is experiencing a time of uncertainty and concerns regarding the measures and reforms approved in the last year. For Miranda[16], social security services – one of them, the PRP – are impacted by societal changes resulting from political reforms, characterized by the emphasis on a neoliberal model, and by measures that minimize the role of the State in guaranteeing social rights and protection. In view of the current political and economic situation, and since the 1990s, the PRP has been undergoing an increasing process of scrapping in Brazil. With this, the return to work through the PRP is a complex challenge for the field of public health and social security.

The objective of the present study was to investigate the socio-demographic, work and health profile of rural workers in a region of Registro (SP), in Vale do Ribeira, and to identify barriers and facilitators in the PR process of the INSS, through perceptions of reference professionals in the region.

Methods

It is a study carried out in two stages. In the first stage, a list of rural workers from the territory covered by the Family Health Strategy (FHS) team from Jardim São Paulo, in Registro (SP), which is located in the Ribeira Valley, was obtained. These neighborhoods were chosen because they had a predominance of rural

economic activity. In addition, because of the proximity of some researchers to the local FHS team, and the possibility of access to places of residence and work. The Ribeira Valley is a region between the southern regions of the State of São Paulo and the east of the State of Paraná, comprising 30 municipalities. Among the municipalities of Ribeira Valley, the municipality of Registro (SP) is of particular importance due to its geographical location and because it is a relevant agricultural and commercial center, in addition to participating in state and federal agencies and services, the municipality being called 'Capital of the Ribeira Valley[21]. Registro (SP) has about 80 neighborhoods and its population was estimated by the Brazilian Institute of Geography and Statistics (IBGE) (2018) with 56.249 inhabitants, of which 48.169 lived in urban areas and 6.092 in rural areas. Also according to IBGE data (2019), banana and heart of palm production are evidenced.

From the list obtained, visits were carried out to the places of work and housing, initially accompanied by a community health worker. During these visits, questionnaires previously prepared with workers were applied individually and in the form of an interview, containing sociodemographic, work and health data, and items on removal from work and links to the PRP. The questionnaires were applied after the subjects' voluntary consent to participate in the study. The criteria for selecting the subjects were: being rural workers linked to the Jardim São Paulo FHS and having some link with the rural property. Temporary workers, who provided services through outsourced companies and who, in general, did not have a bond or register with the FHS, did not participate in the research, as they did not reside in the territory covered by it. In this study, it was chosen to investigate the sociodemographic profile of rural workers in a region of the municipality of Registro (SP) for the impossibility (restriction obtained) of contacting the INSS policyholders and linked to the PRP.

For the second stage, a list of the reference professionals of the PRP of the INSS linked to the headquarters unit of Santos (SP) was also obtained, through the technical responsible of the PR sector, with the names and telephone contacts of the municipality of Registro (SP), in the Ribeira Valley. From this list, only two reference professionals linked to the INSS, working in the PRP in the municipality, were identified. The personal and work data of these reference professionals in the region were obtained, and, subsequently, individual interviews were carried out, which lasted approximately 60 minutes. The interviews took place at the workplace, and were recorded and transcribed in full for thematic content analysis[22]. Content analysis is a set of communication analysis techniques, which uses systematic and objective procedures for describing the content of messages, having speech as its object, that is, the individual and current (in-action) aspect of language[22]. These interviews took place after previous appointments, through telephone contact, in a reserved room, and at the INSS headquarters in Registro (SP). The study was carried out according to the ethical principles of research with human beings, and was approved by the Research Ethics Committee of the Federal University of São Paulo (Unifesp). CAAE opinion number (Certificate of Presentation for Ethical Assessment): 1.510.029

Results and discussions

In the list of rural neighborhoods assigned to the Jardim São Paulo FHS, 10 rural properties with predominant banana production activities were registered. Questionnaires were applied to 36 workers, which represented 95% of rural banana workers in that territory. *Table 1* shows some sociodemographic, work and health data for local workers.

Table 1. Sociodemographic, work and health data of rural workers

Variables (n=36)	Data	%
Sex	Male	94,4%
	Female	5,6%
Age range	<20 years	8,3%
	20 to 29 years	27,8%
	30 to 39 years	19,4%
	Over 40 years old	44,5%
Education	Never went to school	5,6%
	Incomplete elementary school	50%
	Complete elementary school	8,3%
	Incomplete high school	13,9%
	Complete high school	22,2%
Family income	1 to 2 minimum wages	71,4%
	3 to 4 minimum wages	28,6%
Type of employment contract	Registered work contracts/CLT*	58,3%
	Informal or autonomous	41,6%
Rural working time	Inferior to 10 years	18,5%
	Superior to 10 years	81,5%
Musculoskeletal symptoms at work	Yes	90,3%
	No	9,7%
Previous occurrence of withdrawal from work activities by the INSS	Yes	14,3%
	No	85,7%
Treatments performed	Home/ self-medication	80%
	Outpatient/hospital	20%

Source: Own elaboration.

* Consolidation of Labor Laws.

As noted, most workers were male, with low education level and with a family income of one to two minimum wages. Low education level is common among workers in rural areas, as well as low wages[3]. There was a high percentage of informal workers and some self-employed, demonstrating the social lack of protection of the worker. Thereby, social inequalities and inequities can occur and generate mental suffering[23]. The working time was also superior to 10 years for most and, for some, it was superior to 20 years. In relation to health complaints, all presented musculoskeletal symptoms, with the painful symptom being evident in several body regions; some reported the symptoms during the workday. All workers acted with an emphasis on banana cultivation (which is one of the prevalent economic activities in the rural region) and lived in the homes of the farm owners, not paying rent, but bearing the costs of the electricity used.

Among the subjects in the FHS territory, there were few absences from work, and none of them had gone through the PRP. It is worth mentioning that this territory represents only one region. Most of them opted for home medication treatments/self-medication, due to difficulties in accessing health services, since few had a car to get around and there was no public transport

in the territory, at the time of the study, to travel to some Basic Health Unit (BHU). The commuting usually took place on foot (about 1h30m) or by bicycle, which was very painful in the case of accidents and/or diseases, and showed the existing social injustices and deprotections. Social and health problems are faced by the rural population, with difficulties in accessing goods and services, especially health[24].

In the second stage, two (n=02) reference professionals, who worked in the municipality of Registro (SP), participated in the interviews. They have been given fictitious names to preserve confidentiality. After analyzing the interviews, two thematic categories were listed: 'Barriers in the PR process' and 'Facilitators in the PR process'.

Barriers in the PR process in rural areas

The testimonies brought as barriers the problems in relation to the discrepancy between what the service offered and the profile of the agency's insured people. The profile of the insured people assisted, according to the reference professionals, was that of rural workers, who, for most of their lives, dedicated themselves to 'menial' jobs.

> *[...] they are rural workers, banana workers, people who worked carrying excess weight, people who worked in general services, some truck drivers. So, basically, these are the people who are normally affected and come to seek rehabilitation.* (João).

In agriculture, physical efforts are frequent in the performance of activities[25]. Thus, physical effort is one of the characteristics of manual labor, and one of the risks for the development of musculoskeletal diseases[26]. Once injured, there are fears and difficulties to fit in the previous work activity, due to physical demands, generating fear and insecurity for returning to work. This situation was made worse by the fact that many of these rural workers started to work in childhood.

> *[...] they started to work since childhood in the small farm, with loads, with heavy, menial, manual labor. The vast majority of what I answer here, when I ask this question, of those who have spinal problems, anyway, have a child labor relationship.* (Marcos).

Many began to work in childhood, as said, encouraged by their parents. And one of the consequences of child labor is the abandonment of studies to help support their families[14]. As a result, there was a low level of education among the insured persons served, imposing challenges for the incentives to return to studies. *"[...] Then, the guy is in his 40s, almost 50 years old, semi-illiterate, and the guy lives in a rural city. How am I going to rehabilitate this person?"* (Marcos).

Long years out of school can make going back to school something painful. According to data from IBGE (2017), about 15% of rural producers have never attended a school; 31.3% had only elementary education; and only 26.4% completed high school[3]. It is noteworthy that many workers begin to help parents with work activities when they are still children, and, often due to economic and social needs, they end up helping parents until adulthood. For the reference professionals, low schooling was considered a barrier to PR, as one of the resources offered by the Program is rehabilitation in a new position, through courses that require complete high school. The low level of education and the lack of professional preparation of most workers, added to the functional limitations resulting from the disease, impose a non-promising reality for returning to work and, consequently, for economic self-sufficiency[27].

Although some studies have shown that low education level, and housing far from the agency and in rural areas are criteria for ineligibility[14,28], in this study, the reference professionals cited that some workers did not

have the profile for PR. A reflection brought by Cheres et al.[28] recommends that eligibility to the Program requires education, therefore, the referral of a worker with low education level to the Program generates an infringement of this criterion. For the authors, this fact may signal that the INSS is looking for an alternative to include beneficiaries with low schooling in the Program, aiming at qualifying and returning to the job market. Or, there is no alignment for the experts regarding the criteria for referral to the Program. In any case, it is worth reflecting on the processes of exclusion of such subjects, when they are not considered eligible for the Program, and on the existing challenges.

Another barrier pointed out by the interviewees was the difficulty of displacing the insured people (transport), both for the INSS agency and for the places where professional qualification courses were offered, due to the geographic characteristics of the region.

> *[...] Right here, in Ribeira Valley, for example, there are people who, to go to work, need to cross the river, need to walk on bumpy roads [...] there are users, who have back problems, who they have to walk four, five kilometers to get to the track, to be able to take the ambulance, or then, to be able to take their transport.* (João).

Transport difficulties are common, and the distance from where rural workers live to treatment places makes rehabilitation difficult[1]. In addition to this, the PR has been carried out from the referral of the insured people to professional courses of partner institutions of the INSS, however, these courses are often not compatible with the insured people's skills, education and desires.

> *[...] the users who returned, reported to me that, sometimes, they forced him to take a logistics course, and he hates working in logistics; hates working with separation, sending material...* (João).

These situations, according to the interviewees, caused suffering among insured people, as the offer of courses is restricted and there are few free courses, which made their choices and decisions difficult.

> *[...] Here, as there are no strong covenants, and the courses cannot be paid, they can only be free, for example, the* [National Service of Commercial Learning] *Senac, has a hundred courses, and then, there is only a scholarship 'in these' and 'in that', and, sometimes, what he (the insured person) wants to do, it's a paid course.* (Marcos).

This incompatibility resulted in a dissatisfaction of the insured person and demonstrated the ineffectiveness of rehabilitation as it has been done, because, according to the reports, it did not guarantee reinsertion or permanence in work after the PRP, because the insured person took a course in which he/she did not had interest/skill, or did not qualify for the needs of the market. For Vargas[13], the possibility of taking courses is strongly limited by the insured person's level of education and the lack of support from companies in the rehabilitation of their employees. There is little or no interference by the State in relation to compliance with restrictions and guidelines for the return of workers to work. There is only the sending of letters reporting the disability and requesting rehabilitation with the absence of on-site actions[26]. In a study, workers realized that companies made it difficult to return, and that there was no concern with making adjustments to the work previously done, nor the concern with defining a new job for the relocation[18].

Another issue that arose from the interviewees' perceptions was related to the evaluation of the medical legal expert.

> *[...] they are simply seen with a focus centered on the disease and not on the environment or on the issues that this person lives in the environment. It is not understood how it is... the other aspects that influence this person's life, right?* (José).

[...] We see a very medico-centric look, very centered on the disease, without a prospect of solving the person's problem. (Marcos).

The biomedical view of disability is restricted to the physical aspects of injuries and illness. Considering that the International Classification of Functioning (CIF) has not yet been standardized as a parameter in the PRP, by the INSS, the medical expert is limited to the current social security rules, emphasizing his/her analyzes in the biomedical view that privileges the anatomopathological aspects[28]. The INSS medical legal expert is responsible for referring the worker to the Program, for evaluating the work potential and for deciding to be discharged from the Program. According to the agency's worker profile, presented by the interviewees, it seemed to be insufficient to use only the biomedical approach in assessing the worker. The biomedical perspective does not cover all the complexity involved in the health condition of the insured person, as it is unable to answer the social, cultural, political, economic and individual aspects involved.

The difficulties in the PR process did not only impact the mental health of the insured people, according to the interviewees, but reflected, negatively, on themselves.

[...]. You can't do a decent rehabilitation, you can't run a decent professional program with the insured person. He will comply with the formalities within the professional rehabilitation and will be thrown into the job market in a condition that, many times, he cannot return to his usual activity, he cannot. And the course he took is short and insufficient. (Marcos).

There was often a feeling of helplessness and frustration, as they did not perform a job that actually met the demands and interests presented by policyholders in the PR process, as well as, given the context, it was impossible to meet the objective of the Program, although they reported who tried their best to guarantee workers' rights. And professionals, many times, did not feel themselves exercising their roles as social workers. The precariousness of work, with its characteristics of diluting the specific attributions and competences of the professions and the requirement of multipurpose workers, does not leave the social worker out of this reality[17].

The reference professionals also reported that there was a constant effort to transform the difficulties and frustrations of work, caused by barriers in the PR process, into motivation and overcoming.

[...] motivates me to look for ways out [...] you seek, within your limitations, what you can do. Then, within what you can do, I try to guarantee the maximum rights of this rehabilitated. (Marcos).

They were strategies used to continue moving forward.

[...] this frustration, we try to transform it into motivation for the struggle with our users, because it is a frustration that you simply have to overcome. Then, how am I going to overcome this frustration? It is fighting for this to be transformed, and to fight. (João).

These struggles on behalf of workers do not always occur without cost to the health of the interviewees. There was a feeling of guilt, indignation and revolt, for feeling that they were 'favoring' the system, and, consequently, social exclusion. And this should generate, also among insured people, ethical and political suffering. This suffering results in the subjects' daily experience in social situations in which they are treated or treat the other in intersubjectivity, as inferior, subordinate, worthless, useless appendix of society, and which is determined by the social organization at a given historical moment[29]. In a study with workers from Family Health Teams, the main cause of this suffering was the impotence to solve the

health problem, against the background of a broader social-historical process, related to neoliberal macroeconomic policies[30].

Although each profession has its professional project, in the case of social workers, there is an ethical-political project, which expresses the desires and values of these professionals, who may come into contact with a certain institutional reality, which, in most cases, may not be in the same direction as the profession itself, generating the need to face a set of relationships between political and economic forces and subordination to the imposed work processes[30].

Facilitators and challenges in the PR process

Despite the barriers found, the interviewees reported situations and behaviors taken by them that can be considered as facilitators in the process of PR of the insured people. The more comprehensive and empathetic view of the insured people's life by the reference professionals – in this case, social workers – made it possible, eventually, to face adverse and conflicting situations, promoting open dialogues with the insured people about their realities and needs.

> *[...] if I don't talk to this user, if I simply impose the things that have to be done, without arguing with him, without realizing the difficulties, without automatically respecting his own life, we will have a difficult, conflicting relationship; a relationship in which he will not have trust, and will not be linked to me.* (João).

According to Prado and Duarte[31], the INSS adopts the management model based on the rationalization of work, and the entire work process is institutionally controlled, and hierarchized to the maximum, attributing mere executive functions to the professionals. According to the reports, in order that, in fact, there was a possibility of success in the Program, actions and attitudes of the reference professional were necessary, which were not foreseen in the list of technical procedures and, therefore, came from his/her initiative. According to the testimonies of the interviews, the RP mentioned the need to act with 'something else', which should be added to the service and which facilitated the relationship with the insured people.

This form of relationship is possible when one has empathy and an understanding of the life story and the difficulties faced by the other:

> *[...]. I have a daughter. I imagine myself in the situation of that person, right?, and I keep thinking. I revolt a little, more in the sense of empathy regarding the person's situation, and I wake up a little, of restlessness, movement and search.* (Marcos).

The support, relationships and individual attitudes offered by INSS professionals, as well as the acceptance and recognition of the suffering present in the health-disease-work process are factors that facilitate the return to work[32]. Among the main facilitators, according to a study on workers away from work attended at a Occupational Health Reference Center, it was identified that the main facilitator for returning to work is in the support, relationships and individual attitudes offered by professionals of such service[26].

The importance of the multiprofessional team and of different 'views' on the cases was also highlighted.

> *[...] We have to have a different perspective regarding the relationships that this user brings. We have to have a different perspective regarding the access that this user has.* (João).

This difference concerns the view on other aspects involved in the disease, such as biopsychosocial aspects. According to the reference professionals, an assessment that takes into account all aspects involved in the

health-disease process would allow a better referral to professional courses, with possible indications of relocation in other workstations.

This expanded view on the multifactorial nature that involves the health-disease process, removal and return to work, goes against the professional profile itself, the skills and values of the social worker. One of the aspects involved in this process, and which is one of the focuses of these professionals, concerns social support networks. For example, the family, which can also be instrumental in this process of returning to work.

> *[...] some people (family members), also, ask the insured people: 'Are you on sick pay, and why are you staying so long at home?'. So, it is also bringing these people, these relatives to talk to them, explaining to them how the rehabilitation procedure takes place.* (Marcos).

According to the reports, there was a need to deal with support networks, including the family, because insured people often faced situations of discrimination with family members and in health services, for being away from work. The reference professionals mentioned the importance of having these support networks, whenever possible, since they were not a priority for the Program. Sick workers, when living with situations of incapacity and suffering, usually find in the family ways to face the situations[32].

However, there are major challenges for relocating individuals to work posts after being away from work due to illness, due to the neglect of employers and the absence of effective public policies that favor this return, especially in rural areas. Still, the establishment of goals among concerned parties in the return to work process – whether workers, employers, health professionals, service providers, taxpayers and/or society – must be supported by combined social actions among the social actors involved in rehabilitation[31].

Final considerations

According to the data obtained in the first stage, rural workers acted with an emphasis on banana cultivation, lived on employers' farms, most had low education level, and all reported musculoskeletal symptoms at work. They presented difficulties in accessing health services and a preference for self-medication and home medicines. The profile of rural workers found in a region brought some information that complemented and/or reported some data obtained from reference professionals in the studied region, however the study suffered limitations because it presented data from workers from only one territory in the municipality of Registro (SP), and from subjects not linked to the PRP.

In relation to the interviews, among the main barriers encountered were: the profile of the insured people of the region, the fact they are rural residents, 'menial' workers, with low education level; the evaluation of the medical legal expert based on the biomedical model; and the incompatibility of courses offered with the profile of the insured people. In addition, the criteria of ineligibility to the PRP are compatible with the profile of the population served by this agency, which demonstrates that the current PR model is incompatible with the demands of the rural population. Another important issue identified was the possible negative impact of PR on the mental health of the reference professionals, since they felt frustrated and powerless in relation to the results of their work, with aspects that should be further investigated in future studies. Often, they blamed themselves for thinking they performed poor services and were instruments of violating social rights. As for the facilitators, they were related to the attitudes of the reference professionals in the face of the difficulties of the insured people they assisted, among them, welcoming, bonding and empathy, which

were aspects that the reference professionals mentioned because they perceived that they improved the relationship between the insured people and the professional, and established trust and respect between them, which facilitated the PR process.

The social security reform will result in reduced access to social benefits in proportions that are still unknown, but worrying. It will certainly limit access to social security benefits for rural workers, and, therefore, it is extremely necessary to bring to light reflections on the population studied here.

There is a need for improvements in the PR model of rural workers, so that they are compatible with their needs and characteristics, as well as a public policy that ensures, in fact, labor rights, health promotion and safety at work, as they are exposed to inadequate working conditions and fragile employment relationships.

This study had limitations in the first stage, due to the selection of only a few rural neighborhoods, and because only some data from the socio-demographic profile were investigated, and, in relation to health, because only the presence or absence of musculoskeletal symptoms was observed. There were also limitations in relation to the low sample of respondents (n=2), as it refers to a single agency, making it impossible to generalize the data obtained. However, there are few studies on PR in rural areas, and it is hoped that future studies can deepen such debates.

Collaborators

Zavarizzi CP (0000-0002-4143-0192)* contributed to the analysis and interpretation of the data, critical review of the content; and approval of the final version of the manuscript. Simas JMM (0000-0003-1742-3707)* contributed to the design of the data; critical review of the content; and approval of the final version of the manuscript. Santos LF (0000-0003-2923-4962)* contributed to the conception, planning and interpretation of data; draft elaboration; and approval of the final version of the manuscript. Alencar MCB (0000-0001-7555-4153)* contributed to the analysis and interpretation of the data; drafting and critical review of the content; and approval of the final version of the manuscript. ■

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