

The construction of public mental health policies in Brazil with a focus on rural workers*

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Objective: to analyze the inclusion of the mental health of rural workers in the construction of the agenda and implementation of the main public health policies of the national territory.

Method: a cross-sectional and interdisciplinary research study that conducts bibliographic and documentary survey, investigating the “place” of rural workers’ mental health in the construction of the National Mental Health Policy, the National Workers’ Health Policy and the National Integral Health Policy of the Rural, Forest and Waters Populations.

Results: although advances have been made in the national context of mental health and workers’ health, the inclusion of the rural environment is still timid and the consideration of the rural workers’ distress is practically null. **Conclusion:** the rural worker is little mentioned in the main national policies and without an integrative concept, being referenced in a fragmented, decontextualized and excluding manner in the initial process of definition and construction of the main public health policies.

Descriptors: National Health Policy; Mental Health; Rural Worker; Psychosocial Attention.

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A construção de políticas públicas de saúde mental com foco no trabalhador rural

Objetivo: analisar a inclusão da saúde mental do trabalhador rural na construção da agenda e implementação das principais políticas públicas de saúde do território nacional. **Método:** estudo de caráter transversal e interdisciplinar que realiza pesquisa bibliográfica e documental, investigando o “lugar” da saúde mental do trabalhador rural na construção da Política Nacional de Saúde Mental, Política Nacional de Saúde do Trabalhador e a Política Nacional de Saúde Integral das Populações do Campo, da Floresta e Águas. **Resultados:** embora avanços tenham ocorrido no âmbito nacional da saúde mental e saúde do trabalhador, a inclusão do meio rural ainda é tímida e a consideração do sofrimento do trabalhador do campo é praticamente nula. **Conclusão:** o termo trabalhador rural é pouco citado nas principais políticas nacionais e sem conceito integrativo, sendo referenciado de forma fragmentada, descontextualizada e excludente no processo inicial da definição e construção das principais políticas públicas de saúde.

Descritores: Política Nacional de Saúde; Saúde Mental; Trabalhador Rural; Atenção Psicossocial.

La construcción de políticas públicas de salud mental con enfoque en el trabajador rural

Objetivo: analizar la inclusión de la salud mental del trabajador rural en la construcción de la agenda e implementación de las principales políticas públicas de salud del país. **Método:** estudio de carácter transversal e interdisciplinar que realiza pesquisa bibliográfica y documental, investigando el “lugar” de la salud mental del trabajador rural en la construcción de la Política Nacional de Salud Mental, Política Nacional de Salud del Trabajador y la Política Nacional de Salud Integral de las Poblaciones del Campo, de la Floresta y Aguas. **Resultados:** aunque se han producido avances a nivel nacional de salud mental y salud de los trabajadores, la inclusión de las zonas rurales sigue siendo tímida y la consideración del sufrimiento de los trabajadores rurales es prácticamente nula. **Conclusión:** el término trabajador rural rara vez se menciona en las principales políticas nacionales y sin un concepto integrador, se hace referencia de manera fragmentada, descontextualizada y exclusiva en el proceso inicial de definición y construcción de las principales políticas públicas de salud.

Descritores: Política Nacional de Salud; Salud Mental; Trabajador Rural; Cuidados Psicosociales.

Introduction

The current socioeconomic panorama has restructured the meaning of work and redefined the health-disease process, reaching the Brazilian countryside with vigor. This medium, until then segregated and stigmatized, has registered a new identity even in the face of its heterogeneity. Agriculture expands beyond agribusiness and is conditioned to industry, being incorporated into the economic demands, becoming important worldwide. For the worker, the modernization process becomes exclusive on the one hand and the only alternative for citizenship on the other⁽¹⁻²⁾.

This rural is characterized by multi-sectoriality and cultural diversity, coupled with technological, economic and ecosystemic standards but, above all, distinct from the land, productive and social point of view with structural political implications. They are communities with ways of life related to the countryside, forest, agriculture and extraction, such as: peasants; family farmers; rural permanent wage-gaining workers and temporary workers who reside or not in the countryside; settled and with their own camp; quilombolas; extractivists; riverside dwellers; and other traditional communities; among others⁽³⁻⁴⁾.

From the perspective of profiling this sector in Brazil, workers become key players and their work activity becomes more complex, configuring not only a source of income, but also a determinant of life, health, inclusion and territorial interface. In this bias, work has a protective and health-promoting effect, as well as malaise, suffering, illness and death. Such effects are correlated with social isolation, possible vulnerabilities and environmental deterioration, which creates mental health demands that should directly impact on governmental actions and public policies⁽⁵⁾.

The country leads the ranking with the highest prevalence of anxiety disorder and 18.6 million Brazilians, that is, 9.3% of the population, present such condition. Between 2012 and 2016, mental disorders ranked third among the reasons for work absences, totaling 668,927 cases. Depressive episodes were the main cause of sickness benefit payments not related to work accidents, 30.67%, followed by 17.9% of anxiety disorders. These disorders (such as severe stress and adaptation disorders, depressive episodes and others) accounted for 79% of the absences only in this period⁽⁶⁾.

Therefore, understanding this new rural paradigm aligned with health and disease issues with a focus on mental distress is undoubtedly a challenge. In this sense, this reflection is based on the need to encourage an investigation from the mental-work-rural triad, as well as reflect on the inclusion of this demand in the socio-political debate in order to contribute to the construction of public policies with a focus on preventing,

welcoming and treating the mentally ill person working in the fields⁽⁷⁾.

The study is guided by an interdisciplinary cross-sectional discussion based on a comparative investigation of the concepts of rural and mental health in the socio-historical analysis of the main national health policies: the National Mental Health Policy, the National Workers' Health Policy and the National Comprehensive Health Policy for the Countryside, Forest and Waters Populations.

Its central objective is to analyze the inclusion of rural workers' mental health in the construction of the agenda and implementation of the main public health policies in the national territory, based on the following guiding questions: What is the place of rural workers' mental health in public health based on the elaboration of the main national health policies in Brazil?

Method

This is an interdisciplinary and bibliographic research study of a cross-sectional and descriptive nature that has as methodological option an exploratory study with a qualitative approach, with a time frame from 1990 to 2018. The choice of the delimited period was defined according to the decade of the date of the first law that made reference to the three central descriptors of the research: worker, rural and mental health - Law No. 8,213 of July 24th, 1991, which provides for Social Security Benefit Plans and other measures - until the year of completion of data collection (2018).

It analyzes in a comparative way the themes of "rural worker" and "mental health" in the construction of the three National Policies, using the SciELO databases (<http://www.scielo.org>), Official Notebooks published by the Ministry of Health (<http://bvsmms.saude.gov.br>), and the Official Gazette of the Union (<http://www.in.gov.br/servicos/diario-oficial-da-uniao>).

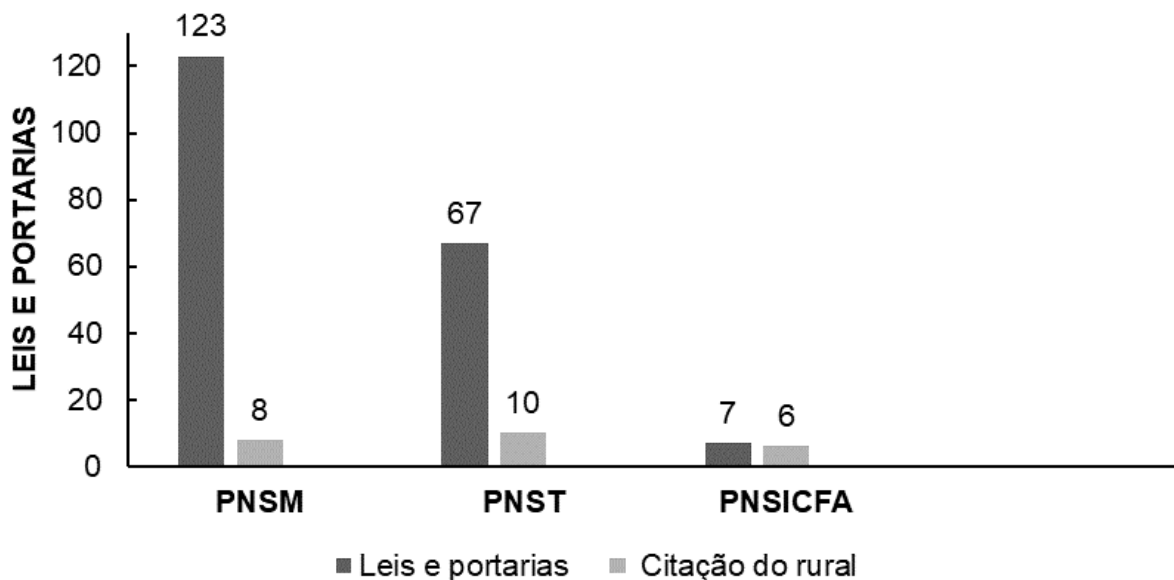
The stages for data collection follow ahead: 1) General identification: search for legislation, ordinance, normative, law referring to the national policies; 2) Screening: delimitation of themes and period; 3) Data confirmation: in official notebooks of the Ministry of Health and the Official Gazette; 4) Eligibility: exclusion criteria - state laws, not officially published and inclusion criteria - federal legislation; 5) Tabulation and final collection: research on each item with new descriptors - in the Mental Health Policy: "user" and the other two: "mental health" and "rural worker".

The choice of the federal field presupposes a safe guiding panorama in order to translate burning problems since its implementation. The methodological framework for the survey is consistent with historical research and correlation, highlighting the creation of the main political guidelines. That is, it is guided by the idiosyncratic search

that regulates this type of research. The study supports the political agenda as the main feature, focusing on identifying the type of problem that aims to correct, in the process covered, the social arenas and rules that will shape the decision and implementation of the public policies⁽⁹⁾.

Results

During the study period, a total of 197 federal laws, ordinances and regulations were found divided into 3 sessions, according to each policy. In the first stage, it is possible to check the number of laws and ordinances with the number of times the rural is mentioned, as shown in Figure 1.



*PNSM (NMHP) = National Mental Health Policy; †PNST (NWHP) = National Workers' Health Policy; ‡PNSICFA (CHHFVNP) = Comprehensive Health of the Countryside, Forest and Waters

Figure 1 - Comparison of the total of laws and ordinances with the citation of the rural in the National Policies: Workers' Health, Mental Health and Comprehensive Health of the Countryside, Forest and Waters, from 1990 to 2018. Brazil, 2019

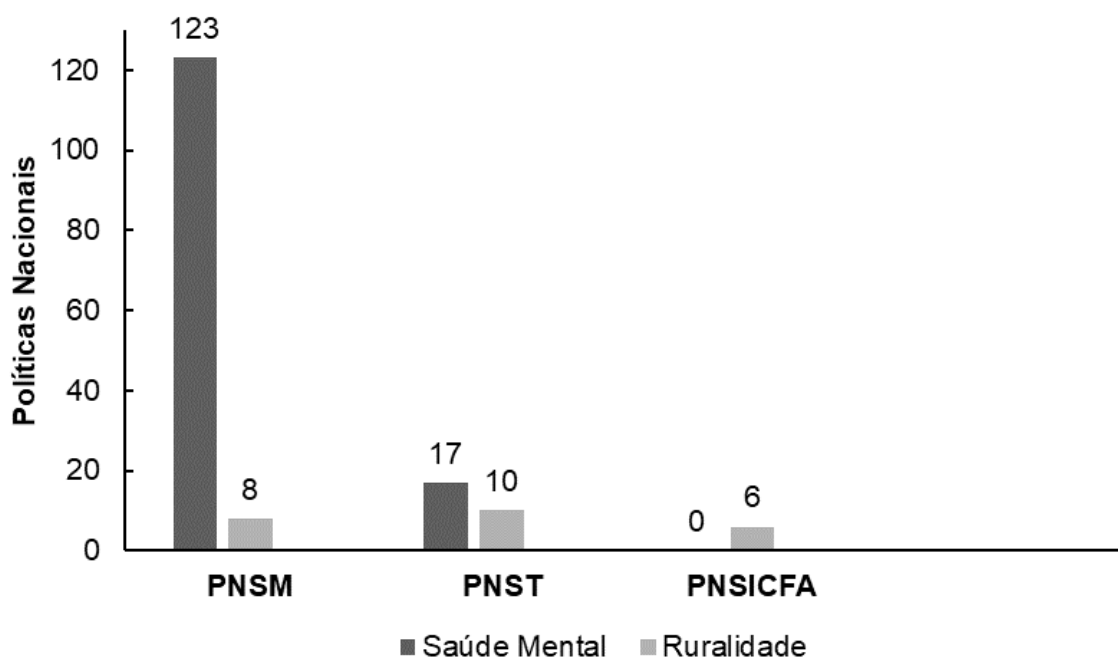
Regarding the Mental Health Policy, of 123 laws and ordinances, only 8 make direct reference to the rural. The qualitative analysis of the terms demonstrates the absence, fragmentation, superficiality and lack of conceptual coherence in the way that this is appreciated. Its concept is diluted in terms, such as: a) "Entities" (National Confederation of Agricultural Workers); b) Children with disabilities or in "specific and vulnerable situations": (...) from the field; c) "users who have no contact with the health system, through fieldwork"; d) "vulnerable populations, such as rural workers exposed to certain toxic agents and/or with precarious living conditions"; e) use of alcohol aimed at the "settlement population", and f) "residents of the agrarian reform settlements".

With regard to the Workers' Health Policy, the data is apparently more organized on an online platform and has 67 items. Of these, only 10 mention rural workers. In

most citations, these references only mark the difference from the urban, but maintain the lack of definition, such as: "for rural and urban workers".

Only with the Comprehensive Health Policy of the Countryside, Forest and Waters Populations (instituted by Ordinance No. 2,866 of December 2nd, 2011) does the rural community gain notoriety. In the analysis of the 7 items found, 5 deal with rural workers. However, the approach does not redirect health care actions or debate the integration of the fields in the services. The rural worker is only mentioned as a request for social representation.

The second stage of data collection integrates the previous data, comparing the reference number to the rural one with the reference number to mental health in the legislations and ordinances of the researched national policies, as shown in Figure 2.



*PNSM (NMHP) = National Mental Health Policy; *PNST (NWHP) = National Workers' Health Policy; *PNSICFA (CHHFWNP) = Comprehensive Health of the Countryside, Forest and Waters

Figure 2 - Comparison between the total citation on rurality and mental health in the National Policies: Workers' Health, Mental Health and Comprehensive Health of the Countryside, Forest and Waters, from 1990 to 2018. Brazil, 2019

This data survey shows that, in the Mental Health Policy, all items include the concept of mental health and only 8 refer to the rural or to rurality. In the Workers' Health Policy, 17 items refer to mental health and 10 to ruralities and, in general, the terms are only cited in a generic manner, restricted to a health condition for admission to work and not as a possibility for distress. In the Comprehensive Health Policy, there is no reference to mental health and almost all items address rurality.

Discussion

Social transformations produce impacts that induce constant re-elaboration of concepts, mainly in the field of sociocultural identity. To understand illness in rural workers, it is necessary, above all, to discuss the rural. In general, it is used as an antonym for urban. This definition receives much criticism, as it fails to build important characteristics to focus on needs in a comparative manner⁽⁹⁻¹⁰⁾.

Some consensual characteristics are the following: a) agriculture is not equivalent to rural, b) it presents multi-sectoriality and multi-functionality; c) low population density; d) and is not totally isolated from urban spaces. Rural work refers to human activity of economic diversity, directly related to nature based on family or familiarized relationships. The valuation of the land is expanded, as the activity is developed on it for the subsistence of the community⁽¹¹⁾.

It is coherent that the concept of rural is based on territory analysis, having Social Geography as its core.

The rural worker must be understood from the territorial conception, a place of construction of personal, social, political and cultural relations that directly influence the ways of life and production of the inhabitants. In Brazil, the constitution of the rural has a slavery mark, legalized until 1888. Negligence, as well as the Rural Worker Statute, which was only created well after the laws guaranteeing the rights of urban employees⁽¹²⁻¹³⁾.

The non-dichotomous definition supports an expanded view. In this research, we followed this concept of rural, including the two main areas of the country's agricultural activity, Family Agriculture and Agribusiness. One does not exclude the other one and the more universal approach makes it possible to understand the interdependence and complementarity of such activities. Often, the antagonistic conception seeks to ideologize reading in a Manichaeian distortion, which confuses or ignores theoretical concepts, creating an unnecessary confrontation⁽¹⁴⁾.

Currently, it is possible to highlight seven factors that are reorganizing a new rural: a) consolidation of the capitalist production mode in agriculture; b) migratory process in the rural-urban sense; c) principles and techniques linked to the global pattern of capital accumulation; d) new forms of population occupation; e) reorganization of geographical spaces related to production and consumption; f) new themes related to the rural labor market; and g) the decision on what to

produce is now externally determined and interdependent on economic agents⁽¹⁵⁾.

If the condition of the Brazilian rurality has been gradually shaped by the State and conditioned by the public policies, the same does not happen in the context of mental health, even less with regard to the mental health of rural workers. Only during the Vargas Administration (1930-1945) does the look at illness and the worker's right begin to be institutionalized and public policies gain shape. Health and work start to build an important social value, so much so that, to be a user of public health, it was necessary to have a job⁽¹⁶⁾.

However, mental health is still a stigma and is not even part of the vocabulary of rural workers. An example of this is the research study carried out with family farmers in the municipality of Santo Antônio do Monte/MG, which found general ignorance. In the view of these workers, health problems are equivalent to physical problems such as "heart problems", and health is linked to healthy food in the countryside, unlike industrialized foods in the city⁽¹⁷⁾.

The challenge of thinking about the issue of mental illness in rural areas is enormous, not only due to stigma and ignorance, but mainly due to the diversity of characteristics and experience of this population in such diverse territories. The economic issue is also an important factor, as approximately 50% of the rural population is living in precarious conditions. Although the data have shown a decrease in this inequality with a significant increase in income, work is still precarious⁽¹⁸⁻¹⁹⁾.

Regarding the analysis of the public policies, it is possible to assert that the right of a given population is not guaranteed simply because it is mentioned in the legislation. However, the frequency and the way in which a given population is referred to in the implementation of important regulations presupposes conceptual relevance, points to a symbolic place within the political agenda and marks its relationship with the State.

If, on the one hand, there is recognition that this population is vulnerable and does not match the urban, on the other hand, the approach ends up in this premise. The advancement of the Health Policies in terms of de-institutionalization and implementation of community-based extra-hospital services is clearly considered in the proposal. However, there is no specificity for rural workers and the services are offered with a generalist and urbanized view.

The psychiatric reform enabled a different view of psychological distress, bringing dignity to the subject who suffers. However, one of the strong criticisms is that it still lacks mainly integrated actions, training of human resources, insufficient professionals, and social policies. Such aspects have a direct impact on the rural area, which has more difficulty in accessing and

understanding the Psychosocial Care Network (*Rede de Atenção Psicossocial, RAPS*)⁽²⁰⁾.

The disarticulation between rural workers and mental health policy is more evident in this analysis. Even with the creation of the National Network of Comprehensive Care to Workers' Health and the Workers' Health Reference Centers, mental health is just another item among many that can have a causal link with work. Above all, what draws the most attention is the difficulty in the legislation itself in defining this causality, addressing the term work-related mental disorder in a generic and difficult to define way.

If there is no definition on the part of the legislators about the rural population, nor about the rural worker, and the relationship between mental illness and work is not clear, much less a priority, how is it possible to expect effectiveness of public policies in this area? The inefficiency of the State's presence is evident from the conception of its fundamental mark, the State as a guarantor of rights. The symbolic ballast and the precariousness of the approach become evident.

One of the first activities to be developed by Primary Health Care would be the diagnosis of the health situation of the territory, including mapping of productive activities, identification of situations of vulnerability and possible impacts, risks and dangers for the health of the workers. In the rural issue, these objectives are extremely impaired, encountering barriers such as: more remote areas, low population density, small populations dispersed over a vast territory, long distance from urban centers, and routes with precarious conditions⁽¹⁹⁻²¹⁾.

The advances regarding the implementation of care for workers' well-being in the health system do not dispel criticism, mainly regarding the lack of articulation with the network, sectorization, lack of operational subsidies that contribute so that the National Network of Comprehensive Care to Workers' Health can fulfill its objectives. In addition, there is lack of planning and responsiveness from the teams at the different levels of performance of the Workers' Health Reference Centers⁽²²⁻²³⁾.

In the most current National Policy, which proposes integration and care to more isolated communities, it is possible to observe a change in concept that in previous policies addresses "rural worker" to be changed to "field worker", without any outline of the theoretical situation. This extension of the term includes the maximum number of users active in the field, including the call of several actors for its formulation. Data analysis preserves the difficulty of understanding the place of the rural worker with mental distress or disorder within the health system.

The Comprehensive Health Policy expands the discussion on the health of rural workers, and marks a positive position by the State regarding the alteration of this demand. However, it is not yet consolidated as a

regulatory framework for the health services, it is little known, and has failed to implement any articulated, significant and efficient action that provokes mobilizations and territorial results. And, especially, it does not address the issue of the rural workers' mental health.

In general, the research authenticates that, historically, the rural area has little governmental action, mainly with regard to health promotion and social assistance. This deficit is announced at all levels of the Federation, with lack of action and attention to the health care measures, with great neglect of the mental health field at the national level⁽²⁵⁾.

In this sense, even with all the advances and paradigmatic changes in psychosocial care, as well as in the public health policies, the historical absence of mental health aimed at these workers is clear in the construction of this path. Some hypotheses can be related to the geographical difficulty, the stigmas and the unpreparedness of the teams. In addition to having to move around and organize themselves in a much more exhaustive manner, workers with psychological distress and illness have not been welcomed and are faced with nobody listening to their way of life⁽²⁶⁾.

Positively, if we articulate the evolution of the ordinances that point to the process of the psychiatric reform, implementation and funding of new models of mental health care, with budgetary deliberations and the realization of services related to workers' health, it is possible to verify important advances, reception of mental and workers' health demands in the primary care network through instrumentalized public policies, with regulatory frameworks and participation of actors from different arenas.

Negatively, rural demands still suffer in this process. There is no comprehensiveness of the themes, even with the proposal of a Policy that prioritizes this segment of the population. This absence is worrying and can represent: a) difficulty in the relationship between the causal link between mental health and work; b) ignorance of the correlation in comprehensive health; c) lack of coordination and inter-sectoral dialog; d) lack of epidemiological studies and registration regarding the diagnosis of mental disorder that corroborates the importance of this insertion; e) lack of data and studies on rural areas' access to the public mental health policies; f) lack of professionals, training and instrumentalization; and g) prejudice and disinterest in the demands of the field.

With regard to the mental health of this population, the situation worsens, to the extent that the credibility of a discussion cannot keep up with the determination, assessment and drafting of the legislation. Likewise, there is no coherence in the conceptual field of the approach taken by the State, nor is there any specific policy action. In other words, the lack of data in the creation of public

policies corroborates the invisibility of the debate and does not reveal the seriousness of the matter.

In short, when talking about mental health and about the rural worker, mental health is mentioned in a shallow manner and with no specific definition or discussion on the access to the services of the basic health network. Therefore, it is verified that the mental health of rural workers is not a priority and is not robustly incorporated into the national political agendas.

Conclusion

This article seeks to contribute to the promotion of the discussion of this practically ignored topic: the public policies for rural workers' mental health. It is possible to verify their invisibility before the State, the precariousness of fundamental principles to the health care of this population, the absence of regulatory frameworks and the conspicuous failure with regard to the construction of the guidelines of national health policies for the rural.

Based on what has been presented, it is possible to assert that mental, workers' and rural health form different fields in the construction of the health policies, confused as to their articulation and displaced as a service demand. The socio-historical detailing of the construction of these policies confirms that this demand appears fragmented, ambiguous and without a defined concept, in the design of the care network instruments and treated superficially within generalizing paradigms, not at all territorialized, articulated and integrative.

Therefore, there is an urgent need to: a) advance research on the topic to generate a response, seeking to build collective awareness of the need to face this problem; b) infer the importance of assessing and monitoring the health and mental distress of the rural communities in which this worker is inserted; c) consider and evaluate this population's access to the services and the development of effective treatments with monitoring and evaluation of mental health actions, rethinking the place where this demand is received; and d) train professionals especially in the basic care network and in primary care that clearly include rural workers.

It is up to the social actors involved with the theme to stimulate the discussion in the different arenas and to hold managers accountable in order to ensure the elaboration and implementation of broad, decentralized and territorialized mental health policies. Fundamentally, for the effort in building epidemiological data, assessing demands and integrating treatment and mental health services into the current general health system.

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