

SELF-RATED HEALTH IN FAMILY FARMERS LIVING IN A MUNICIPALITY OF MINAS GERAIS

AUTOAVALIAÇÃO DE SAÚDE DE AGRICULTORES FAMILIARES RESIDENTES EM UM MUNICÍPIO DE MINAS GERAIS
AUTOEVALUACIÓN DE SALUD DE AGRICULTORES FAMILIARES RESIDENTES EN UN MUNICIPIO DE MINAS GERAIS

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ABSTRACT

Objective: To investigate family farmers' self-rated health. **Methods:** This cross-sectional study included 63 family farmers who lived in a city in Minas Gerais. A data collection instrument was used, and anthropometric assessments were performed. The outcome variable was self-rated health, which could be categorized as good (very good and good) or poor (fair, poor, and very poor). The explanatory variables evaluated were sociodemographic characteristics, food consumption, and health status. Pearson's chi-square tests were carried out to verify the relationships between explanatory variables and self-rated health. **Results:** The prevalence of poor self-rated health was 27.0%. The following variables were related to self-rated health: sex ($p=0.004$), consumption of ultra-processed foods ($p=0.015$), eating meals in front of the television ($p=0.001$), presence of reported morbidity ($p=0.007$), recent illness ($p=0.001$), and recent seeking of medical care ($p=0.001$). **Conclusion:** Approximately a quarter of the family farmers rated their health as poor. Self-rated health can be influenced by conditions such as sex, consumption of ultra-processed foods, eating meals in front of the television, reported morbidity, recent illness, and recent seeking of medical care. It is necessary to formulate public policies to strengthen and promote the health of this population. **Descriptors:** Self-assessment; Rural Health; Occupational Health; Morbidity; Risk Factors.

RESUMO

Objetivo: Investigar a autoavaliação de saúde de agricultores familiares. **Métodos:** Estudo transversal com 63 agricultores familiares residentes em uma cidade de Minas Gerais. Utilizou-se instrumento de coleta de dados e foi realizada avaliação antropométrica. A variável desfecho foi a autoavaliação de saúde, categorizada em boa (muito boa e boa) e ruim (regular, ruim e muito ruim). As variáveis explicativas avaliadas foram características sociodemográficas, consumo alimentar e condição de saúde. Aplicou-se o teste Qui-quadrado de Pearson para verificar as relações das variáveis explicativas com a autoavaliação de saúde. **Resultados:** A prevalência de autoavaliação de saúde ruim foi de 27,0%. Relacionaram-se à autoavaliação de saúde: sexo ($p=0,004$), consumo de alimentos ultraprocessados ($p=0,015$), realização de refeições na frente da televisão ($p=0,001$), presença de morbidade referida ($p=0,007$), adoecimento recente ($p=0,001$) e busca por atendimento médico recente ($p=0,001$). **Conclusão:** Aproximadamente um quarto dos agricultores familiares autoavaliaram a saúde como ruim. A autoavaliação de saúde pode ser influenciada por condições como sexo, consumo de alimentos ultraprocessados, realização de refeições em frente à televisão, morbidade referida, adoecimento recente e busca por atendimento médico recente. Necessária se faz a interlocução e alcance das políticas públicas que promovam o fortalecimento e saúde desta população. **Descritores:** Autoavaliação; Saúde da População Rural; Saúde do Trabalhador; Morbidade; Fatores de Risco.

RESUMEN

Objetivo: Investigar la autoevaluación de la salud de agricultores familiares. **Métodos:** Estudio transversal con 63 agricultores familiares residentes en una ciudad de Minas Gerais (Brasil). Se utilizó un instrumento de recogida de datos y se realizó una evaluación antropométrica. La variable de resultado fue la autoevaluación de la salud, categorizada como buena (muy buena y buena) y mala (regular, mala y muy mala). Las variables explicativas evaluadas fueron características sociodemográficas, consumo de alimentos y estado de salud. Se aplicó la prueba de chi-cuadrado de Pearson para verificar las relaciones entre las variables explicativas y la salud autoevaluada. **Resultados:** La prevalencia de mala salud autoevaluada fue del 27,0%. *Relacionado con la salud autoevaluada:* sexo ($p=0,004$), consumo de alimentos ultraprocessados ($p=0,015$), ingesta de alimentos frente al televisor ($p=0,001$), presencia de morbilidad reportada ($p=0,007$), enfermedad reciente ($p=0,001$) y buscar atención médica reciente ($p=0,001$). **Conclusión:** Aproximadamente una cuarta parte de los agricultores familiares calificaron la salud como mala. La salud autoevaluada puede verse influenciada por condiciones como el sexo, el consumo de alimentos ultraprocessados, comer frente al televisor, morbilidad referida, enfermedad reciente y buscar atención médica reciente. Es necesario dialogar y llegar a políticas públicas que promuevan el fortalecimiento y la salud de esta población. **Descritores:** Autoevaluación; Salud Rural; Salud Laboral; Morbilidad; Factores de Riesgo.

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INTRODUCTION

The World Health Organization (WHO) defines health as a “state of complete physical, mental and social well-being, not just the absence of disease” and its enjoyment a fundamental right for everybody⁽¹⁾. In Brazil, health is also considered a right and, above all, a comprehensive issue that results from the interaction between the different conditions of food, housing, education, income, environment, work, transportation, employment, leisure, freedom, access to and possession of land, and access to health services⁽²⁾.

Operationally, health can be measured based on medical information gleaned from pathological signs and symptoms and diagnostic tests, or through assessments made by individuals themselves, using indicators such as reported morbidity and self-rated health (SRH)⁽³⁾. SRH is an indicator widely used in population surveys as a method of measuring the health status of individuals because of its low-cost and easy application. SRH incorporates the perception each individual has of their health and is related to the aspects of life of a physical, functional, emotional, and cognitive nature. Moreover, SRH is a strong predictor of morbidity, disability, and mortality and is often similar to the health assessment made by doctors^(4,5).

Concerning the perception of health among rural residents, the literature suggests a need for further research on information about this population⁽⁶⁾. In a population-based study conducted in Pelotas, in the southern region of Brazil, no association was identified between being a rural worker and poor SRH⁽⁷⁾. On the other hand, in a nationwide population-based study of adult Brazilian farmers, having an agricultural occupation was found to decrease the chance of SRH being good⁽⁸⁾. However, in general, studies on this topic are scarce among certain populations in the country, such as among farmers or rural residents, due to the difficulty of carrying out studies with respect to the physical environment^(7,8).

In Brazil, Law No. 11,326, of July 24, 2006⁽⁹⁾, defines a family farmer as one who does not have a land area greater than four fiscal modules, who predominantly uses the family's labor force, and who obtains family income from the economic activities of his enterprise or establishment. In carrying out their agricultural occupations, these workers are often exposed to conditions inherent to their work (e.g., heavy physical work, intense working hours, use of pesticides, presence of noise, and handling of machinery) that may favor the manifestation of worse health

conditions compared with other workers^(8,10). The use of SRH can therefore assist in understanding health with respect to rural populations and can thus lead to the subsidization of actions for the promotion, prevention, and recovery of health of these workers in the rural context as they have a peculiar way of life and work^(6,8).

Given the above and considering the relevance of the topic, this study aimed to investigate family farmers' SRH.

METHODS

Study design, period, and location

This cross-sectional study was conducted with family farmers in the municipality of Mariana in Minas Gerais state, Brazil. It is part of a larger research project entitled “Health and Life Conditions in Rural Areas: Profile of Family Farmers in the Municipality of Mariana/MG” that was carried out between July and December 2017. Mariana is located 110 km from the capital of Minas Gerais, Belo Horizonte, and, according to the 2010 census, has a total population of 54,219 inhabitants, of which 6,577 live in rural areas⁽¹¹⁾.

Study population

To be included in the study, family farmers needed to be 18 years of age or older, have an active Declaration of Aptitude to Pronaf (DAP) and, consequently, comply with Law No. 11,326⁽⁹⁾, which establishes criteria for the definition of family farming. The DAP (which was used to identify the study population of the present study) is a registration form for Brazilian farmers that contains personal and property data. The DAP is used as a source of information about family farmers, and yet, it also serves as the gateway for this group to receive financial subsidies and participate in public programs and measures⁽¹²⁾. For example, the DAP allows family farmers to access rural credit and participate in programs such as the National School Feeding Program (PNAE).

A survey carried out via the website of the Ministry of Agrarian Development (MDA) identified 240 farmers with active DAPs in Mariana. The DAPs contain the names of the farmers, the conditions for land use, and the number and status of the DAP. To establish contact with family farmers, we sought to collect information on their addresses and telephone numbers from various agencies responsible for providing some type of assistance to these farmers, including the Mariana unit of the Technical Assistance and Rural Extension Company of Minas Gerais (EMATER), rural associations and unions, and the municipal secretariat for rural development. In addition, an active search was carried out by approaching individuals

who could provide information on these farmers, such as different community health agents (CHA).

After intense investigations, the telephone numbers and addresses of 169 family farmers with whom we sought to establish contact to invite them to participate in the research were identified. Contact was attempted by considering up to three phone calls or three home visits. The farmer was considered an unsuccessful contact when he did not respond to any of these attempts. Of the 169 identified family farmers, 76 were successful contacts and were therefore invited to participate in the research. However, 11 farmers refused to participate, one reported that he no longer lived in the municipality, and one died, thus leaving a final total of 63 participants who were then contacted to schedule the date and time for clarification on the study.

Data collection

A team of previously selected nutrition undergraduate students received training to perform and standardize anthropometric measurements as well as to administer the data collection instrument. The family farmers who consented to participate were interviewed via face-to-face and anthropometric assessments. The data collection instrument used was based on several national surveys, namely: the National Household Sample Survey (PNAD 2015), the National Health Survey (PNS 2013), and the Demographic Census (IBGE 2010) and contained questions on the following aspects: sociodemographic characteristics, agricultural production, use of pesticides, working conditions, health conditions, food consumption markers, alcoholic beverage consumption, smoking habit, physical activity, and nutritional assessment.

For the anthropometric evaluation, an electronic scale, Tanita BF 542®, with a maximum capacity of 136 kg, was used to measure the weight of the participants. The participants were instructed to be barefooted, wear light clothing, and not carry objects that could change their actual weight (e.g., pens, cell phones, watches, or hats). Height was measured using a portable Altura Exata® vertical stadiometer, with a length of 2 m and a scale of 1 mm. A maximum variation of 0.5 cm was allowed between the two height measurements, and the average value of the same was established.

Variables

The outcome variable was SRH, which was investigated using the question "In general, how do you assess your health? Very good, good, regular, poor, or very poor?" Responses were categorized as either good SRH (very good and good) or poor SRH (fair,

poor, and very poor).

The explanatory variables were divided into three blocks: sociodemographic characteristics, food consumption, and health condition.

The variables investigated in the sociodemographic characteristics block were sex (female and male), age range (18 to 34, 35 to 59, and ≥ 60 years old), self-declared skin color (white/yellow and black/brown), schooling (≤ 8 and > 8 years), and family income (≤ 2 and > 2 minimum wages, considering the minimum wage in force in 2017, of R\$ 937).

The food consumption block was devised based on the Guidelines for the Evaluation of Food Consumption Markers in Primary Care⁽¹³⁾, which investigates people's consumption of fresh foods (e.g., fruits, vegetables, and beans) and ultra-processed foods (e.g., sausages, sweetened drinks, salted, industrialized sweets, and spices) the previous day and the habit of eating meals in front of the television (TV).

The responses concerning the consumption of in natura foods were dichotomized as "desirable", when consumption the previous day was equal to three in natura foods, and "undesirable," when consumption the previous day was less than three in natura foods. Responses for the consumption of ultra-processed foods were categorized as "no," for those who reported not having consumed any ultra-processed food the previous day, and "yes," when the reported consumption was of one or more foods. Responses regarding meals in front of the TV could be provided using either "no" and "yes."

The variables belonging to the health condition block were reported morbidity, use of medications, recent illness, recent seeking of medical care, overweight, and cardiovascular risk.

The variable reported morbidity investigated the occurrence of pathologies using the question "Has any doctor already given you the diagnosis of some of the diseases listed below: arterial hypertension, diabetes mellitus, hypercholesterolemia, cardiovascular disease, stroke, bronchitis/asthma, chronic back problem, arthritis, work-related musculoskeletal disorders (WMSD/RSI), depression, chronic kidney failure (CRF) cancer or other pathologies?" The farmer who reported an absence of any pathology was considered without morbidity and those who had a medical diagnosis of at least one of the investigated pathologies with morbidity.

The use of medications was analyzed using the question "Do you use any medications? Yes or no." As for recent illness, the question "In the past two weeks, did you fail to perform any of your usual activities for health reasons? Yes or no." was used. Recent seeking of medical care was investigated using the following question: "In the

last two weeks, did you look for any place, service, or health professional for care related to your own health? Yes or no."

Meanwhile, the presence or absence of excess weight was determined using the body mass index (BMI). For this, anthropometric measurements of weight and height were measured. The cutoff points for the BMI for adults were determined based on those prescribed by the WHO⁽¹⁴⁾, and for the elderly (age ≥ 60 years), those by Lipschitz (1994)⁽¹⁵⁾. Thus, those with low or normal weight (BMI < 25 kg/m² for adults and ≤ 27 kg/m² for the elderly) were not considered to be overweight. In contrast, those classified as overweight and obesity (BMI ≥ 25 kg/m² for adults and > 27 kg/m² for the elderly) were considered overweight.

Cardiovascular risk was assessed using waist circumference. For this, we used a measuring tape, with a length of 2 m, flexible and inelastic, divided in centimeters, and subdivided in millimeters. The measurements of the waist circumference were obtained at the midpoint between the lower edge of the last rib and the hip bone (iliac crest), with care being taken to keep it tight without compressing the tissues. Meanwhile, risk classification was made according to the reference values recommended by the Ministry of Health, which classifies the cardiovascular risk perimeter of > 80.0 cm for women and > 94.0 cm for men⁽¹⁶⁾.

Statistical analysis

The data were tabulated using

spreadsheets in the software Microsoft Excel® 2013 via double typing, and analyzed using the statistical software STATA, version 13.0. Initially, a descriptive analysis of all the variables studied was performed, followed by the calculation of Pearson's Chi-square values to verify the differences in the frequencies of each variable as well as the relationships between the explanatory variables and the SRH. The level of significance adopted was 5% ($p < 0.05$).

Ethical aspects

This study was carried out following the ethical standards of Resolution 466/2012 by the National Research Ethics Committee (CONEP) and was approved by the ethics and research committee of the Newton Paiva Faculty, with reference number 2.049.974 (CAAE: 67343917.9.0000.5097). The family farmers who consented to participate in the study signed the informed consent form.

RESULTS

The study population was mostly composed of individuals aged between 35 and 59 years (55.6%), males (58.7%), individuals who self-declared as having black or brown skin color (60.3%), and individuals with schooling equal to or less than eight years (65.1%). Concerning income, 57.1% had a monthly income less than or equal to two minimum wages (Table 01).

Table 01 – Self-rated health according to sociodemographic variables among family farmers (n=63). Mariana, MG, Brazil, 2017.

Variable	Total		SRH* good (n=46)		SRH* poor (n=17)		p-value**
	n	%	n	%	n	%	
Age range							
18–34 years	16	25.4	12	75.0	4	25.0	
35–59 years	35	55.6	26	74.3	9	25.7	
≥ 60 years	12	19.0	8	66.7	4	33.3	0.858
Sex							
Male	37	58.7	32	86.5	5	13.5	
Female	26	41.3	14	53.8	12	46.2	0.004
Self-declared skin color							
White/yellow	25	39.7	21	84.0	4	16.0	
Black/brown	38	60.3	25	65.8	13	34.2	0.111
Schooling							
≤ 8 years	41	65.1	27	65.8	14	34.2	
> 8 years	22	34.9	19	86.4	3	13.6	0.080
Family income***							
≤ 2 minimum wages	36	57.1	25	69.4	11	30.6	
> 2 minimum wages	27	42.9	21	77.8	6	22.2	0.461

Caption: *SRH: Self-rated health; ** p-value obtained by Pearson's Chi-square test; *** In 2017, the minimum wage in force in Brazil was R\$ 937. In bold, significant variables (p -value < 0.05).

Regarding the consumption of in natura foods, 47.6% had unwanted consumptions, that is, less than three of these foods the day before the survey. As for the consumption of ultra-processed foods, 71.4% reported having

consumed one or more of these investigated foods the day before the survey. As to eating in front of the TV, 33.3% mentioned they had this habit (Table 02).

Table 02 – Self-rated health according to food consumption variables among family farmers (n=63). Mariana, MG, Brazil, 2017.

Variable	Total		SRH* good (n=46)		SRH* poor (n=17)		p-value**
	n	%	n	%	n	%	
Consumption of in natura foods							
Undesirable	30	47.6	23	76.7	7	23.3	0,534
Desirable	33	52.4	23	69.7	10	30.3	
Consumption of ultra-processed foods							
No	18	28.6	17	94.4	1	5.6	0,015
Yes	45	71.4	29	64.4	16	35.6	
Meals in front of the TV***							
No	42	66.7	36	85.7	6	14.3	0,001
Yes	21	33.3	10	47.6	11	52.4	

Caption: *SRH: Self-rated health; **p-value obtained by Pearson's Chi-square test; ***TV: Television. In bold, significant variables (p -value < 0.05).

Concerning health condition variables, 68.2% of the family farmers reported having one or more morbidities. Also, 42.9% stated they used medications. Around 15.9% and 19.0% reported having sickness and having

sought medical attention in the last two weeks, respectively. The presence of overweight and cardiovascular risk was verified in 71.4% of the individuals (Table 03).

Table 03 – Self-rated health according to health condition variables among family farmers (n=63). Mariana, MG, Brazil, 2017.

Variable	Total		SRH* good (n=46)		SRH* poor (n=17)		p-value**
	n	%	n	%	n	%	
Reported morbidity							
No	20	31.8	19	95.0	1	5.0	0.007
Yes	43	68.2	27	62.8	16	37.2	
Use of medications							
No	36	57.1	29	80.56	7	19.4	0.120
Yes	27	42.9	17	63.0	10	37.0	
Recent illness							
No	53	84.1	43	81.1	10	18.9	0.001
Yes	10	15.9	3	30.0	7	70.0	
Recent seeking of medical care							
No	51	81.0	42	82.4	17	17.6	0.001
Yes	12	19.0	4	33.3	8	66.7	
Overweight							
No	18	28.6	14	77.8	4	22.2	0.590
Yes	45	71.4	32	71.1	13	28.9	
Cardiovascular risk							
No	18	28.6	16	88.9	2	11.1	0.073
Yes	45	71.4	30	66.7	15	33.3	

Caption: *SRH: Self-rated health; **p-value obtained by Pearson's Chi-square test. In bold, significant variables (p -value < 0.05).

The proportion of family farmers who rated their health as poor was 27.0% (95% CI: 15.72–38.25%). The following variables were statistically related to SRH: sex ($p=0.004$), consumption of ultra-processed foods ($p=0.015$), meals in front of the TV ($p=0.001$), reported morbidity ($p=0.007$), recent illness ($p=0.001$), and recent seeking of medical care ($p=0.001$) (Tables 01, 02, and 03).

DISCUSSION

Approximately a quarter of the family

farmers who participated in this study reported poor SRH. Statistically significant associations were also observed between SRH and sex, eating meals in front of the TV, reported morbidity, recent illness, and recent seeking of medical care.

The proportion of farmers who self-rated their health as poor in this study (27.0%) was lower than that reported in the PNS 2013 (33.9%), which was a national study that interviewed 60,202 individuals aged 18 years or older⁽¹⁷⁾. It is noteworthy that the PNS investigates residents of households in all regions of the country and also evaluates the urban population, factors that may have

influenced the difference found in the present study, since profound health inequalities exist nationally^(18,19). On the other hand, a study with rural workers in Santa Catarina showed a poor SRH prevalence rate of 35.5%⁽¹⁰⁾; this result, however, was superior to that found in the present study. These differences in SRH prevalence among rural communities can be explained by each community's heterogeneity, with each differing in terms of historical, cultural, economic, and belief aspects⁽⁶⁾.

Compared with residents in urban areas, those in rural areas are believed to be more rigorous when considering a certain condition as a health problem, that is, they do not easily accept the condition as an illness. In addition, it is common for rural populations to consider physical aspects in health assessments or those that affect their independence and self-sufficiency to work and perform daily activities⁽⁶⁾. Other factors that can help in understanding the differences in health conditions through the rural context can be mentioned, namely: the lack of knowledge concerning real health conditions due to generally lower levels of education; long workdays, which would make it difficult to seek health care; and reduced access to health services, a characteristic of living in rural areas⁽¹⁰⁾. Complementarily, possible explanations for the reduced access to health services in rural areas as well as the difficulties in health professionals' carrying out their functions the literature gives include distance and the difficulty of moving to these regions⁽⁸⁾.

Although a considerable portion of the rural farmers reported poor SRH, approximately 73% rated their health as good. One possibility for this is that, although the living conditions of Brazilians have not generally reached higher levels, the development of policies related to the promotion, prevention, and recovery of health for the most vulnerable individuals has contributed to the reduction of health inequities in the country⁽²⁰⁾.

The family farmers' sex was related to the assessment of their health status. Research carried out at the national level has pointed out poor SRH as being associated with being female^(17,21). In addition, a population-based study that used data from the PNAD 2008 found that, after analyzing the health conditions of 24,018 Brazilian rural workers aged 18 or over, women have a lower chance of not self-rating their health as good compared with men⁽⁸⁾. It is generally believed that women have greater concern and commitment to maintaining good health, are more committed to seeking health information and treatments, exhibit good adherence to these treatments, and undergo a greater number of tests compared with men, who generally postpone seeking health services⁽¹⁰⁾.

Another possibility for this relatedness between sex and health status assessment could be the double working hours of women, who are often involved in several tasks, household activities, and land-related activities at the same time, which can thus impact their physical and mental health, or even result in little time to take care of themselves⁽²²⁾.

Regarding food consumption and SRH, recent studies have identified a positive relationship between these concepts, and great efforts have been made in the creation of public health and education policies that contribute to the adoption of healthy eating patterns and reduced consumption of ultra-processed foods⁽²³⁾. Eating meals in front of the TV was also found to be related to SRH, and this may be explained by the increase in inappropriate food practices adopted in recent decades by Brazilians as a whole, regardless of where they live, their stage of life, or their socioeconomic conditions⁽²³⁾.

The presence of reported morbidity was shown to be related to SRH. Another study that had been carried out in Belo Horizonte showed that among individuals with reported morbidity (42.6%; 95% CI: 40.2–45.0%), a higher prevalence of poor SRH had been reported compared with those without reported morbidity (13.1%; 95% CI: 10.9–15.3%)⁽²⁴⁾. It is noteworthy that in the present study, about 70% of family farmers reported morbidities, a worrying finding for an economically active population⁽¹⁰⁾.

For recent illness, a significant relationship with SRH was observed. Farmers who reported that they stopped doing their usual activities in the last two weeks due to some health problems had a higher prevalence of poor SRH. In fact, it would be expected that a recent disease would influence the worst perception of health, especially in this population group, which is marked by SRH linked to the ability to perform their usual activities⁽⁶⁾, and who hardly miss workdays⁽¹⁰⁾. In addition, recently seeking medical care was also related to SRH. The worse perception of health may be reflected in the search for health services and in the adoption of self-care measures in the face of concerns that accompany the occurrence of some disease^(20,24). For example, a qualitative study carried out among Australians with comorbidities related to diabetes and chronic kidney disease showed that the adverse experiences resulting from the diseases had a negative impact on the psychological status of patients, who even emphasized the importance of the availability of services that need to be served⁽²⁵⁾.

A factor that can be interpreted as a limitation of this study is the small sample size

and the lack of localizing some family farmers. This means that the generalization of the study's findings with other populations should be made carefully. However, it is important to note that accessing the study population in Mariana was challenging; there was a great deficiency in contact information (address and telephone number). These data were either missing or out of date, which made obtaining any data about the sought after family farmers very difficult. In addition, the large territorial extent of the municipality should be mentioned, which made it difficult to actively search for family farmers, as from the researchers' headquarters, some locations took up to three hours by car to reach, and the bus lines did not cover all the localities where the farmers resided. The precariousness of the mobile phone network in the rural areas, which in many locations had no telephone signal, also made contact difficult. Finally, financing to enable access to more distant areas or even to pay for the transportation of some farmers to the city headquarters was lacking.

Given the scarcity of national data on the health condition of those living in rural areas, this study provides relevant information for understanding possible determinants of SRH in this population, not to mention the information on sociodemographic characteristics, food consumption, and health conditions. The importance of SRH investigation in this study is reflected in its support for monitoring the health condition of family farmers in Mariana based on perceptions of the dimensions of physical, mental, and social health. Consequently, this

study contributes to the mapping and collection of basic information about this population, calling for the need for greater attention and visibility with regards to Mariana's population concerning the development of health policies and rural development, since health is the result of adequate access to other services, for example, education, food, housing, and leisure⁽²⁾. Specifically, in Mariana, there is a need for actions aimed at gender equality in rural areas, healthy eating habits, and actions aimed at the promotion and prevention of diseases. Hence, local studies that investigate the health condition of local family farmers and the factors that influence them are necessary, and the development of effective local policies should be encouraged to adapt to the realities faced by these communities.

CONCLUSION

Approximately a quarter of the evaluated family farmers reported poor SRH. SRH by family farmers is believed to be influenced by conditions such as sex, the consumption of ultra-processed foods, having meals in front of the TV, the presence of reported morbidity, recent illness, and seeking medical attention.

Dialogues concerning health, social assistance, leisure, and culture policies are necessary in rural areas in order to mitigate the current impacts on SRH which consequently impacts the living conditions of family farmers, while promoting the strengthening and health of this population.

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