http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude
ISSN on-line1984-7513
DOI: 10.4025/ciencuidsaude.v21i0.59527

ORIGINAL ARTICLE

SOCIODEMOGRAPHIC CHARACTERISTICS OF WORK AND HEALTH OF DISABLED MEN AND WOMEN LIVING IN A RURAL SETTING

Ethel Bastos da Silva*
Leonardo Bigolin Jantsch**
Marta Cocco da Costa***
Alice do Carmo Jahn****

ABSTRACT

Objective: Comparing the sociodemographic characteristics of health and work of men and women with disabilities living in a rural context. **Method:** A cross-sectional analytical study with 276 people with disabilities living in a rural setting in eight cities in the Northwest Region of the State of Rio Grande do Sul, Brazil. Data were collected through a closed questionnaire with sociodemographic, work and health variables applied at the participants' residence from September 2018 to July 2019. These were typed and analyzed in the software Statistical Package for the Social Sciences for Windows, version 18.0 by means of descriptive analytical statistics (frequency comparison). To compare the two groups (men and women) the Chi-Square test was used. **Results:** Of the men, 27.8% had physical disabilities and multiple disability was more frequent in women ($p<0.001$). Work in agriculture and home was more frequent in females and autonomous and employment activities in males. Both received PB, although 18% did not have any kind of benefit. Men were twice as likely to be smokers and almost three times higher risk of alcohol than women ($p<0.001$). **Conclusion:** The characteristics of people with disabilities living in a rural setting differ between the genders, with regard to disability, work and habits that make health vulnerable.

Palavras-chave: People with disabilities. Rural population. Public policies. Health of people with disabilities. Health of the rural population.

INTRODUCTION

The Brazilian literature has focused on the theme of people with disabilities (PD) in the rural context in recent years, pointing out the need to reinforce the role of this population in access, obtaining and maintaining rights[1,2], especially in the field of social assistance, as is the case of the benefit of continued provision (BCP)[2]. This benefit is part of a public policy of social assistance in which people receive economic assistance upon proof of disability.

Other inclusive social policies such as education and work are also essential for the development of PD[3]. In many cases, these services are rare in the rural context.

Disability, regardless of its nature, whether congenital or acquired, is conceived based on the classification of the perspective of functionality, that is, the existence of a relationship between body structures and environmental factors that may cause low social participation of the individual[4]. This meaning signals the need to strengthen inclusive social policies[3] articulated to a care network that includes the area of health and rehabilitation. In this, Primary Health Care (PHC), through the Family Health Strategy (FHS), is the place of access and reference of populations to the Unified Health System (SUS) that can guarantee the integrality of care[5].

PD living in the rural context present difficulties in accessing health, especially, which can interfere with their social well-being. These populations are imperceptible to society[1].

At the international level, in rural areas of South Africa, low-income PD have worse conditions of access to health services, compared to those without disabilities[6]. In Australia, people with disabilities are among the most affected, because they cannot access health

*Nurse. Doctor of Science, Federal University of Santa Maria (UFSM), Teacher of the Department of Health Sciences, Palmeira das Missões, RS, RS, Brasil. E-mail: ethelbastos@hotmail.com ORCID: https://orcid.org/0000-0002-6880-7463
**Nurse. Doctor in Nursing, UFSM, Teacher of the Department of Health Sciences, Palmeira das Missões, RS, Brasil, E-mail: leo_jantsch@hotmail.com ORCID: https://orcid.org/0000-0002-4571-183X
***Nurse. Doctor in Nursing, UFSM, Teacher of the Department of Health Sciences, Palmeira das Missões, RS, Brasil. E-mail: marta.c.c@ufsm.br ORCID: https://orcid.org/0000-0002-9204-3213
****Nurse. Doctor of Science, UFSM, Teacherof the Department of Health Sciences, Palmeira das Missões, RS, Brasil. E-mail: jahnalice@gmail.com ORCID: https://orcid.org/0000-0002-7672-4721

services in rural areas[7]. When PD access education, they feel included and motivated to overcome limitations[8], which causes greater enthusiasm for their rehabilitation. The provision of the PD and the support of some health professionals for the use of the care network strain the municipal government to promote access to existing specialized services, even if incipiently[9]. In addition, the PD develops a greater perspective of participation in other social environments[8].

In Brazil, rural populations lack quality and affordable health services and education[9]. When this is associated with people with disabilities, the Inclusion Law, which has been in force since 2015, recommends the existence of an intersectoral network of services with a view to the social development of the PD in the rural setting[10]. And, with regard to health promotion for people living in the field and in the network of care for people with disabilities, these policies are little evidenced[9]. In this sense, from the point of eye of the social model of disability, the environment, social relations related to health and interconnected biological issues can enhance or limit social participation. Identifying and analyzing the sociodemographic, work and health characteristics of men and women with disabilities living in a rural setting promote debate and reflection on public health and social policies that induce inclusion.

Studies on PD living in rural settings at the national level refer to types of disability and barriers to access to health, school and work, disadvantages that produce greater social inequalities in the rural setting, showing differences between men and women[9,11]. There are few studies on this issue, making it a gap in scientific production.

That said, this study has as a research question: How do the sociodemographic, work and health characteristics of men and women with disabilities living in rural setting stem? And, as an objective, to compare the sociodemographic, work and health characteristics of disabled men and women living in rural setting.

METHOD

The present work is a cross-sectional analytical study, which is based on epidemiology, seeks to identify hypotheses of factors that may or may not occur in certain sample groups in a certain period of time, without the need for continuity. The project had the participation of PD living in eight cities, with characteristics/settings of rurality, in the northwest region of the State of Rio Grande do Sul, Brazil. The participants were residents of eight cities of the 16 cities with rural population, belonging to the 15th and 19th Regional Health Coordinators (RHC), and the criterion of choice was more than 70% of the rural population.

The study included 276 people with disabilities living in a rural setting. As inclusion criteria, it was adopted to have some type of disability (acquired, congenital, intellectual, congenital visual, multiple and congenital auditory), having cognitive capacity to answer the questionnaire and/or family that agreed to answer by the PD, according to the perception of the family caregiver. The participants were selected through the records available in the municipal health services, with previous contact and scheduling of interviews with their families. Community health agents were contacted by telephone to schedule interviews, on a day and time of the week according to the availability of the families. They followed the researchers to the households. The entire population with disabilities was selected, considering that the participating cities had coverage of 100% of the CHA.

Data were collected through a closed instrument, which contained characterizations regarding age, gender, color, age group, education, income, type of disability, work, working conditions and health conditions, being applied by researchers in the homes of people with disabilities. The collection took place from September 2018 to June 2019. The data were entered in Excel spreadsheets, and later analyzed under descriptive and analytical analysis (frequency comparison). Regarding the analysis of the variables, frequency comparison tests (using the Chi-Square test) were used in the Software Statistical Package for the Social Sciences for Windows, version 18.0. A statistically significant association was established with the outcome for the variables whose p-value was less than or equal to 5%

($p \leq 0.05$). The Odds Ratio (OR) analysis of variables determines that certain events are more likely to occur in a specific group.

The study followed the ethical recommendations and was approved by the Opinion Embodied of the Research Ethics Committee of the Federal University of Santa Maria, N 2,208,566, through the Certificate of Presentation for Ethical Appreciation (CAAE) N in registration 69973817.4.0000.5346.

RESULTS

Table 1. Comparison between the sociodemographic characteristics of men and women with disabilities living in a rural setting. Rio Grande do Sul, 2018-2019.

	Women 114(41.3%)	**Men** 162(58.7%)	**p-value****
Type of Deficiency			
Physical acquired	10(8.8%)	45(27.8%)	<0.001
Physical congenit	18(15.8%)	21(13.0%)	>0.05
Intelectual	60(52.6%)	73(45.1%)	>0.05
Visual congenit	0	5(3.1 %)	>0.05
Multiple	18(15.8%)	9(5.6 %)	<0.001
Congenital audictive	8(7.0%)	9(5.6 %)	>0.05
Skin color			
White	81(71.1%)	110(67.9%)	
Brown	31(27.2%)	47(29.0%)	
Black	2 (1.8%)	5(3.1%)	
Group age (years old)			
1 - 19	20(17.5%)	19(11.7%)	
20 - 39	36(31.6%)	50(30.9%)	0.529
40 - 64	45(39.5%)	74(45.7%)	
Over 65	13(11.4%)	19(11.7%)	
Schooling			
Never frequented/Incomplete Fundamental Ensino	93 (81.6%)	143(88.2%)	
Complete Elementary School/Incomplete High School	13 (11.4%)	13(7.8%)	
Complete High School/Incomplete Higher Education	7(6.2%)	6(3.7%)	
Complete Higher Education	1 (0.9%)	0	
Household income			
Up to 1 minimum wage¶	41(36.0%)	65(40.1%)	
2 - 5 minimum wages¶	72(63.2%)	96(59.3%)	
> 5 minimum wages¶	1(0.9%)	1(0.6%)	
Leisure Activity			
Yes	89(78.1%)	108(66.7%)	0.045
No	25(21.9)	54(33.3%)	
Use public transport			
Yes	17(14.9%)	19(11.7%)	0.688
No	97(85.1%)	143(88.2%)	
Other Means of Transport (N=201)			
Own car	63(75.9%)	79(66.9%)	
Motorcycle	7(8.4%)	21(17.8%)	0.167
Other	13(15.6%)	18(15.3%)	
PD drives the vehicle			
Yes	3(4.8%)	25(31.6%)	<0.001
No	60(95.2%)	54(68.3%)	
Travel to the Urban area			
1x/week	17(15.2%)	28(20.1%)	
2x/week	10(8.9%)	21(15.1%)	
3x/week	13(11.6%)	16(11.5 %)	
Daily	21(18.8%)	22(15.8%)	
1x/month	41(36.6%)	42(30.2%)	
Other	10(8.9%)	10(7.2%)	

Acronyms: ¶Minimum wage in Brazil= R$ 998.00 (US$ 241.00). **Chi-Square Test.
Source: Authors Database.

Acquired physical disabilities were more frequent in the male population, when compared to females, while multiple disability was more frequent in women ($p<0.001$). It is worth noting that the majority of the PD population in rural areas was white, of adult age, with low schooling and income from two to five minimum wages, and that there was no significant difference between the groups of men and women analyzed. Women had more leisure activities, with little autonomy of locomotion, only 14.9% used public transport; 76% had a car, but only 4.8%, of them had a license to drive. Going to the urban area was less frequent for women, since 15.2% of them went only once a month, compared with 20.1% of men.

Table 1 shows the sociodemographic characteristics of the participants stratified into two groups.

Work characteristics are related to the most frequent activities of agriculture and home in females and to autonomous and work-based activities for men. Domestic activities were significantly more frequent for women, and garden, livestock/livestock activities for men. PB aid was the most frequent for this population, although 18% of them did not receive any. Regarding the comparison of men and women PD and working conditions and income, table 2 is described.

Table 2. Comparison of work characteristics and income between women and disabled men living in rural setting. Rio Grande do Sul, Brazil, 2018-2019.

	Women	**Men**	**p-value**
Has an employment relationship (N=276)	38(33.3%)	47 (29%)	0.532‡
Type of employment relationship (N=85)			
Employee	1(2.6%)	2(4.2%)	
Self-Employed/Owner	6(15.8%)	10(21.3%)	
Agriculture	31(81.6%)	35(74.5%)	
They conduct work activities (N=276)	50(43.8)	69(42.2)	0.638‡
What activities (N=119)			
Household	43(86.0%)	44(63.8%)	0.028‡
Cultivation/Vegetable Garden	5(10.0%)	14(20.3%)	0.001‡
Livestock farming	1(2.0%)	6(8.7%)	<0.001§
Other Activities	1(2.0%)	5(7.2%)	0.01§
Receives Benefit (N=276)			
Pension	7(6.1%)	11(6.8%)	
Family pension	7(6.1%)	2 (1. 2%)	
CB†	56(49.1%)	73(45.1%)	
Retirement	23(20.2%)	46(28.4%)	
Does not receive	21(18.4%)	30(18.5%)	

Acronyms: *Minimum wage in Brazil= R$ 998.00 (US$ 241.00); †CB: Continued Benefit. ‡Chi-Square Test; §Fisher's Exact Test.
Source: Study database.

Men were twice as likely to be smokers and almost three times more likely to be at risk of alcohol when compared to women (p<0.001). The most frequent diseases were SAH, and DM. Depression was in about 15% of women with some type of chronic disease. This higher prevalence may corroborate the continuous use of medications in the female population. Regarding the health conditions of this population, in the comparison between the groups of men and women, table 3 stands out.

Table 3. Comparison of characteristics of health conditions between men and women living in rural setting . Rio Grande do Sul, Brazil, 2018-2019. (N=276)

	Women N=114	**Men** N=162	***Odds Ratio*** (IC 95%)	**p-value**§
Has Chronic Disease	41(36.9%)	44(27.5%)	1.544 (0.919-2.594)	0.100
What Chronic Disease (N=91‖)				
SAH*	25(53.2%)	21(47.7%)		
DM†	2(4.3%)	6(13.6%)		
SAH* and DM†	5(10.6%)	7(15.9%)		
Depression	7(14.9%)	2(4.5%)		
Cancer	0	1(2.3%)		
Other	8(17%)	7(15.9%)		
Use of Medicine	68(59.6%)	83(51.2%)	1.269 (0.778-2.070)	0.340
Acquires Medicine (N=151)				
Purchase	9(13.0%)	13(15.6%)		
Search at BHU‡	33(47.8%)	36(43.4%)		0.553
Purchase if miss at BHU‡	27(39.1%)	34(41.0%)		
Pesticide Poisoning	45(39.5%)	69(42.6%)	1.079 (0.808-1.441)	0.604
Smoking	8(7.0%)	31(19.3%)	2.190 (1.162-4.124)	0.004
Alcoholism	6(5.4%)	30(18.6)	2.669 (1.268-5.619)	0.002

Acronyms: *SAH= Systemic Arterial Hypertension; †DM=Diabetes Mellitus; ‡BHU= Basic Health Unit. §Chi-Square Test; ‖ There could be more than one diagnosis.
Source: Study database.

DISCUSSION

In this study, there was a higher prevalence of deficiency in men, and acquired physical ones were the most frequent when compared to women. Intellectual and multiple disabilities were more prevalent in women. On this, a study conducted in the southern half of Rio Grande do Sul, Brazil, contradicts these findings, since it shows that the number of women with disabilities was higher than that of men in rural areas[2]. Such differences may be related to sociodemographic characteristics of the rural setting in question.

Physical disability was more present in men. This result is corroborated in a study conducted in Florianópolis/Santa Catarina, Brazil, in which this type of deficiency also prevailed in men, having as causes comorbidities and traffic accidents[11]. In the rural setting, men often work in the field and livestock, being more exposed to accidents related to the incorrect use of agricultural machinery and equipment, causing temporary or permanent disabilities[13]. The nature of physical disability and limited access to care devices isolate individuals from society and emotionally ill[14].

In this study, it was found that women had a higher percentage of intellectual (52.0%) and multiple (15.0%) disabilities than men. Contrary to these results, a study revealed a higher prevalence of self-reported intellectual disability in men since birth. Intellectual disability is diagnosed before the age of 18, and hardly diagnosed in the first years of life[12].

As for age, there is a higher prevalence between 40 and 64 years, with a higher percentage among women, and the result presented may be related to aging. In this direction, a study reveals that the aging process correlates with the increase in deficiencies and comorbidities in this age group[12]. The functional decline of the female body may be tied to exposure to more forced labor, which is sometimes present in the daily life of women living in rural settings.

Regarding schooling, in this study, men and women had low schooling. In this respect, the lack of access to education of PD and, consequently, to the labor market is due to the absence of implementation of public education policies and low social inclusion in the rural setting. It is worth remembering that the educational right of PD is guaranteed by Law N 13,146, which establishes as the duty of the family, the state and society to promote a quality and inclusive educational system for people with disabilities[4]. However, these rights are not always guaranteed to the population living in rural setting.

Regarding income, this study shows that 75% of men received up to one minimum wage and 71.4% of women received two or more minimum wages. It is noteworthy that, in wage-employed activities, women received more than men. The low-income conditions among this public are due to the little opportunity to enter the labor market. The higher the socioeconomic position of the family, the better inserted the person with disabilities is in the community and the greater the chances of social participation and quality of health[13]. In this study, men and women faced a lack of economic and educational resources, a condition that is an obstacle to social participation and insertion.

As for leisure activities, rural disabled women experience them more than men, since a simple visit to the neighbor is characterized as leisure for this public. The rural setting, as a place – countryside – is seen as a leisure area for people living in the urban setting and not always for people who live in the rural, considering that, in this setting, the place where they live, study, work and have fun is the same. In many cases, the field becomes a form of cost of urban life. There is no time and place differentiation for leisure for some rural families. Being with the family in moments of tranquility can be considered leisure[15].

The urban space has a wider range of leisure options, which is not seen in the rural area, restricting the residents of the countryside to few options. Most of the activities are football, bocce and deck and most enjoyed by men, the leisure options connected to the home and children are enjoyed by women. In the rural setting, the leisure of men and women is determined by the social construction of gender[16]. Therefore, when relating gender, disabled women and leisure, the social and cultural perspective can define leisure activities in their lives. Receiving or making visits to friends can be seen as a form

of leisure. However, in this respect, the importance of public policies that provide more entertainment spaces for PD living in rural settings is emphasized.

The women had less autonomy of locomotion, had little access to public transport, in addition, some had a car, but did not have a license to drive. The lack of accessibility in the setting in which they are inserted can become one of the determining factors for the condition of low autonomy. These barriers are even stronger due to the absence of inclusive policies[3].

The men with disabilities in this study performed activities of cultivation and cattle ranching, i.e., animal husbandry and planting. If we relate this to the higher percentage of commuting to urban centers, it would be due to the commercialization of the products they cultivated, while women had higher activities of the home and did not go to the centers with the same periodicity. In this regard, women still have unequal positions in relation to males, are suppressed rights and benefits not only in the labor market, but also in other spheres of life[14].

As for income, the women in the study received more than men in paid activities and this implies female financial independence, which on the one hand is beneficial, because it indicates that women with disabilities can gain their salary autonomy. However, for this, they need to leave the rural scenario to obtain their own income, because there they do not have job offers equally to men, which represents the professional inequality and subalternity experienced by women in the labor market in this setting[17].

This study shows that domestic activities were significantly more frequent as a responsibility of women, while autonomous work activities and vegetable garden, livestock/farming activities were the responsibility of men. This result is corroborated in a study conducted in the city of Brejo/MA, which attests that it is man's productive and sustenance work of the family. Women have domestic activity not recognized as fundamental for the maintenance of the family and agriculture[18].

In this study, the work characteristics are full-time activities, with more than 15 years of experience, with no significant difference between the groups. The work described occurred within family property, that is, without outsourced employment, thus, cultivation and livestock can be for family consumption and commercialization in the market, being characterized as an informal method of income generation[17]. Considering that the individuals studied were farmers with limiting disabilities, they were unaware of and enjoyed little of their rights and work benefits.

The benefit of continued provision (PB) was the most frequent for the population of this study, although 18.5% of people did not receive any. The lack of benefit is an aggravating factor for the low-income population, and most of them do not have paid work with employment. In this case, participants were either ineligible to obtain the benefit or did not recognize the right to have it. In this sense, a study shows that the considerable number of rejected processes occurs due to deficiencies and alterations of lower intensity that do not prevent the individual from guaranteeing his own maintenance. Environmental obstacles, to be taken as an example, are difficult to access and an ineffective support network, become triggering factors for ineligibility to the benefit[19].

And, on chronic diseases, it was noticed that they were more frequent in the women studied, about 36.9%, with systemic arterial hypertension (SAH) and diabetes mellitus (DM) being the most prevalent. In this aspect, aging may be related to the manifestation of chronic-degenerative diseases, contributing to the occurrence of diseases such as SAH and DM. A study shows, as a cause of disability, chronic non-communicable diseases in older women[12].

In this research, women used medicines continuously, withdrawn from the reference FHS itself. The use of medication continuously may be related to the type of deficiency of the individual and its comorbidities. Among the most used drugs were antiepileptics, antipsychotics and anticonvulsants.

On the other hand, in terms of pesticide poisoning, it was more present in men, which may be related to greater exposure due to work with planting. A study reveals that men, even in smaller numbers, are more responsible for work in agriculture and low schooling and income

may be related to the high rate of intoxication by this population[20]. Moreover, the lack of planning in family health services of approaches related to exposure at work and damage caused by pesticides with educational actions contributes to the maintenance of this reality[21].

Compared to women, men in this study were twice as likely to be smokers and almost three times as likely to have alcohol consumption. Analysis conducted in the rural setting shows that men who smoke are more likely to trigger alcohol-related disorders than women and men who do not smoke. Men who smoke consume more alcohol[22]. The excessive consumption of alcohol and tobacco evidenced in rural populations may be related to low health promotion and few prevention policies offered by services in these settings.

Some methodological limitations of the present study should be pointed out, and the cross-sectional design used for data collection, which makes it impossible to establish the nature of the relationship between exposure and event.

The study population may not be representative, considering that the degree of disability compromises the participation of the research. More studies are needed to access this population.

CONCLUSION

In this study, acquired physical disabilities were prevalent in men, while multiple and congenital deficiencies in women. In the majority, the PD declared themselves white, in the adult age group, with low schooling and income from two to five minimum wages.

The women enjoyed leisure activities more, however, with little autonomy of locomotion, almost did not use public transport, had a car, but rare had a license to drive, and little moved to the city.

At work, women developed their activities in the domestic sphere and men were involved with cattle raising and autonomous activities, moving more to the urban environment. The work shifts were integral, with more than 15 years of experience. Among wage earners, women received more than men. PB aid was the most frequent for this population.

Women had more chronic diseases than men, the most frequent being SAH and DM, and also took more medications. It is noteworthy that men were twice as likely to be smokers and almost three times higher risk of alcohol consumption.

The sociodemographic, work and health characteristics of PD living in rural settings are different between men and women. Moreover, there is little scope of rights to public health and social policies, reinforcing barriers to social participation. It is recommended to expand policies offering inclusive schools and adapted public transport, as specialized services are in urban regions.

In addition, it is necessary to (re)think PD registration actions in a system with more specific address and characteristics for future analysis. Rural health teams are the best opportunity for these populations to access the disability care network in addition to rehabilitation. Strengthening actions to promote and rehabilitate tobacco and alcohol issues and mediating and articulating education, labor, entertainment, income and better development opportunities policies in the rural setting, considering the differences between men and women, is a recommended strategy.

CARACTERÍSTICAS SOCIODEMOGRÁFICAS, DE TRABALHO E SAÚDE DE HOMENS E MULHERES DEFICIENTES RESIDENTES EM CONTEXTO RURAL

RESUMO

Objetivo: Comparar as características sociodemográficas, de saúde e de trabalho de homens e mulheres com deficiência que residem em contexto rural. **Método:** Estudo transversal analítico, com 276 pessoas com deficiência residentes em cenário rural de oito municípios da região noroeste do Estado do Rio Grande do Sul, Brasil. Os dados foram coletados por meio de um questionário fechado, com variáveis sociodemográficas, de trabalho e saúde, aplicado na residência dos participantes nos meses de setembro de 2018 a julho de 2019. Esses foram digitados e analisados no programa estatístico software *Statistical Package for the Social Sciences for Windows*, versão 18.0 por meio de estatística analítica descritiva (comparação de frequência). Para comparar os dois grupos (homens e mulheres) empregou-se o teste Qui-Quadrado. **Resultados:** Dos homens, 27,8% apresentaram deficiência física e a deficiência múltipla foi mais frequente na mulher (p<0,001). O trabalho na agricultura e do lar eram mais frequentes no sexo feminino e as atividades autônomas e empregatícias, no sexo masculino. Ambos recebiam BPC, ainda que 18% não

tivessem nenhum tipo de benefício. Homens tinham duas vezes mais chance de serem tabagistas e quase três vezes maior risco de etilismo que as mulheres (p<0,001) **Conclusão:** As características de pessoas com deficiência que residem em contexto rural se diferenciam entre os sexos, no que se refere à deficiência, trabalho e hábitos que vulnerabilizam a saúde.

Palavras-chave: Pessoas com deficiencia. População rural. Políticas públicas. Saúde da pessoa com deficiencia. Saúde da população rural.

CARACTERÍSTICAS SOCIODEMOGRÁFICAS, DE TRABAJO Y SALUD DE HOMBRES Y MUJERES DISCAPACITADOS RESIDENTES EN UN CONTEXTO RURAL

RESUMEN

Objetivo: comparar las características sociodemográficas, de salud y de trabajo de hombres y mujeres con discapacidad que residen en contexto rural. **Método**: estudio transversal analítico, con 276 personas con discapacidad residentes en escenario rural de ocho municipios de la región noroeste del Estado de Rio Grande do Sul, Brasil. Los datos fueron recogidos a través de un cuestionario cerrado, con variables sociodemográficas, de trabajo y salud, aplicado en la residencia de los participantes en los meses de septiembre de 2018 a julio de 2019. Estos fueron introducidos y analizados en el programa estadístico *software StatisticalPackageforthe Social Sciencesfor Windows*, versión 18.0. por medio de estadística analítica descriptiva (comparación de frecuencia). Para comparar los dos grupos (hombres y mujeres) se empleó la Prueba de chi-cuadrado. **Resultados**: de los hombres, el 27,8% presentó discapacidad física y la discapacidad múltiple fue más frecuente en la mujer (p<0,001). El trabajo en la agricultura y en el hogar eran más frecuentes en el sexo femenino y las actividades autónomas y de empleo, en el sexo masculino. Ambos recibían BPC, aunque el 18% no tenía ningún tipo de beneficio. Los hombres tenían dos veces más probabilidades de ser fumadores y casi tres veces mayor riesgo de etilismo que las mujeres (p<0,001).**Conclusión**: las características de las personas con discapacidad que residen en un contexto rural se diferencian entre los sexos, en lo que se refiere a la discapacidad, trabajo y hábitos que vulneran la salud.

Palabras clave Personas con discapacidad. Población rural. Políticas públicas. Salud de la persona con discapacidad. Salud de la población rural.

REFERENCES

1.Tonini H, Lopes MJM. Desenvolvimento, cuidado e vulnerabilidade: pessoas com deficiência em áreas rurais do RS. R. Interd.[Internet].2017;10(3):110-124. https://dialnet.unirioja.es/revista/26280/V/10.

2.Tonini H.Lopes MJM. Pessoas com deficiência no rural da metade sul do RS: uma análise do censo de 2010. 2016; 21(3):180-195.DOI:https://doi.org/10.17058/redes.v21i3.5744.

3. Paiva JCM, Bendassolli PF. Políticas sociais de inclusão social para pessoas com deficiência. Psicologia em Revista. 2017;23(1):

418-429. DOI:https://doi.org/10.5752/P.1678-9563.2017v23n1p418-429.

4. Santos W. Deficiência como restrição de participação social: desafios para avaliação a partir da Lei Brasileira de Inclusão. Ciênc. saúde colet. 2016;21(10):3007-3015.DOI:https://doi.org/10.1590/1413-812320152110.15262016.

5.Amorim EG, Liebrali R, Medeiros N. Avanços e desafios na atenção à saúde de pessoas com deficiência na Atenção Primária no Brasil:uma revisão integrativa. Holos. 2017;34(1):224-236.

DOI:https://doi.org/10.15628/holos.2018.5775

6. Vergunst R, Swartz L, Hem KG, Eide AH, Mannan H, MacLachlan M. et al. Access to health care for persons with disabilities in rural South Africa. BMC Health Serv Res.[Internet]. 2017 [citado em 2021 jan 19];17(1):741-748.Available from: https://pubmed.ncbi.nlm.nih.gov/29149852.

7. McKinney V, Amosun SL.Impact of experiences lived by people with disabilities in the built environment in South Africa.Afr J Disabil.2020;6(9):1-11.DOI:http://doi.org/10.4102 / ajod.v9i0.518.

8. Mitchell O, Malatzky C, Bourke L, Farmer J. A modified Continuous quality improvement approach to improve culturally and socially inclusive care within rural health services. Aust J Rural Health. 2018;26(3):206-210. DOI:https://doi.org/10.1111/ajr.12409.

9. Ursine BL, Pereira EL, Carneiro FF. Saúde da pessoa com deficiência que vive no campo: o que dizem os trabalhadores da Atenção Básica? Interface. 2018; 22(64):109-20.DOI:https://doi.org/10.1590/1807-57622016.0666.

10.Brasil. Lei n0 13146, de 06 de julho de 2015.Institui a Lei Brasileira de Inclusão da Pessoa com Deficiência (Estatuto da Pessoa com Deficiência).Diário Oficial da União de 7.7.2015. Seção 1, p.2. 2015.

11Malta DC, Stopa SR, Canuto RGNL, Mendes VLF, Goulart BNG, Moura L.Self-reported prevalence of disability in Brazil, according to the National Health Survey, 2013. Ciênc. saúde colet. 2016 ;21(10):3253-3264 .DOI:https://doi.org/10.1590/1413-812320152110.17512016.

12.Nogueira GC, Schoeller SD, Ramos FRS, Padilha MI, Brehmer LCF, Marques AMFB. The disabled and Public Policy: the gap between intentions and actions .Ciênc.saúdecolet.2016;21(10):3131-3142.DOI:https://doi.org/10.1590/1413-812320152110.17622016.

13. Begnini S, Almeida LEDF. Desenvolvimento e acidentes de trabalho no meio rural de Santa Catarina. Revista Brasileira de desenvolvimento regional 2017;(2):111-136 .DOI:http://dx.doi.org/10.7867/2317-5443.2017v5n2p111-136.

14.Neille J. A qualitative inquiry into the ways in which space and place influence the lived experiences of adults with disabilities in rural South Africa. Rural and Remote Health 2021; 21: 6241.DOI: https://doi.org/10.22605/RRH6241.

15. Felicíssimo MF, Frich AAL, Xavier CC, Proietti FA, Neves JAB, Caiaffa WT.Socioeconomic position and disability: "The Belo Horizonte, Brazil Health Study" Ciênc. saúde colet. 2017;22(11):3547-3556. DOI:https://doi.org/10.1590/1413-812320172211.22432017.

16. Maziero C, Godoy CMT, Campos JRR, Mello NA. O lazer como fator de permanência e reprodução social no meio rural: estudo do município de Saudade do Iguaçu, PR. Interações 2019;20(2): 509-522

.DOI:https://doi.org/10.20435/inter.v0i0.1763.

17. Biroli F. Divisão Sexual do Trabalho e Democracia. Dados rev. ciên. Sociais. 2016; 59(3):719- 681. DOI:https://doi.org/10.1590/00115258201690.

18.Hirata H. Gênero, patriarcado, trabalho e classe. Revista trabalho necessário.2018;16(29):14-27.DOI:https://doi.org/10.22409/tn.16i29.p4552.

19. Duarte CMR, Marcelino MA, Boccolini CS, Boccolini PMM.Social protection and public policy for vulnerable populations: an assessment of the Continuous Cash Benefit Program of Welfare in Brazil . Ciênc. saúde colet. 2017; 22(11):3515-3526 .DOI:https://doi.org/10.1590/1413-812320172211.22092017.

20. Santana CM, Costa AR, Nunes RMP, Nunes NMF, Peron AP, Cavalcante AACM. et al Exposição ocupacional de trabalhadores rurais a agrotóxicos. Cad. Saúde Colet. 2016 ;24(3): 301-307 .DOI:https://doi.org/10.1590/1414-462X201600030199.

21. Machado LM, Beck CLC, Coelho APF, TH, Camponogara S. Atuação dos profissionais de saúde da família frente ao trabalhador rural exposto a agrotóxicos. Cienc Cuid Saude 2017; 16(3): 1-8.DOI:https://doi.org/10.4025/cienccuidsaude.v16i3.37051.

22. Batista EC, Rocha KB. Saúde mental em comunidades quilombolas do Brasil: uma revisão sistemática da literatura.Interações.2020;21(1):35-50 DOI:https://doi.org/10.20435/inter.v21i1.2149

Corrresponding author: Ethel Bastos da Silva. Av. Independência, nº 3751, Bairro Vista Alegre, Palmeira das Missões, RS, Brasil, CEP: 98300000. E-mail: ethelbastos@hotmail.com

Submitted: 13/07/2021
Accepted: 21/01/2022

FINANCIAL SUPPORT

Work financed by Call FAPERGS/MS/CNPQ/SESRS No. 03/2017 - Research program for SUS: shared health management PPSUS – 2017.