Elements of comprehensiveness in the professional health practices provided to rural women victims of violence*

ELEMENTOS DE INTEGRALIDADE NAS PRÁTICAS PROFISSIONAIS DE SAÚDE A MULHERES RURAIS VÍTIMAS DE VIOLÊNCIA

ELEMENTOS DE INTEGRALIDAD EN LAS PRÁCTICAS PROFESIONALES DE SALUD A MUJERES DE ÁMBITO RURAL VÍCTIMAS DE VIOLENCIA

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ABSTRACT

The present article refers to a qualitative study that was performed with the objective to identify and analyze the practice of healthcare professionals regarding rural women victims of violence, under the perspective of comprehensive care, in cities located in southern Rio Grande do Sul state. Participants were healthcare professionals and workers from health services who work in rural areas. The information was generated through interviews and analyzed using the thematic mode. In regards to care elements provided to rural women who are victims of violence, the study pointed out not only the relational strategies – welcoming, attachment and dialogue – but also the construction of collective actions through group activities, recognized as supporting health promotion, as well as individual and collective empowerment in the dimension of violent events. It was found that the professionals' care practices are aimed at focusing care on the rural women, establishing a relationship between the worker andclient to produce comprehensiveness of care.

DESCRIPTORS

Violence against women
Primary Health Care
Rural health
Comprehensive health care
Nursing care

RESUMO

O presente artigo trata de estudo qualitativo que buscou conhecer e analisar práticas de cuidado de profissionais de saúde a mulheres rurais vítimas de violência, na perspectiva da atenção integral, em municípios da Metade Sul, RS. Participaram da pesquisa, profissionais e trabalhadores dos serviços de saúde, que atuam em áreas rurais. As informações foram geradas por meio de entrevista e analisadas pela modalidade temática. Apontam-se como elementos de cuidados às usuárias rurais em situações de violência não só os dispositivos relacionais – acolhimento, vínculo e diálogo – como também a construção de ações coletivas por meio de atividades grupais, reconhecidas como potencializadoras da promoção da saúde e do empoderamento individual e coletivo na dimensão dos eventos violentos. Constatou-se que nas práticas de cuidado dos profissionais há um direcionamento para a inclusão das usuárias rurais como protagonista do cuidado, estabelecendo uma relação entre trabalhador-usuária para a produção da integralidade.

DESCRITORES

Violência contra a mulher
Atenção Primária a Saúde
Saúde da população rural
Assistência integral à saúde
Cuidados de enfermagem

RESUMEN

Estudio cualitativo que apuntó a conocer y analizar prácticas de cuidado de profesionales de salud a mujeres de ámbito rural víctimas de violencia, en la perspectiva de atención integral, en municipios de la Mitad Sur de Rio Grande do Sul. Participaron profesionales trabajadores de servicios de salud actuantes en áreas rurales. Datos generados mediante entrevistas y analizados según modalidad temática. Se determinan como elementos de cuidado a pacientes rurales en situaciones de violencia no sólo a los dispositivos relacionales, acogida, vínculo y diálogo, sino también a la construcción de acciones colectivas mediante actividades grupales, reconocidas como potencializadoras de la promoción de salud y del empoderamiento individual y colectivo en la dimensión de eventos violentos. Se constató que en las prácticas de cuidado de los profesionales existe un direccionamiento hacia la inclusión de las pacientes rurales como protagonistas del cuidado, estableciendo una relación entre trabajador-paciente, para la generación de la integralidad.

DESCRIPTORES

Violencia contra la mujer
Atención Primaria a la Salud
Salud rural
Atención integral de salud
Atención de enfermería

*Taken from the project "A violência contra a mulher em áreas rurais e municípios de pequeno porte do estado do Rio Grande do Sul", Universidade Federal do Rio Grande do Sul, 2011.

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Português / Inglês
www.scielo.br/reeusp

Received: 11/30/2011
Approved: 03/19/2012

INTRODUCTION

The theme violence against rural women is extremely relevant for the health and nursing sector, as violence rates against women, the *invisibility* of this problem in the health area and services' incipient intervention strategies are elements that jointly put a strain on the care system. In addition, little academic research with a focus on resident women and female rural workers exists and, particularly, little is known about this geosocial particularity. Therefore, this study problematizes violence against women from a health perspective in rural areas in the South of Brazil, considering care practices and care comprehensiveness in its professional and public service dimensions.

Violence against women is present throughout society. The phenomenon is related with gender cultures and the power distribution within each social group. This event is characterized as an action a man commits against a woman, under the influence of cultural models, the *cultural pedagogies* of what it means to be a man, of what it means to be a woman and of how violence takes place in interpersonal relations, strengthens and perpetuates power asymmetries between the genders[1]. In that sense, gender cultures grant somewhat *legitimize* the existence of this type of violence, which is more frequently expressed in women's social space: the private space, the family, the home.

When considering violence against rural women, one can reflect on its overlapping with and enhancement in problematic and excluding contexts. The distancing from collective social care and protection resources adds up to the large geographical distances from urban centers, where these resources are present, increasing the invisibility and non-coping with these situations.

As regards the violence triggered in radicalizations of social movements in rural areas, from a collective perspective, women have been participating in these conflicts since the colonization of Brazil, although literature does not always evidence the female presence in this kind of movements. About domestic violence, on the other hand, little is known, little has been said, as the daily realities of rural women are times and spaces of invisibility[2].

This discussion causes tension in the health sector, as the potential space to detect these events. Studies have shown, however, that health services do not always offer a satisfactory response to the problem (which is not recognized as legitimate in the diagnostic area, to give an example), resulting in the dilution of violent events amongst other problems, ignoring the intentional nature of the act that produced the state of illness[3-4].

In view of these findings, the reflexive dimension is added as a possibility to analyze health practices in the field of violence against women, within a holistic care dimension. This analytic device takes form in the proposal to deliver holistic care to female violence victims as a strategy to trigger alternatives for the fragmented and disjointed health model. It can be affirmed that, for the Brazilian public health system (Unified Health System – SUS), care comprehensiveness serves as an action principle and model. Therefore, it is impossible to reflect on it in isolation, without considering intersectoral action, particularities, contexts and situations.

Thus, it is acknowledged that holistic care delivery results from and unites the knowledge from different multiprofessional teams in the concrete and singular space of health services. This comprehensive dimension is called focused integrality[5]. Hence, at the encounter between the user and the team, what should always prevail is the commitment and concern with listening to the health needs that person who comes to the health service brings in the best possible way, presented in the form of some specific demands.

...holistic care delivery to female violence victims in the specific sphere of rural areas and of each health service could represent the effort and work of the team involved in translating and attending to these women's complex needs and suffering in the best possible way.

Therefore, it could be argued that holistic care delivery to female violence victims in the specific sphere of rural areas and of each health service could represent the effort and work of the team involved in translating and attending to these women's complex needs and suffering in the best possible way. For this purpose, they would have to be understood in their singular expression.

In the same perspective, in the attempt to cross meanings and practices, the focused integrality dimension can be articulated with expanded integrality, which presupposes the institutional, intentional, process-based articulation in networks of the multiple focused integralities which, with each health service as the epicenter, articulate in flows and circuits, departing from people's needs[5].

In situations of violence against rural women, expanded integrality would taken place in the articulated, complementary and dialectic relation, between the range of holistic care delivery by each professional, each team and the service network, in line with political, technical and ethical guidelines. It presupposes the use of a large intersectoral network that enhances different routes, based on each woman's singularities and life projects.

In view of these dimensions and possibilities for reflection, questions were elaborated in the attempt to clarify some readings and looks that can contribute to the understanding of this problem. Thus, it is questioned what professional and service practices in the rural realities studied

are organized towards holistic care delivery to female victims of domestic violence. And the aim is to get to know and analyze care practices professionals and health services deliver to rural women who are victims of violence in a holistic care perspective, in cities in the Southern half of Rio Grande do Sul.

METHOD

To reach the proposed objective, an exploratory-descriptive research with a qualitative approach was chosen. The qualitative approach reveals the purpose of the problem under study, getting deeper into the world of the subjects' meanings, beliefs and values[6].

The geographical base of the Interidsciplinary Research Program (PROINTER) was chosen as the place of study, as a result of a French-Brazilian interuniversity cooperation program between *Universidade Federal do Rio Grande do Sul*, Université Paris 7, Université Paris 10, Université Bordeaux 2 and *Universidade Federal do Paraná*. The selected region to develop this program was the Southern half of the State of Rio Grande do Sul, which has been victim to an increasing economic slowdown in comparison with other regions in the State, revealing regional disparities. Each cities are included in the program: Arambaré, Camaquã, Canguçu, Chuvisca, Cristal, Encruzilhada do Sul, Santana da Boa Vista and São Lourenço do Sul[7].

Participants in this study were professionals who worked at health services active in rural areas, attending to women's demands, delivering care to female victims of violence and who had been working at the service for more than six months. In total, 43 professionals participated: 19 community health agents, 14 nurses, nine physicians and one psychologist. It was evidenced that 79% of these participants are female and 21% male, showing the classical female predominance in the health work context.

The term data production was chosen instead of data collection, with a view to covering a range of relations between researcher, social world and broader data, which is the intent of qualitative research[8]. Therefore, to produce information, discourse elements were sought through semi-structured interviews. A guide was constructed for the interviews, organized around two axes: the first dedicated to the interviewees' socio-demographic characteristics; the second with open questions that addressed the study problem. The interviews were previously scheduled with the professionals, held at the health units where they were active, between July and November 2010.

To treat the data, the Content Analysis method was used, applying the thematic analysis technique, which involves pre-analysis, exploration of the material and treatment and interpretation of the obtained results[6]. The analyses were developed with the help of QRS NVivo software, version 7. This study complied with the standards of Resolution 196 for research involving human beings, issued on October 10th 1996[9]. Approval was obtained from the Research Ethics Committee at the Rio Grande do Sul Health Secretary School of Public Health, under protocol CPS-ESP 496/09.

RESULTS

The presentation of the results starts with the first elements identified in the study, which refer to comprehensive care delivery to rural users in violent situations. These results center on relational devices like welcoming, bonding, dialogue and orientation. The first device mentioned was welcoming,

> The first thing is welcoming, it involves projection, respect, admiration, which the team conquers in the community and among users. (...) it's the welcoming that will make people believe we will be able to solve their problem, mainly when we're talking about violence against women in the rural context (...) (MED23).

> ...we have to go there first during the home visit, as a nurse, make that women feel welcomed and gain that trust (NUR19).

> ...there was a case that took a long time for the woman to make a decision because here, in the rural area, it's more difficult for women to get out of certain situations (...) I used to welcome here, talk, explain how things work (...) I always try to accompany, and never say do this or do that (CHA18).

Beyond understanding, welcoming involves respect for the time this woman often needs to make the right decision. It involves an understanding of why the woman returns to the relation with the aggressor, not because she likes to get hit, but because she still needs support to take attitudes of change in the relations she establishes with her partner. The statements demonstrate opening to welcome and bond with these women, encouraging them to report the suffering, permitting the detection of violence, which may be accompanied by depression, anxiety or even masked by some kind of complaint.

Bonding, the second relational device mentioned, mainly by the Community Health Agents, happens more frequently during home visits, as it provokes an encounter between subjects (workers and users), which in many cases permits the unveiling of the violence experience.

> ...mainly through our visits. Those continuing visits, that friendship, makes us see where to start first (...) get into the home, achieve friendship, gain trust, the bond we construct, that helps to get to know the women, and they often feel we are someone they can blow off steam with (CHA5).

It is observed that the establishment of bonding with rural women permits the construction of relations of trust and opening to the other, as well as reciprocal experiences, and encourages dialogue among the subjects. This enhances forms of negotiation that are based on a consensus between needs and horizontally shared responsibilities and the acknowledgement of the other as the holder of power or rights and knowledge, questioning care actions that are merely focused on workers' knowledge.

Anchoring reflections in the practice under study, it was verified that, to constitute and strengthen bonds and trust, some professionals referred to the importance of valuing communication and dialogue with rural women, so that these women's living conditions can enter the dynamics of health work, often allowing them to overcome their feelings of fear and share to talk about the situations of violence they experience. Thus, the interest demonstrated in the care act, in hearing these users' concerns in a welcoming way, represents the start of bonding.

> ...when I know about a case of violence here with the rural women, I try to remain closer, talk more, talk to the father, to the mother, to a neighbor, about what we could do to help, make this person react, showing some routes (CHA4).

> ...I always try to leave room for the woman to report, generally they talk a lot during nursing consultations, that's the reason for the dialogue with the women, mainly from rural areas it's important, sometimes they just want to talk, be heard, blow off steam (NUR28).

In the relation between users and professionals, the *orientation* dimension frequently appeared in the statements as a tool that permits showing the women routes, so as to strengthen their attitudes to alter the situations of violence, leading to their rupture, as the following statement expresses,

> ...what I have to tell you is that the strongest tool we have here in the rural area is the orientation tool (...) in general we attempt to orient, show the woman that she does not have to stay in the violent situations, that it is possible, and that she has her rights (CHA2).

The orientation dimension emerges as an important strategy to mediate dialogues between the subjects, empower and strengthen the women to cope with the violent situations. Thus, mainly the Community Health Agents have privileged access and a distinguished relation of proximity with the users' homes and community life. Thus, they can potentially assume the promotion of non-violence through dissemination, information and orientation about rights and existing services in and beyond the community, i.e. they are privileged agents[10].

Another element mainly nurses and Community Health Agents signal as drivers of holistic care in the field of violence is the *construction of collective actions* for these women, through group activities. According to the interviewees, these actions constitute privileged spaces for health promotion and the individual and collective empowerment of female service users.

The professionals mentioned the group space as a privileged locus to identify cases of violence against rural women, also with a view to offering a protected place to exchange experiences and construct citizenship. This is frequently the sole space that permits rural women to spend time in another environment than their homes. In general, they are limited to isolation in their own naturalized suffering, distanced, often also geographically, from any service that can function as a support network.

> We always do activities with health groups, we work with hypertensive, diabetic patients, and also with women (...) we do not only call those women of whom we know that they suffered some kind of violence, but we leave it open to anyone and always reinforce their rights. I think that these groups are also a way for them to interact and to encourage these women to talk about this problem, and it's also one of the sole activities there is for them (NUR19).

In this study, the report of one nurse is highlighted, in which she affirms that the establishment of the community women's group in which she is active originated in a rural woman who experienced situations of violence in her family context:

> ...we have a women's group that originated in a woman who suffered psychological violence, physical too, and she decided to abandon the family and leave, and the husband ended up committing suicide. So everyone associates her leave, that she fled the rules, cultural, of abandoning one's home, blames her for her husband's suicide. He assaulted her, he was an alcoholic, and frequently threatened to kill her. And then this group started, from her experience, women from different age ranges, not all of whom are victims of domestic violence. And they participate and meet, an experience exchange, a different environment, exchange ideas, this group takes place once a month (NUR25).

In view of the above, it is evidenced that people, in this case rural women, get organized in groups for specific ends, as a form to cope with the difficulties deriving from the social-family system they live in. According to the report, participants themselves structured this group, with health professionals' support.

Moreover, in various statements of professionals, it was identified that a partner of the group's actions is the *Associação Riograndense de Empreendimentos de Assistência Técnica e Extensão Rural* (EMATER/RS), specifically with the extensionists. The activities this sector develops include actions that promote the protection of people's health and the preservation of the environment, as well as income generation activities. In this context, the

health and work sectors join to develop collective activities with the rural women. A small sample of intersectoral work can be abstracted from this partnership, which can effectively intervene in domestic violence.

Besides the income generation activities developed in partnership with EMATER/RS, participants reported on other experiences, called *workshops with the rural women to generate income,* which according to them enhance their empowerment and autonomy.

> ...the women's group is where we are able to get them out of their home, to get some distraction. We work with craftsmanship, they even tell me: "but how on earth am I going to learn that? 'Never'. "Never does not exist, you can, you'll learn". In a couple of days they're doing crochet, they're making a painting, it's a way for you to show them their value. It's a way to improve their self-esteem and value them (CHA38).

The collective actions some of the cited professionals develop enhance these women's autonomy, as they imply the possibility for them to reconstruct the meanings of their lives and this new meaning gains importance in their way of life. This includes the struggle to see to their needs, in the broadest possible sense, and more symmetric relations between users and health professionals.

Another activity they mentioned was *theater***,** as a health promotion and education strategy to cope with violence. Besides the experiences discussed, in two cities in this study, the structuring of theater plays was identified as a health promotion strategy in coping with violence against these women.

> ...now we got together to have a theater group, the health agents from the rural area (...) we have worked in schools, also in associations, getting all families (...) we work with theater plays, with orientation. We present a family, which is basically what we observe in our work, many of the wives and many of the husbands see each other, and this calls their attention because it's not something isolated just from their home which nobody can know, it's something that really exists (CHA5).

The theater strategy is acknowledged as a tool to mobilize and empower the women, as well as to promote health, coping and reduced violence. The reports affirm that the playful nature of the strategy calls the public's attention and that the stories told refer to situations and problems that are similar to the users' or the community's experiences. This stimulates inquiries about the situations and can help many women to break the silence.

DISCUSSION

In the dimensions discussed, *welcoming* was the first relational element mentioned. Thus, it is considered that welcoming presupposes an ethical and care attitude, interest in the other person's needs, sensitivity, respect for the user, as well as risk and vulnerability assessment as elements that certify the materiality of violent events. Hence, it is noteworthy in the discourse, mainly of medical professional, as this professional group tends to show greater resistance against the inclusion of other diagnostic elements that address relational evidence into traditional clinical practice. This appoints some, although punctual, approach possibilities in health. Welcoming can be understood as a proposal aimed at improving health professionals' relations with the users who are victims of violence, concretized in the encounter between user and professional, through listening, acknowledgement of her demands and search for possible solutions.

In this perspective, welcoming is not necessarily an activity by itself, but part of all care activities. It consists in the constant search to increasingly acknowledge users' health needs and possible forms of seeing to these needs, resulting in forwarding, transfers and movements through the care network, mainly mediated by the dialogue with the user[11]. In this sense, it is argued that these welcoming elements are recognized as one of the components of the interactions health professionals use.

Thus, it is observed that one of the welcoming proposals involves two fundamental elements: one ethical and political, in which the aim is to improve professionals' posture when in contact with clients; and the other related to management and the care model, aimed at reformulating the bureaucratic and strict tradition by improving the access to and the service's portfolio, by making the clinic more flexible and broader, facilitating interdisciplinary care[12]. The presented study appoints that, although welcoming appears in most health professionals' discourse, mainly in the Community Health Agents' testimonies, it is part of each professional's individual practices, including difficulties to integrate service management and to serve as a driver of new health actions.

In their discourse about the elements of welcoming, many of the interviewees mentioned that the fact of working with a certain population permits greater approximation with people, which created the meaning of responsibility for users' health. This potentially makes it possible to welcome their needs, bond with the women and construct spaces of dialogue, and trust opens room, in many situations, to talk about this problem.

Thus, the *bond* represents one of the fundamental aspects of holistic care and, to create it, close and clear relations with the individual or group are needed, being touched by their suffering and becoming a reference for them, in an exchange process that can serve to construct the users' own autonomy[13]. Therefore, bonding demands an attitude of respect for women in violent situations, showing interest in their situation and listening without judging, as trust is associated with secrecy and privacy,

which make the women who report on their daily experiences of suffering feel safe[13].

The study shows that the spaces of dialogue allow the women to express their needs. Hence, it is this encounter that permits problematizing the daily situations of violence that are naturalized in the dimension of the asymmetrical relations in the family's private world. The encounter with some health professional can turn into a foundation for changes, revealing and empowering women to assume attitudes of coping in reaction to these situations.

Thus, dialogue is not a mere resource to obtain information that is necessary to manage the disease, but to share, get familiar with and get hold of what used to be unknown in the other person until then, based on the relations between subjects and health professionals[14].

The attitudes that mobilize the relational devices under analysis aim to enhance holistic care delivery to rural women who are victims of violence and point towards the need to seek interactive action, based on listening, orientation, welcoming, emphasizing communication between users and health workers. It was observed throughout the study that this form of health action seems predominantly linked with Community Health Agents' care practices. The other professionals who participated in this study continue reproducing attitudes that naturalize violence.

Thus, it is highlighted that Community Health Agents display concrete potential to participate in the process to establish a new health model, with holistic care delivery as the central axis. In that sense, these workers bond with the women and the community and are capable of contributing to users' autonomy. This potential is associated with their knowledge, which results not only from scientific knowledge, but also from popular knowledge and their interaction in the context of rural communities.

Another element evidenced in the study was the *construction of collective actions* through group activities. Group work offers the opportunity to stimulate members to find collective strategies aimed at coping with the problems they experience, recognizing people with potential in the community. Hence, these collective moments represent concrete possibilities (distanced from home, space of protection) to gain awareness and recognize alliances capable of offering alternatives to the life they had experienced until then.

In practice, the study shows that, to put group actions in practice, professionals depart from an educative approach based on dialogue, conversation, around the axis of the development of citizenship and autonomy. In this approach, communication as a tool for dialogue in health education activities and as a mechanism for exchange between scientific and popular knowledge enhances the socialization of scientific knowledge and the acknowledgement of popular knowledge. In addition, it is highlighted that the group format stimulates the sense of inclusion, valuation and identification among participants, many of whom seek support for their health problems in these spaces[15].

Besides, the participants mentioned these actions as *enhancers* of women's *empowerment*. This strengthening allows the women to gain awareness of their rights, of their power and the possibility to control their decisions and problems in their personal life. Empowerment implies the acknowledgement of the social restrictions the women are submitted to and the need to revert this situation, through changes in more specific or individual contexts[16].

The work experience that assessed the role of groups as a support device for women in situations of gender vulnerability showed that, through group actions, women in vulnerability situations can be helped to become more autonomous, rescuing experiences based on their life histories and the ritualization of the violence experiences. Empowering women in these collective spaces represents a strategy capable of changing their lives and producing transformations in the life and work structures[17].

These collective actions provide spaces of learning and also stimulate rural women to produce either craftsmanship or other utensils as a form of income generation, breaking with strict forms of being and living, of silenced women who are submitted to a gender destiny, thus enhancing places where they can feel welcomed.

In rural areas, productive places (ploughing, crops) are a male symbolic and real domain, while the female domain is established in the private, i.e. reproductive and, in a way, unproductive space in the income generation system. Awareness of these domains, which are different in agricultural practice, where women move around and have responsibilities in both spheres, becomes clear in the spaces for discussion, experience exchange, granting visibility to the asymmetries and the acknowledgement of equal rights between the sexes in the public space and in the family's private world. It can be affirmed that some of the professionals feed these ideas, leading to the valuation of female work in- and outside the home and encourage ruptures with the materiality of gender inequalities.

In this sense, it is highlighted that health professionals' role is to *act on the other who is placed under our care, but also to help others help themselves*[18], stimulating women's problem-coping ability, based on their concrete living conditions, mainly by valuing users' potential.

The groups and workshops that encourage rural women's income generation also affect their valuation very strongly and enhance their self-esteem, which is impaired for many rural women according to the participants. Therefore, developing it makes it possible to face life with more trust, good will and optimism. In addition, it permits enhancing the ability to be autonomous and happy.

To stimulate the subject's autonomy in group spaces, professionals work to establish increasing possibilities for individuals to create standards for their lives, ways of dealing with difficulties, limits and suffering; to be more creative, solidary and produce movement. At the same time, they work to create possibilities to satisfy these women's needs, desires and pleasure[19].

The *theater strategy* was also identified as a tool that enhances holistic care delivery and aims to recover the health concept as social production and is characterized as an action that takes place in the collective space, goes beyond prevention and is part of health promotion. This approach can help to break with the hegemony of the biocentered medical model.

The use of theater is a dramatic art, based on representations of moments, situations or problems, involving a collective and social practice, arousing creativity and learning through the relaxation the public is granted[20]. Could we inquire about the potential of this activity to unveil meanings of life and as a health promotion practice?

In short, the collective actions described enhance holistic care delivery, as illustrated by the different posture that is recognized in the participants' discourse, valuing comprehensive socio-educative actions that guide the care process. They signal that joint actions permit further approximation with rural communities, so as to get to know them and obtain support to sustain practices and construct shared forms of overcoming the identified problems.

CONCLUSION

It is highlighted that the elements that enhance holistic care delivery to rural women who are victims of violence, as discussed here, represent important tools in the construction process of health actions. Although isolated actions are acknowledged, which still depend on individuals, it is evidenced in this study that professionals' care practices are turning towards the inclusion of violence as events in the action area of the health sector, and of female rural users as care protagonists, establishing a worker-user relation.

In view of the above, to put in practice holistic care in a broader sense, the practices and structures of public health services need to be reconsidered. Rural women serve as protagonists of singular situations that need to be acknowledged as such, and violence is a singular diagnosis for the health area, but often considered and treated as external to this field. Therefore, unveiling violence inside health services is fundamental for its understanding. Therefore, knowledge and practices need to be transformed, services need to be recognized and held accountable for collective health care delivery. In addition, besides their technical aspect, professionals need to turn into committed citizens with civil duties in the fight against unacceptable practices of violence.

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Acknowledgements
To the Brazilian Scientific and Technological Development Council (CNPq) for the funding granted through Call MCT/CNPq/SPM-PR/MDA No. 57/2008.

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