Original Article

Rural women and violence situation: access and accessibility limits to the healthcare network

Mulheres rurais e situações de violência: fatores que limitam o acesso e a acessibilidade à rede de atenção à saúde

Mujeres rurales y situaciones de violencia: límites de acceso y accesibilidad a la red de atención de salud

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ABSTRACT

Objective: To analyze the access and accessibility to the healthcare network of women dwelling in rural contexts undergoing violence situation, as seen from the professionals' speeches.

Method: A qualitative, exploratory, descriptive study with professionals from the healthcare network services about coping with violence in four municipalities in the northern region of Rio Grande do Sul. The information derived from interviews, which have been analyzed by thematic modality.

Results: (Lack of) information of women, distance, restricted access to transportation, dependence on the partner and (lack of) attention by professionals to welcome women undergoing violence situation and (non)-articulation of the network are factors that limit the access and, as a consequence, they result in the lack of confrontation of this problem.

Conclusion: To bring closer the services which integrate the confrontation network of violence against women and to qualify professionals to welcome these situations are factors that can facilitate the access and adhesion of rural women to the services.

Keywords: Violence against women. Primary healthcare. Rural health. Health services accessibility. Women's health.

RESUMO

Objetivo: Analisar o acesso e a acessibilidade à rede de atenção às mulheres em situação de violência, residentes em contextos rurais, a partir dos discursos de profissionais.

Métodos: Estudo qualitativo, exploratório descritivo, com profissionais dos serviços da rede de atenção à violência de quatro municípios da região norte do Rio Grande do Sul. As informações foram geradas por meio de entrevistas realizadas entre agosto e dezembro de 2014 e analisadas pela modalidade temática.

Resultados: (Des)informação das mulheres, distância, acesso restrito ao transporte, dependência do companheiro, (des)atenção dos profissionais para acolher as mulheres em situação de violência e (des)articulação da rede são fatores limitantes do acesso e têm como consequência o não enfrentamento dessa problemática.

Conclusão: Aproximar os serviços que integram a rede de atenção à violência contra a mulher e qualificar os profissionais para acolher essas situações pode facilitar o acesso e a adesão das mulheres rurais a esses serviços.

Palavras-chave: Violência contra a mulher. Atenção primária à saúde. Saúde da população rural. Acesso aos serviços de saúde. Saúde da mulher.

RESUMEN

Objetivo: Analizar el acceso y la accesibilidad a la red de atención de las mujeres en situación de violencia, residentes en contextos rurales, desde los discursos de los profesionales.

Método: Estudio cualitativo, exploratorio descriptivo, con profesionales de los servicios de la red de atención en el enfrentamiento a la violencia en cuatro municipalidades de la región norte de Rio Grande do Sul. Se generaron las informaciones por medio de entrevista que fueron analizadas según la modalidad temática.

Resultados: (Des)información de las mujeres, distancia, acceso restricto a transporte, dependencia del compañero, (des)atención de los profesionales para acoger a las mujeres en situación de violencia así como (des)articulación de la red son factores que limitan el acceso y, a consecuencia, resultan en la falta de enfrentamiento de esa problemática.

Conclusión: Aproximar los servicios que integran la red de enfrentamiento de la violencia contra la mujer y calificar a los profesionales para acoger desde la perspectiva de género pueden facilitar el acceso y la adhesión de las mujeres rurales a los servicios.

Palabras clave: Violencia contra la mujer. Atención primaria de salud. Salud rural. Accesibilidad a los servicios de salud. Salud de la mujer.

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INTRODUCTION

Violence against women derives from hegemonic social values, which naturalize inequalities between men and women and their roles, giving man greater power in relationships, which often justifies the oppression/submission of women. Therefore, this asymmetry of power in the relations present in society is one of the determinants of gender violence [1]. These social behaviors vary according to the cultures, the more traditional the societies, the more oppressive and with the greater potential for violence; the more evolved in issues of gender equality/equity and human rights, the lower the prevalence.

In Brazil, when it comes to rural women, situation of violence become more potent, considering the context of life that places them in territories far from the large centers and, consequently, of social, political and communitarian resources that could promote greater protection. In this space, family and social hierarchies, supported by gender cultures, are constitutive and, at the same time, reflections of the socialization of men and women. Thus, violence takes on multiple and complex forms and manifests itself in daily social relations, which is evidenced by the discrimination regarding the possession, treatment and management of the land and in the "masculine legitimacy" of the sexual division of labor[2].

Observing the international scenario, a study with rural Pakistani women has revealed issues that corroborate the Brazilian reality, in which women in this context are particularly vulnerable to violence, due to their relatively weaker social position and lack of awareness regarding their legal rights. The data from this study has showed that about 65% of the interviewees had experienced different types of violence, with psychological violence being the most common[3].

Thus, in rural contexts, gender relations are strongly influenced by a patriarchal organization that places women in a lower position than men. Women's work includes caring for the home, children, food, hygiene, and helping the partner in the land. Hence, man has the control of labor, he organizes and manages the family and the financial production, which places him in a superior and more powerful position in the family[2]. These behaviors have consequences on the life and health of women, making them habitually look for police services, social assistance, justice and health, sectors that make up the network of care, since these are the most accessible in cities and in large centers[4-5].

In this respect, it is observed that the society and the public managers meet, in part, the recommendation of the World Health Organization (WHO), whose orientation is that the actions are intersectional, considering the complexity of the problem[6] and also the Law No. 11,340 of August 7, 2006 - Maria da Penha[7], which stipulates that assistance to women in situation of domestic and family violence must be provided in an articulated manner among health services, social assistance and public security.

Therefore, the composition and integration of a network is a challenge for society and for public managers regarding the availability of access and the interrelationship among the services(8). This condition is aggravated when the users are rural women in situation of violence.

In addition, the availability of these network services does not guarantee quality care, since the set of services can only show the sum of actions whose performance does not establish the necessary integration so that the assistance is efficient[8]. Therefore, as important as the availability of the different sectors/places for healthcare, is the way that professionals work in the network; some reiterate conceptions and practices based on gender inequalities, understanding that these issues must be solved in the private environment; and others, taking into account the gender as a category that determines the violence in the family, begin the care at the attention network location[9].

The professionals' perceptions and practices regarding the critical route that women travel to look for assistance/support to face situations of violence serves as the basis for structuring the care network[10]. Obstacles, which are represented by the difficulty of articulation and lack of dialogue among the services, may be observed due to the lack of ability of some professionals to meet this demand[11]. Often, the healthcare network professionals work in their own area and refer women in situations of violence to other places, without any integration among them, which weakens the efficiency of the policy in dealing with violence[4].

In this direction, there is a study that sought to characterize the professionals' beliefs (of the security, education and health sectors) most directly involved in the response and prevention of marital violence in services, in Portugal. The results show that, although they are on the way to constructing spaces for support and listening to the victim, efforts still need to be made in order to eradicate beliefs that may blame the victim or to inhibit them from looking for support and planning changes in their lives. The services also need to discuss and elaborate measures of collective confrontation of this aggravation[12].

Accordingly, this study analyzes the notions of accessibility and access, in relation to the rural areas, which are considered fundamental, because although these terms are commonly used ambiguously, they present comple-

mentary meanings. Accessibility means the possibility that people have or not to reach the services. And access concerns the offer, which allows the timely use of the services in order to achieve the best possible results, that is, the way the person experiences the service[13].

In the broad field of social rights, accessibility and access to services as citizenship rights are limited for women in rural contexts, mainly due to urban/rural iniquities, geographical distances and service offers. Not only is the geographical accessibility expressed there, but also the access, the result of inequalities in the public offering and the existence of options for healthcare resources[2].

Therefore, discussing and reflecting on these issues can contribute to the development of appropriate policies to address violence against women living in rural areas, taking into account the specificities and singularities of this context. Regarding nursing, specifically, it is considered that this professional category has an important role, since when integrating with multiprofessional teams it has the potential to boost the articulation of the healthcare network.

In this way, the research question of this study is "what are the factors that limit the access and accessibility of women in situation of violence, residing in rural contexts, to the network of attention?". Aiming at analyzing the access and accessibility to the network of attention to women in situation of violence, residing in rural contexts, based on the professionals' discourse.

METHOD

It is a descriptive, exploratory, qualitative approach study. The qualitative research allows knowing in depth the experiences and the representations that the participants have of their life experiences[14]

This study has been carried out in the cities of Palmeira das Missões, Frederico Westphalen, Jaboticaba and Palmitinho, located in the northern region of the state of Rio Grande do Sul. The first two cities have been chosen because they are of medium size and poles of reference of services of average complexity for the region. The last two are small cities and their populations are larger in rural than in urban areas. The economy of these cities is based on the primary production, agricultural, covering large territorial extensions and small properties with family agriculture.

Twenty-six professionals working in the service network and supporting the fight against violence against rural women in the cities have participated in the study. The sectors and services involved are: Municipal Department of Agriculture (MDA), Technical Assistance and Extension Agency (TAEA), Social Welfare Secretary, Social Assistance Reference Center (SARC), Municipal Women's Council (MWC) , Regional Health Coordination (RHC), Civil Police Office (CPO), Women's Assistance Office, Municipal Education Secretary (MES) and Municipal Health Secretary (MHS). It should be highlighted that all these services are located in an urban area.

The invitations to the participants of the survey have been delivered through scheduling with the managers or with the professionals. Initially, the managers of the health secretaries of the cities have been invited to participate, which during or after their interviews indicated the other sectors and/or services in the cities that used to participate in some form of coping with violence against rural women. Then invitations have been made to their respective officials.

The inclusion criterion was: to be manager or to act in the services of coping with violence and to be in the position for more than a year. And as exclusion criteria: be on vacation or on leave in the period of data generation.

For the creation of the data, a semi-structured interview with open questions has been used. The interviews have been conducted individually with the participants, at which point the perceptions, beliefs, motivations and attitudes about the research problem have been obtained. The contact, scheduling and interviews with the participants of each city were carried out from August to December of 2014. The research has began after approval of the Ethics Committee of the Universidade Federal of Rio Grande do Sul, Case No. 514.865 (2014) and Presentation Certificate for Ethical Assessment (PCEA): 15126813.4.0000.5347.

In this study, the norms of the Resolution 466/2012 of the National Health Council (NHC) have been respected, and, before starting the interview, it has been read and delivered to each participant, for signing, the Informed Consent Term. Participants have been identified with the letter "P" of participant and the sequential number of the interview, followed by the corresponding "RU" registration unit.

The generated empirical material has been submitted to the thematic content analysis, following the recommended steps of pre-analysis, material exploration and treatment of the obtained results and its interpretation[15]. In order to do so, the participants' speeches have been recorded, transcribed, read and classified as registration units, which have been grouped according to similarity of meaning and given to the unit of thematic content or meaning. In the sequence, the units of registry and thematic/meaning have been re-read, emerging the category: limits of access to the network of attention to women in the rural context in a situation of violence. From this category derived

the following subcategories: (mis)information; distance, restricted access to transport and dependence of the partner and (dis)attention of the professionals and (dis)articulation of the network.

RESULTS AND DISCUSSION

In relation to the characterization of the participants, 19 are female and seven are male. As for education, 6 were graduated in the health area, 17 were graduated in courses in different areas (education, social assistance, law and others) and 3 participants had high school education. And regarding the distribution of the activity sectors, seven participants were from the agriculture sector, six from the social assistance sector, five from the health sector, five from the police sector and three from the educational sector.

In this study, the "(mis)information" subcategory appears as a limit of access to the network, in which participants have the idea that the diffusion of the information in the rural context is restricted due to lack of accessibility to the communication services. In the view of the participants, when comparing the rural woman with the urban woman, it is emphasized that the urban woman is more informed about the orientations and news transmitted by the various mass media.

> *[...]As I said, the rural [woman] I see as more delicate because sometimes, not enough information comes to them, for them to get out of that environment [...] (P2UR2)*

> *[...]and she's there in an uninformed environment because the urban woman has more access to information, right? (P23UR2)*

> *[...]I think, maybe, the urban [woman] has more access to some things that the rural woman still does not have, in the sense of communication [...] (P18UR1)*

By analyzing the results found, it is verified that the absence of information, evident in this study, is an integral condition of the universe of many women living in the rural area, and this is, perhaps, due to the lack of availability of means of communication - public mail, telephone lines, Internet, TV channels - as well as municipal educational policies and programs that promote the development of citizenship and the autonomy of rural women. When social policies reach this population group, as is the case of the National Rural Workers' Documentation Program (NRWDP), it can be observed that women learn, organize and mobilize in search of information related to their rights[16]. But in the context of this study, according to results found, it seems not to be a reality, revealing a certain lack of preparation of the public authorities in the implementation of public policies for these women.

The comparison made by the participants between urban and rural women living in situation of violence shows the idea that the urban women are more likely to obtain information and, therefore, can access the services of the healthcare network, which brings them closer to a project to confront this problem. However, this access is directly linked to the way in which intersubjective relationships and the exchange of values between network workers and women happen, and the articulation and flow of the services that may or may not cause changes in women's lives. When network services respect the needs of women, these services are articulated and have a structured flow, they can support women to reorganize their lives[17].

The conception that rural women are unaware that social and labor policies are insufficient to make them independent and autonomous reinforces the need for greater investment by the public authorities in favor of this group of women. It is understood that the autonomy of women is protective against violence, both at the private and public levels[18]. And, in order to reach it, it is necessary that nursing, as part of the network of attention, strongly use communication (dialogue and listening) in its practice in order to inform women about their rights, and with that, to initiate a process of awareness of the situation, with the possibility of acquiring power to transform reality itself[19].

The information/orientation can reach women through socio-educational actions in collective spaces as groups that, besides promoting the acquisition of knowledge, serve as a stimulus for the production of forms of income generation. The group can become the place where women gain the strength to change reality[2].

The subcategory "Distance, restricted access to transportation and dependence on the partner" was considered by the participants as a factor that makes it difficult for women to reach the healthcare network, because the place where they live is far from the social and institutional support resources. Likewise, the police, justice and health services are also mentioned by participants as sectors which are difficult to access.

> *For the rural [woman], the difficulty is because it is far away; most houses are far [...], so it is more difficult to access. The difficulty I see is more of access [...] (P2UR4)*

> *[...] the difficulty of the rural woman would be mainly in relation to the distance of the great centers... consequently,*

the access of the woman to the public agencies that could give her assistance is more restricted, both because of her difficulty in getting to the big center [...] (P22UR2)

The means of transportation most used by the rural populations are the bus, the motorcycle, their own cars, trucks, carts and bicycles. The collective bus has scheduled time and day to make the urban-rural and rural-urban line, and the family travels by means of public transportation when they do not have their own car. The fact that the woman has to wait for the day and time of the bus can discourage her to seek the network services, because, most of the time, what leads her to look for the services is the severity of the physical injury and the feeling of anger that arises from the situation. After this condition, the man asks for forgiveness and the woman tends to believe that everything will change, the cycle repeats itself and the violence becomes naturalized for the woman and the family, and invisible to the services.

A study that has been carried out with managers and health professionals in this area reinforce the findings of this research, because they also found the issue of transportation, that is, the displacement of users to the network services are scarce and precarious, due to the geographic distance and the difficult accessibility, which often makes it impossible for women to look for support and she ends up in a situation of violence[2]

The dependence on public and/or private transportation, which is not always available, was another factor mentioned. When they refer to private transport, managers and professionals emphasize the dependence that women in rural areas have to move from one place to another, since the automobile is most often owned by the man and only he is enabled to use it.

[...]the dependence of leaving home, the question of locomotion, access to other means, depends exclusively on the man, of course, because it is he who drives, who has the car. So I see that the issue of the rural family is much more complicated because of this; access is more difficult than for women from the city. (P21UR6)

The frequency with which rural women in situation of violence look for support services can be reduced by the geographical issue, the difficulty of access to collective transportation and the dependence on the partner. Added to this are the actions of the aggressor, who most often restricts the social ties of the woman, since she confers domestic and exclusive obligations to the home as part of the conjugal dynamics and that she accepts them as her tasks without feeling that this keeps her under his control [17].

The social isolation experienced by rural women keeps man's control over her and it contributes to the naturalization and invisibility of violence[20]. This condition can be aggravated, as often relatives and friends are distant, and the nearest neighbor is very far. Women who have family support are less likely to suffer violence, reinforcing the importance of the social network in preventing violence[18]. Thus, it is highlighted that "solidary and trustful relationships can be decisive in the insertion of women in the service network, constituting themselves a link between the woman and the search for a type of assistance"[17:1301]. The support of community members and the call of a friend or neighbor can assist the woman in a successful solution to the problem. The lack of the socio-human network limits and hinders her access to the network of attention[17].

Women's access to the healthcare network can be initiated by the services of the primary healthcare network with the reception of the multidisciplinary team, and for that, a committed stance is required with these women[19]. The established link between the professional and the rural woman can generate the support that many women need to face in the socio-family situation that they live[2]. In this sense, nursing in its practice constitutes as an articulating element of the services with the objective of giving continuity to the care[19]. It should be noted that in the network of attention all sectors have this role of integrating with others, which is not a current reality.

The subcategory "(dis)attention of the professionals" and "(dis)articulation of the network" is related to the unpreparedness of the professionals that care for the women who look for the services. The participants of this study observe as limit the perception of some professionals based on the conception that the problem is not of public character, although they are part of these services. This notion is present in some sectors, as it is the case in the Security sector, and it compromises the service to women when they do not value their complaint, on the contrary, it is disqualified, devalued and it ends up exercising institutional violence.

[...]but the problem I see here for me is a lack of people, a police officer who is prepared to work [to serve women]. (P7UR6)

[...]for some professionals it [violence] is still not treated as a problem and a concern, sometimes it gets there and I think it is met with a bit of vulgarity, and it seems to me that it is there, at least in smaller cities [...] (P18UR3)

Studies which have been carried out in urban contexts show that women who suffer violence repeatedly look for health and police stations[4,9], which shows that it takes a long time to achieve a change in the lives of women in situations of violence[4]. It is also evident that the relationship between women and service workers is still tense regarding the implementation of practices that take into account gender inequalities and that have generated institutional violence against women and non-adherence to the services[17].

The results show agreement with a study which says that police workers are not committed to care and that they need training to address violence against women and understand it as a complex phenomenon[9]. The notion that violence is anchored in gender inequalities is not present in the practices of police workers, on the contrary, they reinforce inequities, justifying that women are responsible for the violence suffered by not behaving properly[17]. A study carried out in South Africa showed that some professionals from the police station presented an unfriendly, impersonal and indiscreet attitude in the reception, as well as a lack of referrals with essential documents that guarantee the rights and protection of women in situations of violence, such as the request for protection[11].

The limits of accessibility and access to the network of attention in dealing with violence, related to the preparation of the professionals found in this study, certainly contribute to the fact that the number of rural women in situation of violence remains low when compared to urban women. It is confirmed that the solution to the problem remains within the family and also that there is a lack of confidence in the network's services in order to provide effective support to women[9].

Rural women seek services elsewhere because these are often not available in the area in which they live[17]. When services are available in their regions, they also look for them in other places because they feel ashamed and afraid that the partner will know. The discrimination suffered by women in assuming the situation they have been facing is a deterrent for them to seek the support network. Confidentiality on the part of the professionals who work in the services is another condition that worries women, when receiving the visit of the social assistant or of a health professional in their houses without discretion can make the situation worse. As mulheres rurais preferem procurar o suporte fora da comunidade para evitar a exposição e diminuir os riscos de novas violências ao acessar o serviço[11].

Added to this discussion is the reflexive study developed in the United States that sought to discuss issues about intimate violence in rural areas and the work of the nurse practitioner. The authors mention that in many rural communities, it is common to believe that what happens between a man and his wife is a private matter, which makes it difficult for abused women to talk about violence. These beliefs and social and cultural norms can contribute to feelings of guilt and shame, which may hamper the search for healthcare[20].

Another element found in the findings of the study refers to the disarticulation of the network, in which the sectors have difficulty communicating, have their own distinct logics, and the axis of their organization often does not have at its center the policy and the health needs of the users as beaconing, acting in a disjointed way. These difficulties are possibly materialized by the inexistence of an effective service network and an integrated policy between the spheres of government.

> *You need a networking which involves other sectors, the difficulty, I think, is the engagement of all sectors regarding the importance of this and to make a teamwork [...] (P23UR1).*

> *[...]sometimes everything should work, but so domestic violence from the health agent, the PIM, we all, everything should work, the hospitalizations in the hospital that many times happens to hospitalize and we do not even know, functioning in a whole within the city that there is a few inhabitants would not be difficult, but it is not always how it works (P18UR3).*

It can be mentioned that the limitations of access and accessibility to the network of attention found in this study are often due to the lack of articulated local public policies that offer effective responses to women in these situations, so that many occurrences are still resolved based on goodwill, improvisation and case-by-case analysis. In addition, the fragility of networking and limited responses reduces the chances of a fast outcome, ensuring the safety and preservation of the rights of rural women.

In order to confront violence, it is necessary to adopt a dynamic of institutional work that favors intersectional articulation, favoring adequate intra and intersectional communication. Therefore, professionals are required to be knowledgeable about other services, their skills and the role of the network in coping with violence[7]. Thus, it is considered that it is possible to articulate sectors with an effective potential for intervention, albeit small and isolated[2]. The nurse in the healthcare attention to woman in a situation of violence can have the role of articulator of the attention network, because when welcoming the woman

and identifying their demands, the importance/need of the other sectors for the care sequence is recognized [19].

FINAL CONSIDERATIONS

This study shows the (mis)information, distance, restricted access to transportation, dependence on the partner, the (dis)attention of the professionals and the (dis) articulation of the network as limits of access and accessibility of rural women to the network of attention and confronting the violence. Historically, the inequality of supply and the geographical accessibility of actions directed to rural communities prevail, that is, the constitution of the services is located in urban areas and these are selective to respond to a certain demand.

It is also observed that social constructions of gender are strongly present in families in rural areas, especially the hegemonic conception of male power that keeps women in an environment of submission and lack of social, cultural, economic and political autonomy, being isolated from socio-institutional support.

The obstacles experienced by rural women in situations of violence arising from this patriarchal, classist and sexist social conception can discourage the search for network services. Therefore, thinking about ways to bring services closer together and to qualify them for a trustworthy, welcoming practice may be an alternative that will help women to feel more secure in accessing the supporting services. Besides that, it is believed that considering this perspective may qualify the care practices targeted at these women. Regarding the nursing professionals in particular, it is considered that all of them have the potential to develop a truly welcoming attitude and also the ability to promote the articulation of the different actors and sectors that make up the network.

Thus, the construction of networks of attention to combat violence against women in rural contexts presents itself as a challenging strategy and requires extrapolating and displacing individual actions from professionals to users, creating possibilities to increase the participation of individuals in the implementation of solutions. It is necessary to recognize this scenario as a unique space, in which the epidemiological, social, cultural, organizational characteristics are specific, and also promote the articulation of different disciplinary perspectives so that one can work with generalized practices.

The limitations of the study are related to the regional character of the study, which may not represent generalizations of the findings. It is proposed to carry out new studies in other rural realities, in order to assess the access and accessibility to the network of attention to confront situations of violence in these places, considering the complexity of this problem.

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