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REVIEW ARTICLE

Sexual and reproductive health of women living in the rural context: an integrative review

Saúde sexual e reprodutiva de mulheres que vivem no contexto rural: revisão integrativa

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ABSTRACT

Objective: To identify in the literature aspects related to the sexual and reproductive health of women living in the rural context. **Method:** Integrative review composed of studies in Portuguese, English or Spanish from the last seven years (2015 to 2021) in LILACS, MEDLINE and SCOPUS databases. The final sample comprised eight articles. **Results:** Geographic and economic barriers related to accessibility in health services were identified, in addition to gender inequality that makes domestic violence prevalent, affecting the sexual and reproductive health of these women. **Conclusions:** Barriers to access and accessibility make it difficult or prevent women from exercising their right to health, restricting actions to prevent and promote sexual and reproductive health. Domestic violence is based on gender inequality and sociocultural factors. Nursing has the potential to act effectively in promoting the health of these women in Primary Health Care.

Descriptors: Women's Health; Sexual Health; Reproductive Health; Rural Population; Primary Health Care.

RESUMO

Objetivo: identificar na literatura aspectos relacionados à saúde sexual e reprodutiva das mulheres que vivem no contexto rural. **Método:** Revisão integrativa, composta por estudos de 2015 a 2021, nas bases LILACS, MEDLINE e SCOPUS, incluindo publicações em português, inglês ou espanhol, com recorte temporal dos últimos sete anos, obtendo-se como amostra oito artigos. **Resultados:** foram identificadas barreiras geográficas e econômicas relacionadas à acessibilidade nos serviços de saúde, além da desigualdade de gênero que torna a violência doméstica prevalente repercutindo na saúde sexual e reprodutiva destas mulheres. **Conclusões:** as barreiras de acesso e de acessibilidade dificultam ou impedem as mulheres de usufruírem do direito à saúde restringindo as ações de prevenção e promoção da saúde sexual e reprodutiva. A violência doméstica se sustenta na desigualdade de gênero e nos fatores socioculturais. A enfermagem tem potencial para atuar efetivamente na promoção da saúde dessas mulheres na Atenção Primária à Saúde.

Descritores: Saúde da Mulher; Saúde Sexual; Saúde Reprodutiva; População Rural; Atenção Primária à Saúde.

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INTRODUCTION

The World Health Organization (WHO) highlights equity as a key issue in the government of health services so that regardless of social, economic, demographic and geographic issues, all people have access to health services[1].

In rural areas, the access to health services is difficult, the quality of these services is lower compared to urban areas and socioeconomic conditions are unfavorable, showing that equity is not yet a reality in this context[2]. The rural population has a lower life expectancy than the urban population, higher rates of chronic diseases, cancers and birth rates, in addition to the scarcity of health services and health prevention and promotion activities[3].

In Brazil, the rural reality is the result of its economic, political and cultural history based on the concentration of land, wealth, the use of natural resources, slavery, the extermination of indigenous peoples and the marginalization of peasant families and women[4].

In 2011, Ordinance No. 2.866 was approved, establishing the National Policy for the Comprehensive Health of Rural and Forest Populations (PNSIPCF) within the scope of the Unified Health System (SUS). The rural context is composed of the rural population, where rural women are inserted. Such a population is characterized as people who have their ways of life, production and social reproduction predominantly related to the land, such as peasants, family farmers, salaried and temporary rural workers who reside or not in the countryside[4].

The PNSIPCF was launched in 2013, having as one of its objectives the encouragement of research and the production of knowledge about the risks, quality of life and health of rural and forest populations, respecting the specificities of generation, race/color, gender, ethnicity and sexual orientation[4].

In 2004, the National Policy for Comprehensive Care to Women's Health expanded the discussion of women's health in the sexual and reproductive health dimension beyond maternal and child health, incorporating the issue of gender, integrality and health promotion as guidance in its principles and guidelines. The policy highlights the improvement of obstetric care, family planning, care for unsafe abortion and the fight against domestic and sexual violence, signaling progress in relation to the theme[5].

Women in the rural context are often deprived of autonomy and the right to decide, including over their own body[5]. Difficulties in relation to reproductive planning, the impediment of health care linked to sexual and reproductive health, repression in relation to the expression of sexuality and domestic violence are some nuances of how gender inequality influences the sexual and reproductive health of these women[6].

Faced with this uniqueness, there is a need to improve access to quality health actions and services, seeking to meet the peculiarities of this population, considering the diversity of rural women with their production and social reproduction processes, respecting their beliefs, values and specificities[4].

The work of Primary Health Care (PHC) professionals in rural regions must consider the cultural, social and economic formation of this population, and the work of primary care professionals is essential for the promotion and protection of women's health in rural areas[7].

Discussions on issues of sexual and reproductive rights are recent, with little more than two decades. The international frameworks that defined these issues were built from Conferences promoted by the United Nations, namely the International Conference on Population and Development (ICPD), held in Cairo in 1994; and the IV World Conference on Women, held in Beijing in 1995[8].

Difficult access to health services and worse rates of prevention, diagnosis and treatment aimed at women's sexual and reproductive health in the rural context are realities present in Brazil and other Latin American countries[9].

Therefore, the aim of this article is to systematize the knowledge produced in relation to the sexual and reproductive health of women living in the rural context.

METHOD

This is an integrative literature review that will allow the synthesis and analysis of studies conducted using quantitative and qualitative methods, observing the approach to the topic in research and identifying gaps in the theme[7].

The performance of the review was based on the following methodological steps: guiding question, inclusion and exclusion criteria, data collection and article selection criteria, analysis, grouping of evidence by similarity, discussion and interpretation of results[10].

The research question was defined in accordance with the PICo strategy, in which P corresponded to participants (women), I is the phenomenon of interest (sexual and reproductive health), and Co represents the context of the study (rural)[11]: What is the scientific production on women in the rural context related to sexual and reproductive health?

The data collection period was September 2020. The review was updated in December 2021, since some of the studies found did not directly address the theme proposed in the title. The search was performed in the Latin American and Caribbean Health Sciences Literature (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE) and SciVerse Scopus (SCOPUS) databases.

The inclusion criteria were articles in English, Portuguese or Spanish with a time frame of the last seven years, from 2014 to 2021. Articles addressing urban and rural data without distinction, articles with a neonatal bias and those that did not address the proposed theme in the title were excluded.

The descriptors used can be found in the Health Sciences Descriptor Database (Women's health; Rural population; Rural population health; Sexual health; Reproductive health) and in the Medical Subject Headings (Women's health; rural population; rural health; Sexual health; Reproductive health).

The Boolean operators "AND" and "OR" were used in the operationalization of the search. Initially, the descriptors were combined with each other using the Boolean operator AND; first in pairs, seeking to associate the Women's health descriptor with the others.

When the three descriptors were associated: "women's health", "rural population" and "sexual and reproductive health" or "women's health", "rural population health" and "sexual and reproductive health", the search results were null. Only the strategy of crossing the four descriptors, "women's health" AND "rural population" OR "rural population health" AND "sexual and reproductive health" showed results.

The search strategies of the studies were performed by the two researchers with the aim to standardize the sequence of descriptors and crossings, and then, performed separately. The search results were reviewed and compared by both to identify possible disagreements.

Chart 1 illustrates the synthesis of searches performed in databases and the results found.

In the selection stage, the titles of the 639 publications found were read, excluding 300 that did not address the study theme in the titles. Of the 339 articles selected, 23 were duplicates and 279 were not available in full. The abstracts of the 37 remaining articles were read and 29 were excluded because they did not attend inclusion criterions. Therefore, eight articles remained to compose the study sample (Figure 1).

Data were organized from the selected articles based on a validated and adapted instrument including information about the authors, objective, methodological characteristics and main results of the study[13].

The following classification was considered for the level of evidence[14]: level I-Evidence from a systematic review or meta-analysis of all relevant randomized controlled clinical trials or from clinical guidelines based on systematic reviews of randomized controlled clinical trials; level II-Evidence from at least one well-designed randomized controlled clinical trial; level III-Evidence from well-designed clinical trials without randomization; level IV-Evidence from well-designed cohort and case-control studies; level V-Evidence from a systematic review of descriptive and qualitative studies; level VI-Evidence from a single descriptive or qualitative study; level VII-Evidence from the opinion of authorities and/or expert committee reports.

A bibliometric analysis was performed; articles were identified by title, authors, professional category, country, year of publication and language, study context, type of publication, objective, sample, techniques and instruments, steps of data collection, data analysis, main results, implications and level of evidence.

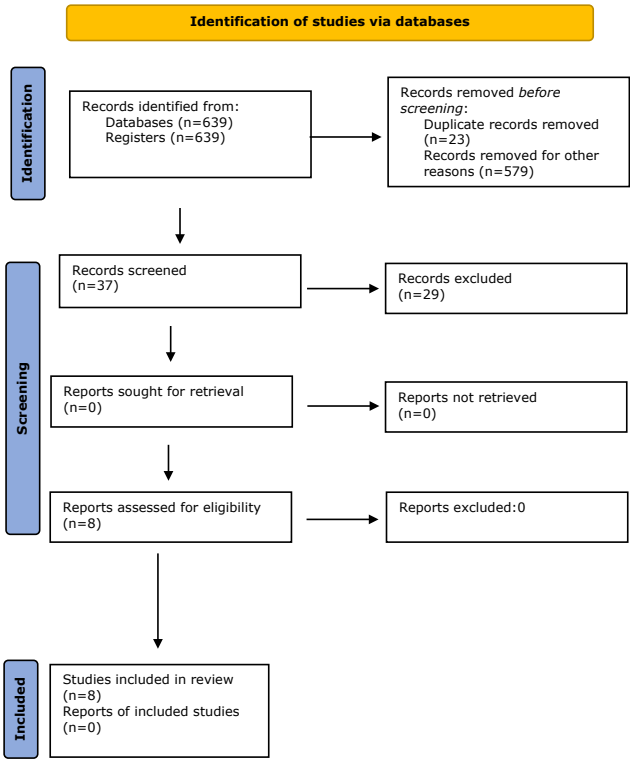
Subsequently, a qualitative analysis was performed focusing on the content of articles, with the objective of categorizing the information inherent to the sexual and

Chart 1. Search strategies used and the respective databases, 2020

Database	Search syntax	Result
LILACS	saúde da mulher [Descritor de assunto] AND saúde da população rural [Descritor de assunto]	2
	saúde da mulher [Descritor de assunto] AND população rural [Descritor de assunto]	7
	saúde da mulher [Descritor de assunto] AND população rural OR saúde da população rural [Descritor de assunto] AND saúde sexual AND saúde reprodutiva [Descritor de assunto]	null
MEDLINE/ PubMed	"women's health" [MeSH Terms] AND "rural health" [MeSH Terms] AND ("2015/10/09"[PDat]: "2020/10/06"[PDat])	13
	"women's health" [MeSH Terms] AND "rural population" [MeSH Terms] AND ("2015/10/09"[PDat]: "2020/10/06"[PDat])	97
	("women's health" [MeSH Terms] AND "rural population" [MeSH Terms]) OR "rural health" [MeSH Terms]) AND ("sexual behavior" [MeSH Terms] AND "reproductive health" [MeSH Terms])	3
SCOPUS	TITLE-ABS-KEY ("women's health" AND "Rural health") AND PUBYEAR>2014 AND (LIMITTO (PUBYEAR, *2020*) OR LIMIT - TO (PUBYEAR, *2019*) OR LIMIT	120
	TITLE-ABS-KEY ("women's health" AND "rural population") AND PUBYEAR>*2014* AND (LIMIT-TO (PUBYEAR, *2020*) OR LIMIT-TO (PUBYEAR, *2019*) OR LIMIT	380
	TITLE-ABS-KEY ("women's health" AND "rural population" OR "rural health" AND "sexual health" AND "reproductive health")	17

Source: Prepared by the authors.

Figure 1. Selection process of publications, articles involving sexual health and reproductive health of women living in the rural context, 2020



Source: Adapted from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses - PRISMA protocol (2020)[12].

reproductive health of women living in the rural context, identifying their specificities.

In the last methodological step, the results were discussed and interpreted based on references of the Ministry of Health, such as the National Policy for the Comprehensive Health of Rural and Forest Populations, National Policy for Comprehensive Care to Women's Health: Principles and guidelines. Sexual Health and Reproductive Health, represented 27%[4-5,8] of the total number of studies and studies in the area of women's health, represented 63%[15-22].

RESULTS

Of the eight articles selected, five (62.5%)[15-19] were found in Scopus; one (12.5%) in Medline/PubMed[20]; and two (25%) in Lilacs[21-22]. Four (50%) of the productions are published in international journals[18-21] and the other four (50%) in national journals[15-17,22].

As for the design of studies, two are descriptive[15,22], one is observational[17], two case studies[17,21], one cohort[19], one longitudinal[21] and one with the application of interpretive phenomenology[18].

All studies are original; 75% (*f*=6)[15-18,21-22] are qualitative and 25% (*f*=2) quantitative[19-20]. Regarding level of evidence, the level VI[15-18,21-22] prevailed, accounting for 75% (*f*=6) of articles, followed by 25% (f =2) with level of evidence IV[19-20].

The studies were published between 2015 and 2019. In relation to language, 37.5% are in English[18-20], 12.5% in Spanish[21] and 50% in Portuguese[15-17,22]. Among the population studied, four were in Brazil[15-17,22]; one in Argentina[21]; one in Africa[18]; one in India[19]; and one in Australia[20].

Regarding the professional area of the main author, according to information contained in the article, in four it was nursing[15,17,21-22], in two psychology[16,20], in one physiotherapy[17] and in one medicine[19].

Regarding the sample of studies, in three, participants were health professionals, such as nurses and community health workers[17,21-22]; while a study was conducted with professionals working in the support network to face violence against rural women[15]. In the other studies, participants were women living in the rural context[16,18-20].

All articles corroborated the issue of geographic barriers and economic aspects as aggravating factors to the access to health services of women living in the rural context. The articles addressed topics such as the prevalence of domestic violence in the rural context[15,20,22]; restricted access to health prevention and promotion measures in the aspect of sexual health and reproductive health[17,21]; difficulty in accessing water and basic sanitation that increases the possibility of infection of the reproductive system[19]; contraception as a possibility for empowering rural women[20]; and the prevalence of depressive symptoms in women living in the rural context[16].

After reading and organizing the information from selected studies, the synthesis of articles was performed (Chart 2) and two thematic axes were identified: Access and accessibility that hinder the actions of prevention and promotion of sexual and reproductive health; and Domestic Violence supported by gender inequality and sociocultural factors.

DISCUSSION

The scientific productions included in this integrative review addressed issues such as women's difficulty of access and accessibility to health services and domestic violence sustained by the gender inequality prevalent in this context. These two aspects signal a broader discussion of sexual and reproductive health beyond maternal and child health.

Most studies (75%) were qualitative[15-18,21-22], revealing that the complex situations experienced by women in the rural context require an investigation aimed at the universe of meanings, motives, aspirations, attitudes , beliefs and values, which are important for the description and understanding of situations, and for interpretations made by people about their experiences and their way of feeling and thinking[23].

Chart 2. Synthesis of articles on the sexual and reproductive health of women living in rural areas, 2021

Authors/ journal/year/ database	Objective	Method/level of evidence	Singularities of women living in the rural context that influence sexual and reproductive health	Contributions of studies to the sexual and reproductive health of women in the rural context
Landini et al.[21] 2015 *Saúde e Sociedade (USP)* LILACS	To identify, describe and analyze the geographic, economic and administrative barriers that limit access to the health service, specifically maternal health, in three rural locations in northern Argentina.	Case study; interviews with 15 health professionals. Level of evidence–VI	In the rural context, administrative and economic barriers are added to geographic barriers, making pregnant women's access to health services difficult. The presence of support units in these areas is an aspect that facilitates accessibility.	The need to invest in public policies that take into account the specificity of rural women to generate consistent strategies. The incorporation of the rural origin of women who die from maternal causes into the statistics would be appropriate for the assessment of its incidence.
Dillon et al.[20] 2016 *Plos One* MEDLINE	To investigate the role of rurality in the association between exposure to intimate partner violence (IPV) and self-reported health in a group of community-dwelling Australian women.	Longitudinal study that evaluated the lifestyle and demographic factors of Australian women living in rural areas. Level of evidence–IV	Women living in rural settings had slightly better levels of mental health compared to women living in metropolitan areas. This may be associated with rural women's perceptions of wellbeing and resilience in relation to IPV.	Women who experience domestic violence have lower educational level, low social support and income deprivation. Long-term benefits could be gained by investing in interventions that allow women to become financially independent and improve their employment prospects.
Costa et al.[15] *Revista Gaúcha de Enfermagem* 2017 Scopus	To analyze access and accessibility to the care network by women in situations of violence living in rural contexts based on speeches of professionals.	Descriptive study developed from interviews with 26 professionals working in the support network to face violence against rural women. Level of evidence–VI	(Mis)information; distance from health services; (lack of) attention from professionals and uncoordinated network.	Thinking of ways to bring services closer and qualify them for user embracement and a reliable practice. Construction of care networks to cope with violence against women in the rural setting, recognizing this scenario as a unique space with specific characteristics.
Parreira et al.[16] *Acta Paulista de Enfermagem* 2017 Scopus	To identify the symptoms of depression and the influence of sociodemographic, economic, behavioral and reproductive health variables on the score of depression symptoms in women of childbearing age living in the rural area of the city of Uberaba-MG.	Observational study of 280 women living in the rural context. Level of evidence–VI	Conflicting relationship with the partner and the number of children were also aggravating factors for symptoms of depression.	In addition to a bad relationship with the partner and the number of children, sociodemographic, economic, behavioral and reproductive health factors can influence the mental health of rural women.

Continue...

Chart 2. Continuation

Authors/ journal/year/ database	Objective	Method/level of evidence	Singularities of women living in the rural context that influence sexual and reproductive health	Contributions of studies to the sexual and reproductive health of women in the rural context
Baker et al.[19] 2017 *Plos One* Scopus	To assess if hygiene practices and access to water and basic sanitation were associated with self-reported symptoms of reproductive system infection in girls and women in rural India, and if these associations varied across socially defined reproductive life stages.	Cohort study; 4,020 women were surveyed. Level of evidence–IV	Rural areas have more precarious infrastructure, and access to water and basic sanitation is often limited, making adequate body hygiene difficult and affecting women's health, especially with regard to reproductive system infections.	Improvements in safe access to water and basic sanitation could have far-reaching implications for other reproductive diseases and reduce the burden of treating gynecological infections in rural women.
Alano e Hanson[18] 2018 *Plos One* Scopus	To understand perceptions about the use of female contraceptives and the consequent benefits for women's empowerment.	Phenomenological study conducted through focus groups with 82 women of reproductive age and 18 in-depth interviews. Level of evidence–VI	Women in rural areas face difficulties in decision-making capacity and postponing unwanted pregnancy is a form of emancipation.	Contraception empowers women in four fundamental ways, encompassing economic, autonomy, mobility and relationship effects.
Arboit et al.[22] 2018 *Saúde e Sociedade (USP)* LILACS	To know the care practices developed by community health workers in the care of women in situations of domestic violence living in rural areas.	Descriptive study performed through focus groups and interviews with 13 community health workers working in rural areas. Level of evidence–VI	The difficulties in accessing health services and other sectors imposed on women living in rural areas still represent a major challenge. Community health workers have numerous strengths to act in dealing with situations of domestic violence against women.	Community health workers need multidisciplinary and intersectoral support to meet the demands of rural women in situations of violence. The results show the need to create spaces of reflection for professionals from different areas and managers about their daily care practices in relation to the problem under study, so that they (re)constitute or (re)signify such practices.
Fernandes et al.[17] *Cadernos de Saúde Pública* 2019 Scopus	To evaluate access to uterine cancer cytology in the Family Health Strategy in municipalities in a health region in the state of Bahia.	Case study developed from 10 focus groups with 70 nurses and community health agents working in rural areas. Level of evidence–VI	Difficulty in accessing health services; search for cytopathology from a symptom complaint; submission to the partner, sexism. Positive point in relation to the option for the professional nurse to perform the cytopathological examination.	Need to adapt the response of services to the specificity of the rural context and expand investments in the Family Health Strategy in the face of weaknesses in infrastructure and availability of inputs.

Source: Prepared by the authors.

All studies were developed by health professionals; the highest concentration was in nursing[15,17,21-22], followed by psychology[16,20]. This result reveals nursing is a fertile ground for investigations and actions, providing the expansion and qualification of care for women in the rural context, contemplating cultural, social and economic aspects that require an interdisciplinary approach.

Half of studies in this review were conducted in Brazil and it is noteworthy that according to the last census by the Brazilian Institute of Geography and Statistics (IBGE) in 2010, the distribution of the rural population by household situation is 30 million and represents 15.3% of the Brazilian population[24]. Researchers have turned their eyes to the most vulnerable populations, in which social and economic inequalities are a way of identifying and understanding the obstacles that hinder the population's universal access to health services and seeking solutions to such obstacles.

Thus, for a deeper analysis of contents of articles related to the sexual and reproductive health of women living in rural contexts, we will discuss the two thematic axes identified: Access and accessibility that hinder the actions of prevention and promotion of sexual and reproductive health; and Domestic violence supported by gender inequality and sociocultural factors.

Access and accessibility to sexual and reproductive health: geographic, economic and sociocultural barriers

Five studies pointing the different types of organizational barriers to access and accessibility to sexual and reproductive health services were part of this topic: two conducted in Brazil discuss the deficiency in reproductive planning as a risk factor for symptoms of depression[16] and the limited offer of collection of cytopathological examination in rural areas[17]; a study from Ethiopia highlighted the importance of having access to contraception care as an empowerment factor[18]; one from India discussed the lack of access to water and basic sanitation as risk factors for infections of the reproductive system[19]; and a study from Argentina related geographic, economic and bureaucratic barriers with negative pregnancy outcomes[22].

Accessibility comprises the relationship between the location of the offer of health actions and users that can be hampered by the distance between them (geographical barriers), trafficability of roads, form and cost of travel, availability of public and/or private transport[15,17,21,23,25-26]. With restricted accessibility, it is not possible to have efficient and effective access, since access refers to the provision of resolute services[15].

Access to the health service is not restricted to the user's entry into the services, but includes the problem-solving capacity of this service, which is achieved through user embracement and the creation of a bond between health professionals and users. In case of women living in the rural context, in addition to the barriers identified above, there are social barriers related to sociocultural issues and low educational level, aspects that must be considered during user embracement[17].

Access and accessibility to health services constitute the pillars of Primary Health Care (PHC) and should be one of the main priorities of public health policies. In the rural context, the findings of this review have demonstrated that the distance between women and health services, associated with the financial capacity needed to reach these services and bureaucratic obstacles limit and sometimes make accessibility impossible[21].

Regarding accessibility, a study reveals that the presence of support posts with trained professionals established in rural areas reduces the impact of geographic, financial and administrative barriers in this context[21].

The consequences of geographic, financial and administrative barriers are the higher incidence of health problems sensitive to primary care, diseases that can and should be prevented and treated at this level of care[21].

This service has strategies of extreme importance in the area of women's health, such as antenatal care, gynecological consultation with collection of Pap smears, sexual and reproductive rights groups and reproductive planning. Difficulty in accessing these services leads to worse rates of cervical cancer and compromised maternal and child health, in addition to unwanted pregnancies[17,21].

The collection of Pap smears is an efficient method for preventing and reducing cases of uterine cancer when performed properly in harmonious coordination within health services, providing timely follow-up to women[17]. However, one of the studies reveals that women living in a rural context face some barriers to access this exam due to lack of human resources and poor infrastructure. The small number of days and times for the cytopathological examination and the need for nurses' extensive travels in unfavorable conditions are some of the factors showing these barriers[18].

Part of women living in the rural context revealed that they seek the cytopathological examination based on a symptom complaint[18], showing the lack of knowledge about the need and purpose of the examination. The low demand for this procedure is also influenced by personal and social values, such as submission to the partner, sexism, taboos, stigma and the professional's sex[17].

The irregular provision of inputs and inadequate infrastructure for collection is also a reality in this scenario, which impacts on women's adherence to screening, since this affects availability, accessibility and acceptability[17].

Once again, the central role of nursing in carrying out the cytopathological examination of women living in the rural

context was identified as an important quality marker in the organization of screening. Women showed a predilection for nursing consultations, highlighting qualified listening with greater adherence and satisfaction of users in performing cervical cancer screening, in contrast to the medical clinic, perceived as centered on the procedure and with a fragile bond with the community[17].

In one of the studies, the issue of access to contraception as a form of empowerment is addressed in the discussion. In this study, women living in rural areas report the benefits of contraceptive use such as economic and educational empowerment, and effects on autonomy, mobility and relationships. The use of contraceptives was evaluated as emancipatory and transformative for their lives[18].

Women's psychosocial health is affected when they do not have control over their sexuality and fertility. According studies, the number of children is one of the factors that lead women living in rural areas to present symptoms of depression. Therefore, the use of contraceptive methods creates opportunities for women to get involved in other aspects of life outside the merely reproductive dimensions, reducing the chances of depressive symptoms[16,18].

Therefore, creating strategies for guidance on reproductive planning and access to contraceptives is essential to avoid unwanted pregnancies and empower these women, bringing better prospects and quality of life. In addition, having safe sex without being linked to conception is part of the concept of sexual and reproductive health, that is, contraception is a right of women and men[7,27].

At this point, the need to expand this discussion regarding contraception is highlighted, given the sexist and authoritarian culture we live in, especially in the rural context where responsibility for fertility control is imposed on women[28-29].

A study reveals that women living in rural contexts use dual protection less, almost twice as less, compared to the national prevalence and to women in urban areas[30]. In the meantime, PHC has a fundamental role in promoting sexual and reproductive health and expanding this discussion[7].

Another unique aspect of rural areas is the reduced access to water and sanitation, which influences the increase in infections of the reproductive system, since the lack of access to a toilet and water supply lead to unhygienic practices that can promote infection by pathogens or imbalance of the vaginal microbiota[19].

Chronic psychosocial stressors arising from discrimination and poverty to which these women are exposed have been related to vaginosis associated with low access to water and basic sanitation, which make hygiene habits difficult and increase the risk of infections in the reproductive system. Reducing these types of diseases can prevent the occurrence of other reproductive problems, including pelvic inflammatory disease, infertility, sexually transmitted diseases, ectopic pregnancy, miscarriage, premature birth and low birth weight newborns[19].

Thus, the necessary interventions in this field go beyond biological issues, as they encompass sociocultural and environmental aspects, hence the importance of expanding these discussions in an interdisciplinary way.

The expanded understanding of health beyond the eyes of physicians and health teams was a consensus at the Alma Ata International Conference on Primary Health Care. Although medical interventions are understood as necessary, they are insufficient to improve the health of populations and individuals, especially the most vulnerable populations such as women in the rural context[31].

Thus, it is necessary to work in an integrated manner with intersectoral policies to be able to meet the demand of this population. Moreover, vulnerabilities have to be reduced through comprehensive actions for women's health by considering sexual and reproductive health, as well as sexual and domestic violence[3].

Health services must be organized in relation to the provision of professionals, infrastructure, and optimization of inputs for the implementation of practices in the area of women's health, especially in rural contexts, expanding investment in PHC.

In this topic, we aggregate studies from several countries such as Brazil[31], Argentina[32], India and Ethiopia. India and Ethiopia work with Community Agents programs, while Brazil has created Family Health Teams composed of a physician, a nurse, a nursing technician and four to six community health workers[31]. The health service in Argentina is known for its segmentation, fragmentation, low efficiency and equity[32].

The Brazilian experience of PHC configured in the Family Health Strategy, a structuring and inseparable part of the constitution of our national health service, the SUS, with its 41,000 multidisciplinary teams assisting 130 million Brazilians, is a worldwide example of a universal health service[28].

Domestic violence in the rural context: unequal gender relations and sociocultural factors

This component was organized around issues of unequal gender relations and sociocultural factors that intensify domestic violence in the rural context.

Scientific evidence points to the prevalence of domestic violence in the rural context. One of the roots of this problem lies in unequal gender relations strongly influenced by a patriarchal organization that makes women submissive to men[15].

In the rural context, the lives of most women involve taking care of the house, children, food, hygiene and helping their partners in their field activities. They are not

inserted in the job market, do not have an income, depend financially on the partner who has control of the work and is responsible for the organization and administration of family and financial production[15,20].

In one of the studies that is part of this topic, women who experience situations of domestic violence report the harmful effects of this violence in relation to mental health, especially depression, and to physical health, such as gynecological problems, musculoskeletal injuries, chronic pain and skin problems[15,20].

The study that addresses symptoms of depression in rural women found that having a bad relationship with the partner is the main factor for the onset of depressive symptoms, and this fact can be aggravated by social, economic and behavioral difficulties[15].

The difficulty of these women leaving the circle of violence is often related to their educational level; the lower the educational level the worse the health status of women who suffer violence. Low education increases the level of income deprivation causing greater dependence of these woman on their partner[20].

Another obstacle identified concerns the cultural issue. From this point of view, the solution must be restricted to the family and private sphere, and women who admit suffering violence are often targets of discrimination, and these factors prevent them from seeking the care and support network[15].

In the study that investigated the role of rurality in the association between domestic violence and women's self-reported health, slightly higher levels of mental health were found in comparison to women living in urban areas. In this study, was identified that concepts of wellbeing, resilience and coping with domestic violence suffer influence of the patriarchal culture in which these women are inserted, leading to the naturalization of this abusive relationship[20].

In addition to unequal gender relations and sociocultural factors, the distance between rural areas and urban centers makes access to information difficult and intensifies the isolation of women living in this context. It is necessary to think of ways to bring services closer and qualify them so these women feel safer in relation to the access and support of health services[15].

Thus, sociocultural factors, difficulty in accessing education, financial dependence on the partner, work overload, abusive use of alcohol, the number of children, as well as geographic, economic and administrative barriers were situations identified as prevalent in the rural context that interfere in women's sexual and reproductive health[15-17,20-22].

Recognizing the rural setting as a space with its own characteristics is a starting point for building care networks to cope with violence against women, and an interdisciplinary articulation is crucial to address this complex issue involving several social and economic factors[15].

In Brazil, the National Policy for Comprehensive Care to Women's Health and the National Policy for the Comprehensive Health of Rural and Forest Populations address the issue of combating domestic and sexual violence against rural women, and aim to contribute to reduce the health vulnerabilities of the rural population by developing comprehensive actions aimed at women's health considering their sexual and reproductive health, as well as sexual and domestic violence[3,7].

The care practices of community health agents have potential to help in coping with these situations of violence, as they play an important role, especially in relation to guidance and support in teamwork[22].

However, these professionals report limitations, mainly related to the lack of specific training to deal with the issue of violence against women, which is a complex problem and requires multidisciplinary and intersectoral support[22].

Studies reveal that women demonstrate trusting community health agents and nurses to report violence. Therefore, training and investing in these professionals seems to be a way to promote resolute services and overcome the barriers to access health services faced by rural women[15,17,21].

In addition, the role of nursing in promoting the sexual and reproductive health of these women has the potential to significantly contribute to the quality of life of this population, since nursing is responsible for developing educational activities, nursing consultations and other primary care actions such as antenatal and family planning services[7].

CONCLUSION

Barriers of access and accessibility were identified so that women living in rural contexts can exercise their right to health. In addition, domestic violence in this context is reinforced by unequal gender relations and sociocultural factors.

Primary health care and, in particular, the Family Health Strategy are essential for overcoming such barriers and putting into effect the principles of universality, integrality and equity, in addition to the central and potential transformative role of nursing in promoting the sexual and reproductive health of women in the rural context.

Limitations of the study are related to the time frame (2014 to 2021), the significant number of articles unavailable as open access and the non-inclusion of articles in languages other than Portuguese, English and Spanish.

The development of studies in this area is necessary to qualify the care to women living in the rural context and to consolidate the actions foreseen in public policies directed to this population. In Brazil, research can help to propose strategies that contribute to a better coordination between sectors of the National Health Service, given that integrality, equity and accessibility constitute its principles.

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