~~Norway, with health and criminal justice professionals in each country). We focused on their perceptions of existing workflows between identifying cases of violence and dealing with these cases and analyzed the transcribed interviews using a focused open coding process. We assigned codes to statements through a line-by-line, cross-interview analysis of the raw data. Results: The participants ranged in age from 32 to 59. All of them work with domestic violence victims both with and without supervision. According to the opinions of some participants, violence against women is a historical problem rooted in: a society that accepts the superiority of men and imposes a submissive role for women; the subordination of women; and the domination of men over decision-making and women's lives. This problem is aggravated by women's social, cultural, and economic dependence. Some respondents recognized and linked patriarchy to violence against women, while others seemed unaware of the concept. Both countries have regulations to provide professionals with guidance on navigating services related to domestic violence cases; and their governments try to give professionals some rules to follow when helping domestic violence victims. For many reasons, professionals do not always follow these regulations, but the situation is more complicated in Brazil, where service providers face several challenges in comparison to the circumstances in Norway. Conclusion: Personal beliefs and observed norms concerning the acceptability of domestic violence are critical risk factors for women. Individual characteristics, family, the environment, and even one's professional profile can affect the way health or criminal justice workers perceive and deal with domestic violence cases.~~

Poster 8 - Community Health Workers feelings on Digital Health, Presenter: Renata David (Brazil)

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Abstract: Background: Brazil has a large Primary Health Care (PHC), with Family Health Teams (FHT) strategy, a complex governance and financial schemes attempting to integrate three different levels: local, state and federal. PHC in Brazil is delivery mostly at Primary Care Center (PCC), facilities that harbor the Family Health Teams (FHT). The FHT is composed by at least one physician, one nurse practitioner, two auxiliary nurses and four community health workers (ACS), hired as municipal civil servants. The FHT aim is to deliver the comprehensive PHC, delivering prevention, treatment, care and health promotion actions, but the range of services varies a lot. This general model has been subsided by Ministry of Health (MoH) for 25 years, promoting some uniformity and national coverage. The model is successful, playing a hole in reducing child and mother deaths, reducing unneeded hospitalizations and improving overall health. In 2018 MoH announced US$4 billion investment in informatization of PCC. But two question remains: are CHW ready for change? And is the change the way it should be, considering CHW daily challenges? Objective: to leverage qualitative data to support the digital transformation of the work of the Community Health Agents (ACS). Methods: In order to support change, Oswaldo Cruz Foundation launched the mobile ACS initiative, offering a web-based platform where FHT, managers and tech providers can safely share data and experiences on digital transformation of PHC. Fiocruz Brasilia is responsible for qualitative studies. The research uses field visits and in-depth interviews to address whether the digital solution apply to their realities or if they will be an additional paperwork on digital media. Results: There are several initiatives in Brazil that claims offering flexible technological solution focused on the work of the Community Health Agents (ACS). These claims include the incorporation of mobile technologies and its application to enhance the analysis and use of the data to plan, direct, and support health interventions in individual and community levels. Visits so far indicate that digital solution will only be well received if user experience is adequate, jumping dull questions and providing meaningful, geospatial and epidemiological smart alerts and feedback. Conclusions: digital health efforts needs to be based on qualy evidence.