Commentary

Authors' Commentary: Domestic Violence Against Women, Public Policies and Community Health Workers in Brazilian Primary Health Care

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Abstract

In this commentary paper, we highlight the key role that community health workers and family health professionals can perform for the identification and care for women experiencing domestic violence in communities. These workers are part of the primary health-care strategy in the Brazilian public health system, who are available in every municipalities and neighborhoods of the country. Based on our ethnographic research, we argue that identification and care of abused women by these workers and professionals follow a pattern which we described and named "the Chinese whispers model." We also point gaps in training these workers to deal with complex issues, such as domestic violence, arguing for the need of formal qualification for both community health workers and family health professionals by, for example, incorporating such themes into curricula, further education, and continuing professional development.

Keywords

violence against women, primary health care, Brazil, community health workers, public policies

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Community health workers can play a significant role linking women experiencing domestic violence (DV) with health-care professionals and the public health-care system (Brazilian Unified Health System – SUS) in Brazil, as we have previously discussed.[1] There may be a possibility also for other scenarios in other countries, but some important aspects need to be considered with some additional potentials and challenges.

We observed a pattern through our ethnographic study with Family Health Strategy teams from the Brazilian primary health care that we named "the Chinese whispers model." This model can be summarized in Figure 1.

1. The community health workers know the women living with violence in their communities, because they are part of this community and have a nonhierarchical relation with their families. In Brazil, community health workers should live in the area for which they are responsible. These paraprofessionals know all their patients by their names, know all about their living conditions and community problems, and they visit their patients' home usually twice a month. Community health workers are aware of their patients' needs and health habits, their social determinants of health (e.g., level of education, work and housing conditions), and also about some of their intimate problems, such as DV. The majority of community health workers in Brazil are women; thus, women from community feel confident to reveal some of their intimate problems to these workers. In our research, some women invested confidence and hope in this disclosure. This fact that was not commonly observed with other health professionals, probably because health professionals, typically wearing a uniform and speaking in biomedical terms, have

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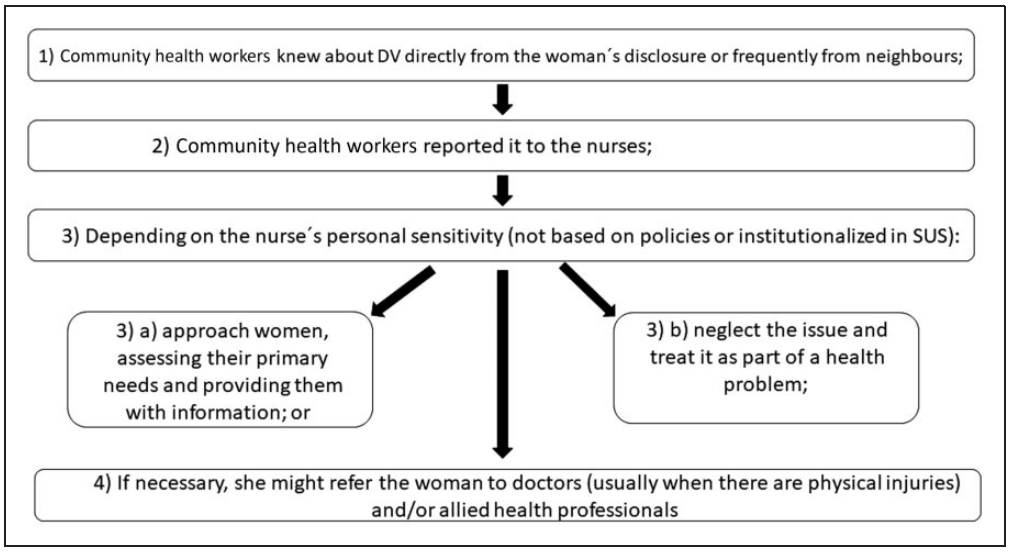

Figure 1. The Chinese whispers model of information about women living with domestic abuse and the role of family health strategy teams. Source: Signorelli et al.[1]

a higher social status and therefore power compared with women. In our ethnographic study, either women disclosed directly to community health workers, or their neighbors did it. Thus, community health workers were usually the entry point for information about DV against women within the system, and not only violence against women, but also about other forms of DV, such as against children, the elderly or people with disabilities, due to their bonds with families in their communities. Community health workers revealed in our study that they even know information that they wish to not know, such as who the drug dealers in the community were and what they are able to do.

2. Each community health worker is obligated to report significant issues from their patients, like DV, to his/her respective Family Health Nurse. Family Health Nurses are usually responsible for a couple of community health workers in a circumscribed area, that in Brazil is named "adscript territory." Each primary health-care unit (with its Family Health Strategy teams) has a map on its walls. These maps are designed/colored by the health teams and divided into specific areas, which are cared by their specific community health workers and Family Health Nurses in these "adscript" areas.
3. Depending on the family health nurse's personal sensitivity to DV, she may approach the problem or not, with the following two alternatives: (3a) approach the women living with DV, assess their primary needs and provide them with information or (3b) neglect the issue and treat it as part of a common health problem, that is, only treating injuries caused by physical violence, for example;
4. In addition, if necessary, she might refer the women to doctors (usually when there are physical injuries) and to allied health professionals, such as social workers or psychologists, including family violence specialized services, for integrative care.

At the same time that the community health workers could be an "entry point" for women living with DV in the primary health-care level of the public health system, some important barriers exist to prevent transforming it into an opportunity for women. First, community health workers are not trained to deal with complex problems in Brazil,[2] such as DV. Community health workers training is not a priority for the Ministry of Health. While paraprofessionals are part of the family health strategy teams, institutionalized, and paid by the public health system and available in almost every corner of the country,[3] there are many gaps in their formal training and lack of support from the system to develop their and stimulate their potential.[4] Community health workers clearly have potential, but front-line DV training should be regularly provided nationally to support their actions, together with other family health workers who also play a key role in caring for women. This training should include ethical and policy guidelines to care women living with DV,[5] information about the local available networks to support women, discuss safety issues for these workers themselves and help women to define safety planning according to their needs. Community health workers are in a complex situation, because they live in the same neighborhoods as their patients. In our study, some community health workers revealed that when they reported cases of abuse to authorities, the aggressors started to stalk and harass them. Consequently, the efforts made by some community health workers and family health nurses should be observed and fostered through specific training to guarantee their own

safety and avoid attitudes based only on personal sensitivity or activism. Instead of this, they need strategies to implement actions that are legitimated by formal policies, programs, and protocols in the system, engaging these workers but with proper support and tools to guarantee sustainability. The World Health Organization recognizes the critical role of the overall health system[4] and the key role of the health-care professionals and has provided a clinical handbook, guidelines, and now a suggested continuing professional development curriculum for health-care professionals.[5,6]

(c) Finally, but not less important, we argue that nowadays, all the potential revealed in our study, which includes the key role of community health workers and family health nurses to care women experiencing DV is under threat in Brazil. The threat is due to severe budget cuts from the Brazilian government, that in 2016, through an austerity approach,[7] froze the increase in investments in public health and education for the following 20 years. More than that, the actual government is dismantling several public policies for disadvantaged groups, including women; lesbian, gay, bisexual, and transgender; and black and Indigenous people. For example, the "National Special Secretary for Women's Policies" created in 2003 and that we mentioned in our original article, together with the "Special Secretary for Promotion of Racial Equity," were incorporated into the already existent "Ministry of Human Rights." This merging means a reduction of three budgets into only one, and it also dissolves the specific demands of women and Black/Indigenous people into the generic "human rights" agenda. This government threat is also accompanied by a societal conservative wave that culminated into the Christianization of issues related to gender; women's rights; lesbian, gay, bisexual, and transgender; and human rights.[8] Another threat comes straight from the Ministry of Health with the new "National Policy of Primary Health Care"[9] launched in 2017. The new policy is not increasing the coverage of the Family Health Strategy anymore or fostering the implementation of more community health workers. Other countries may also face similar threats under austere governments and this could compromise the sustainability of actions. So, the challenges continue, but we hope the crisis is only temporary.

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