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Family Health Program professionals' view on family structures and health implications

ABSTRACT

OBJECTIVE: To describe perception of family structures and understanding of a healthy family by Programa Saúde da Família (Family Health Program) team members

METHODS: Research with a qualitative approach, employing the focus group technique, and involving the Program professionals from the city of Campo Bom, Southern Brazil, between June and August 2005. Sample was comprised of 12 professionals, including doctors, nurses, nursing technicians and community health agents. The following issues were investigated: the meaning of family; the meaning of the role of family; type of family most frequently cared for by professionals; the meaning of a healthy family; and types of family causing more difficulties of care. The methodological instrument used was content analysis.

RESULTS: Two main categories were observed: family structures, where a great diversity of arrangements was found; and healthy family, where the predominance of speech is consistent with a multifaceted view on health, involving political, social, economic and cultural aspects. Professionals identify and respect distinct family structures and adapt medical treatment accordingly.

CONCLUSIONS: Findings reveal that professionals are willing to deal with the different family structures present in their routine.

DESCRIPTORS: Health Personnel, psychology. Health Manpower. Health Knowledge, Attitudes, Practice. Family Health Program. Qualitative Research.

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INTRODUCTION

Studies on family as a place of social protection show three spheres responsible for individuals' well-being: family, society and the State, emphasizing that the latter must guarantee the required conditions for families to fulfill their role of providing complete protection for their members.[10] Thus, the Ministry of Health raised family health to the level of strategy for health care change, currently representing the main health program in the country, gradually covering all *Sistema Único de Saúde*'s (SUS – Unified Health System) basic health service network.

In this sense, the *Programa Saúde da Família* (PSF – Family Health Program), proposed by the Ministry of Health as a strategy to reorganize the health care model that predominates in basic care, has the following purposes: to integrate

health prevention and promotion actions, to manage resources aimed towards secondary and tertiary care, to solve problems of urgencies and emergencies, to promote integration between SUS and universities, and to define human resources policies to meet health service demands.[3]

This health care reorganization focuses on family and implementation of different procedures by a multidisciplinary team. However, the type of family category the Program refers to and intends to serve is questionable. Likewise, one may question what PSF professionals' perceptions of and ways to handle distinct family arrangements are and how they would understand family as a health unit.

Family structures are the object of investigation of several fields of knowledge, such as social sciences, psychology and anthropology. Even though there have always been distinct forms of family organization, the image of a nuclear family comprised of a mother, father, and children remains in people's minds as reference. PSF professionals' work consists in daily care for families with different arrangements.

Thus, the present study aimed to describe PSF professionals' perceptions of family structures.

METHODOLOGICAL PROCEDURES

Sample was comprised of 12 professionals, intentionally selected among the city's seven teams, guaranteeing that all health sectors were covered, according to a proportional distribution of roles performed and with at least two years of experience in the PSF. Categories of the 12 professionals selected were the following: three doctors, of which two were male and one female, all aged between 33 and 35 years; three female nurses, aged between 33 and 47 years; two nursing technicians, one female and one male, aged between 45 and 49 years; and four community health agents, all female and aged between 34 and 44 years.

Focus groups with selected professionals were performed. Before these groups were organized, visits to each of the PSF units were made, in addition to three visits to observe monthly team meetings, in which community health agents did not participate.

The focus group guide was based on four themes: 1) principles and assumptions followed by the PSF; 2) professionals' care practice; 3) relationships established among professionals and with the community; 4) cultural tradition of the community served.

Next, a total of eight meetings with the selected group were held, two for each theme of the discussion guide. Sessions lasted one hour and thirty minutes each and they were recorded and subsequently transcribed. Focus groups were conducted from June to August 2005.

In the material pre-analysis, initial reading of participants' speech and subsequent thematic analysis of data were performed, according to Bardin[1] and Minayo.[8] After data codification, two categories resulted – family structures and healthy family – which were interpreted for content analysis.

The study deals with "cultural tradition of a family from the community served", analyzing the accounts referring to item 4 of the guide. The two last meetings focused on the following questions: What is a family? What is the role of a family? What is the most common type of family that you care for? What is a healthy family? Among the different types of family, which are more difficult to care for? In addition, data associated with types of family and healthy family, reported in the other six meetings, were identified, analyzed and added to the study.

The study was approved by the Vale do Rio dos Sinos University Research Ethics Committee (Process nº058/2004).

ANALYSIS AND DISCUSSION OF FINDINGS

The material analyzed was divided into two main categories: family structures and healthy family. The first category referred to the professionals' perception of what a family is, its role and the type of family they routinely care for. The second category referred to what a healthy family is and what types of families were more difficult to care for during their routine.

Family arrangements

A great diversity of family structures was found, such as homosexual couples with children, extended families and reconstructed families living on the same plot of land, and elderly people cohabitating with younger partners: *"There are these women, the two who live together (…) they go to the gas station, walk hand in hand on the streets… Where I live, there are two gay families…"*

Another type of family mentioned were the women with children, who live in brothels, *"…this old man runs a brothel. It's just like a marriage. He takes care of them (…) some go there with children, and they live together."*

The family arrangements mentioned, which are part of the routine of these professionals, correspond to those found in studies on Brazilian family organization and dynamics. There are many reasons why different family structures have appeared. Moraes[9] indicates the change in work organization as one of the factors involved with changes in family dynamics. The country's progressive urbanization and industrialization has caused it to break away from the old unit between home and place of work, as found in family farming.[9] The productive

family unit became less important than the factory regime of work. Family living space became only a place of residence and consumption. Domestic work is now characterized as a private activity, not paid work.

Changes in family and female condition can be observed in the financial autonomy women have achieved, breaking away from the wife's economic subordination to the husband. Women's financial independence enabled the female single-parent family to exist, or the woman to become the provider at home, like the husband, thus causing changes in family roles.[9]

Such changes in roles happen in several aspects. In the economic aspect, women work out of the home and their salary is part of the family income. In the division of domestic chores, the husband helps with these chores, even when he does not work out of home. There are also situations when the husband is responsible for most tasks and care for the children, *"the husband stays home, doing the house chores, and the wife goes out to work. He cooks, he's got a handicapped daughter, you know, so he walks with her, does everything at home…"*.

Sarti[12] considers the changes that have occurred in the family to be related to a loss of the sense of tradition. Roles in the family used to be pre-established, whereas these same roles are currently constructed alongside the typical individuation process of modern culture (individualism). This was in large part possible due to women's ability to control reproduction, enabling a reformulation of their place in the public and private spheres.[12]

Changes do not occur individually. Several factors influence new customs and behavior. Urbanization and the resulting change in place of work, alongside economic changes, led women to search for a profession. The fact that women stopped giving birth and raising children, with the advent of the pill, enabled control over reproduction and the opportunity to work out of the home. As a result, this female economic autonomy caused cultural changes.

Given the diversity of family arrangements, they were analyzed in terms of how they were present in the work routine of PSF professionals. Accounts referred to moral values and prejudice, *"…what we many times have to face as natural now used to be a scandal for society some years ago (…) These people view life in a different way (…) You have to learn to deal and work with this"*.

The idea of not trying to judge in any way how the family was organized, but feeling concerned, instead, to care for them to prevent risks they may be exposed to, predominated in speech. Willingness to learn to deal with different arrangements, regardless of the values professionals have, was also present, *"…it's not up to me to think something's right or wrong… Each one has their values and concepts (…). You have to work on this, the question of prevention obviously…"*.

The way distinct family structures are viewed determines professionals' performance with families. Speech reveals flexible attitudes, which enables more efficient practices. This does not mean that a certain family dynamics requires the health professional's approval, but rather an open attitude and the ability to listen to better understand this dynamics and consequently perform more satisfactory health practices. Szymanski[13] observes the importance of considering that families have their own culture, codes, rules and rites within a context of intertwined emotions.

Health professionals also need to develop their own culture. According to Helman,[6] there are professional subcultures, such as medicine and nursing, forming distinct groups, with their own concepts, rules and social organization. These professionals, in the author's view, suffer from a form of "endo-culturalization", as they gradually acquire the culture of the career they have chosen, obtaining a perspective on life markedly different from that of laymen, which may interfere with both health care and the relationship with the user, in this case, the family.

Regardless of family structure types, there is something in common among them that can be named anthropological meaning. The family appears as union, support, protection, safety, the roots, *"It gives safety, support for your life, a direction (…)"*.

In this way, professionals view the family as a space for listening, respect, and sharing of responsibilities and good and bad moments, *"Family is someone who listens (…) we stop to listen to them (…) when you find someone who listens to you as well"*. Their speech alludes to the anthropological meaning of a family, by indicating elements necessary for the complete development of an individual in the social, emotional and biological spheres. This sense attributed to the family is in accordance with Ferrari & Kaloustian,[5] who conceive the family as the vital space to guarantee survival, development and complete protection of their members, regardless of how it is structured.

Healthy family

This category referred to what professionals considered to be a healthy family, their way of approaching it and the limits of their abilities to treat it.

This theme was one of the key points for the PSF, once *"the family constitutes perhaps the most important social context, where disease occurs and is dealt with. It acts, as a result, as a primary health care unit for its members"*.[4]

One of the challenges the health professional faces is whether "family health means the sum of the health of individuals who comprise it, or if the family also has a 'health status' that can be identified, distinct from

its members' health".[4] Elsen[4] emphasizes that family intervention depends on the professional's view on this issue.

The *Grupo da Assistência, Pesquisa e Educação na área da Saúde da Família* (*GAPEFAM* – Family Health Education, Research and Care Group) defined a healthy family as "united by emotional bonds expressed as love and care, free to show feelings and question, and sharing beliefs, values and knowledge (…)".[4]

In this regard, Ribeiro[11] adds that "family health care requires a multidimensional focus on being and experiencing family, in its interface with the health-disease process, and which comes true in the several environments where it is present, as well as in its routine".[11]

Professionals describe that healthy families take the initiative and seek solutions, *"…they're the families that are good to work with (laughs) (…), that have a certain resilience (…), that have structure to seek their health, to become better, to handle more basic things…".*

Participants described families that come together, due to a disease and, even without material conditions, find a way to face it, *"…the whole family took responsibility when there was a disease, but I can see it as healthy, because nobody was complaining about being tired and spending nights awake…".*

This speech alludes to Elsen's[4] statement that considers individual health to be different from family health, even though both are interconnected, because a healthy family supports its members, it is flexible to change its functioning to see to their needs, and it allows the sick individual to continue their treatment, enabling their health recovery and/or rehabilitation.

Healthy families were considered to have favorable sanitary and socioeconomic conditions. In addition, it was irrelevant whether these families were nuclear, single-parent, extended or homosexual. The reference given as relevant was whether the family lived well and had mutual support, *"…they're people who live well, in peace, helping each other (…), it's much better if a child is raised by a homosexual couple than a mother and father who hate each other"*. The idea of a healthy family follows a multifaceted view on health, involving political, social, economic and cultural aspects.

The opposite of a healthy family was described as a problematic family, where members did not seek to help each other and which was classified as sick. They were regarded as difficult to work with and with characteristics passed on between generations, *"…they don't keep the same job (…) problems get worse, once they have no structure, and these families make a lot of visits…".* Sick families were characterized by a reduction in or absence of physical, mental, socio-cultural, and physical space resources, preventing them from having a balanced life when facing a difficulty or new fact.[2]

Vasconcelos[14] points to the existence of families who are experiencing a crisis, posing a risk to their member's life, and also to some indicators of these situations, comparable to the ones mentioned by participants. According to the author, these families require "visits and studies to better characterize the situation and verify the need for systematic support, centered on the family's global dynamics, and not only on individual members".[14] Thus, the healthy family is not limited to the absence of diseases, once the presence of one or two sick individuals does not mean that the family cannot be considered healthy. Their healthy state is in the search for reorganization when a disease is present.

As regards the way families are approached, the idea of working with the whole family prevailed. Professionals seek to know the family structure, and who supports it, i.e. the head of the family, so they could work with the whole family, *"…to see who's the head of this family. Then, based on this person, you can work with the rest of the family. (…), I got a connection with that family (…), to get to know the family structure(…)".*

Participants reported that they sought not to take sides among family members and tried to work on their relationships with one another. They also attempted to form a bond with the family. In case of conflict or difficulty to approach the family, the intervention would be postponed until the team could find a more appropriate way to intervene, *"…sometimes we postpone the other meeting (…) for 15 days, so we can think… we put it on hold for a month… OK, now we can talk!".* Accounts showed attitudes that are in accordance with the PSF premises of working with the individual in a relationship.

According to Ribeiro,[11] in some cases, much is expected in terms of family roles, duties and responsibilities, and also in terms of health education in patient care and treatment. Exhaustion and harmful effects of this condition to which the family is exposed are not always noticed or considered by professionals.

Some approaches to families, adopted by the PSF "because they do not talk with each other or complement each other, end up creating a picture of diversities/partialities, resulting in the following question: how to achieve complete care, if the one who is going to be cared for is not sufficiently identified?".[11] This points to the need to find out about the family context, their resources and limitations as a decisive factor for a suitable approach, instead of passing onto the family attributions they are not prepared for.

Accounts by professionals raise the question of the limit of their capacity to deal with family issues. These professionals also question their qualification and competence to meet the demands that range from basic health matters to the delegation of family tasks, *"…these family matters (…) go beyond our qualification (…). We work with limited resources, which are also staff-related, in a way (…)".*

Not only the family that has problems seeks PSF professionals, but also people in the community, when they realize some neighboring resident has a difficulty which they cannot solve, *"…it's not even the family that came to ask for help, the community wants something to be done, you know. And whose responsibility would this actually be? The family's"*.

Professionals acknowledged that health education was one of their functions, but reported that the community required them to handle issues that were beyond their function, *"…I can't solve her problem of not having where to leave her child (to go to work)…"*. They are called by neighbors to solve family quarrels, when the police should actually intervene.

According to Marsiglia,[7] family health teams have been prepared to develop new abilities that facilitate bonds with families cared for to be formed. However, little is done to prepare them for these approaches, as if this resulted from an individual innate talent or from personal experiences, or, yet, as if the issue were not an object of specialized knowledge.[7]

Moreover, teams reported the need to incorporate professionals from other areas, such as social workers and psychologists, to help to care for families, *"…And we end up doing things that aren't our responsibility, they're social assistance's…"*.

Even considering the importance of the presence of participants from other areas in PSF teams, it must be taken into consideration "whether demands, made to PSF professionals at the moment, are not pointing to the need to create new specialties within health professions".[7]

In addition to gathering professionals from other areas and investing in specialization courses, the importance of including the community to solve problems through health education should be considered. This should be regulated by a more horizontal dialogue that values popular knowledge and stimulates people's autonomy. Vasconcelos[14] emphasizes that popular knowledge must be valued to begin the pedagogical process, enabling the student to feel "at home" and their initiative to continue. There is also the need to consider the potential of social support networks. The PSF must not operate independently from other segments of society. It is important that it is linked to the sectors comprising the community. Thus, the proposal of complete family care will be closer to the PSF's proposal.

CONCLUSIONS

Professionals caring for the multiplicity of family arrangements described are willing to learn to deal with this reality, regardless of whether they agree with the family life models or not. They tend to adapt the treatment, according to the specific needs of each family arrangement.

Professionals also describe characteristics they consider to be associated with a healthy family, emphasizing the family's capacity to organize itself and seek solutions for situations that cause imbalance, regardless of how it is structured. They also describe what they consider to be an unhealthy family, referring to those without resources to deal with problems and those that are difficult to treat.

In addition, professionals become restless, due to the pressure of responsibilities that go beyond their capacity to intervene. They often find themselves trapped between management requirements to obtain quantifiable results, as recommended by the program, and the needs required by families. Such demands cause these professionals to realize the importance of complementing the team with professionals from other areas.

There is also the question of lack of qualification to deal with the problems faced. Given the complexity of demands the PSF has to respond to, other abilities need to be developed. Health professionals' preparation must qualify them for a new health care model, with an emphasis on all the dimensions involving the individual and health/disease process, rather than caring for patients' physical needs (disease).

Finally, findings from this study indicate the importance of advancing knowledge about healthy family indicators and the elements associated with a family visit. In-depth investigation into these issues is required to qualify PSF professionals' practices.

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