

The family(-ies) in primary care: perspectives of professionals in the Family Health Strategy

A(s) família(s) na atenção básica: perspectivas dos profissionais na Estratégia Saúde da Família

La(s) familia(s) en atención básica: perspectivas de los profesionales en la Estrategia Salud de la Familia

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This is a qualitative, exploratory and descriptive study conducted in the city of Teresina, in the state of Piauí, in 2019. It aimed to discuss the family(-ies) perspectives of the professionals who are part of the Family Health Strategy in a Basic Health Unit. The participants were 12 professionals (1 doctor, 3 nurses, 2 community health workers, 2 nursing technicians, 2 oral health technicians and 2 dentists), to whom was applied a semi-structured interview script. Data analysis was based on the content analysis method. Two empirical categories emerged: *Perspectives of family(-ies) under different points of view* and *Dynamics of everyday life in the work process*. Professionals understand that the family is a universe that transcends the sacred and idealized perspective based only on the love between members, and, through their work processes, they learn that new family constitutions have been consolidated and this implies new attitudes in the assistance of teams of the Family Health Strategy, in search of comprehensive and quality care. However, this stands out as a challenge to be faced with the dynamics and daily work.

Descriptors: Family Health Strategy; Primary health care; Health personnel; Family.

Este é um estudo qualitativo, exploratório e descritivo realizado em Teresina-Piauí, em 2019, com o objetivo de discutir as perspectivas de família(s) dos profissionais que fazem parte da Estratégia Saúde da Família numa Unidade Básica de Saúde. Participaram 12 profissionais (1 médico, 3 enfermeiros, 2 agentes comunitários de saúde, 2 técnicos de enfermagem, 2 técnicos de saúde bucal e 2 dentistas), aplicando-se um roteiro de entrevista semiestruturado. A análise dos dados foi fundamentada no método de análise de conteúdo. Duas categorias empíricas emergiram: *"Perspectivas de família(s) sob diferentes olhares"* e *"Dinâmica do cotidiano no processo de trabalho"*. Os profissionais compreendem que a família é um universo que transcende a perspectiva sacralizada e idealizada baseada apenas no amor entre seus membros, apreendendo, a partir dos seus processos de trabalho que novas constituições familiares se consolidaram e que tal feito implica em novas posturas na assistência das equipes da Estratégia Saúde da Família, em busca de um cuidado integral e de qualidade, contudo, destaca-se como um desafio a ser enfrentado a dinâmica e cotidiano de trabalho.

Descritores: Estratégia Saúde da Família; Atenção primária à saúde; Pessoal de saúde; Família.

Este es un estudio cualitativo, exploratorio y descriptivo realizado en Teresina-Piauí, en 2019, con el objetivo de discutir las perspectivas de familia(s) de los profesionales que forman parte de la Estrategia Salud de la Familia en una Unidad Básica de Salud. Participaron 12 profesionales (1 médico, 3 enfermeros, 2 agentes comunitarios de salud, 2 técnicos de enfermería, 2 técnicos de salud bucal y 2 dentistas), aplicando un guion de entrevista semiestructurada. El análisis de los datos se basó en el método de análisis de contenido. Surgieron dos categorías empíricas: *"Perspectivas de familia(s) bajo diferentes miradas"* y *"Dinámica del cotidiano en el proceso de trabajo"*. Los profesionales entienden que la familia es un universo que trasciende la perspectiva sacralizada e idealizada basada sólo en el amor entre sus miembros, aprehendiendo a partir sus procesos de trabajo que se han consolidado nuevas constituciones familiares y que esto implica nuevas posturas en la asistencia de los equipos de la Estrategia Salud de la Familia, en busca de una atención integral y de calidad, sin embargo, se destaca como un reto a enfrentar la dinámica y el cotidiano de trabajo.

Descriptores: Estrategia de Salud Familiar; Atención primaria de salud; Personal de salud; Familia.

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INTRODUCTION

The Family Health Strategy (FHS) is seen as a priority tool for the expansion and consolidation of primary care, having its direction linked to the peculiarity and sociocultural insertion of people, with the historical mission of changing the work process focused on the disease and on the individual for more collective social processes, seeking to produce comprehensive care and singular health practices, in which the family, the community and other forms of collectivities are considered relevant, conditioning and determining elements in care¹.

In this sense, the FHS prioritizes health promotion, protection and recovery actions, in an integral and continuous way, having as main pillar the recognition of the needs of the populations in their singular aspects, from the establishment of bonds between the users of the services and the health professionals, in permanent contact with the territory, proposing, in this way, that health care should be centered primarily on the family understood through its physical and social aspects, allowing professionals an expanded and complex understanding of the health - disease process - care and the need for intervention that transcends curative practices².

With the advent of the neoliberal model, and the formatting of state responsibilities, the family becomes the main object of health care and in general in public policies, having recognized its potential, that is: the family is a social group that shares responsibilities, a space for building relationships between its members and with society and an environment that articulates strategies for the survival of its members and of itself³.

However, there are difficulties in processing changes, taking into account the predominance of the biomedical model, the service, as usual, has an individualized character, constantly revolving around the disease, losing its integrality, desires, beliefs, values, relations with other family members and the social environment⁴.

The official documents^{1,2} state that the health sector's performance has traditionally been centered on the individual, resulting in fragmented attention with an emphasis on the individual's organs and/or organic systems, that is, outside their family context and social, which results in the production of people, often without autonomy and social protagonism.

In the proposal of the FHS, which has the family as the focus of attention, the premise is to approach the individual globally and integrated into their family and social context. The family is understood as participating in the whole process, as it influences and is influenced by the impacts of the disease and health interventions, and may even constitute a protective factor and even risk in health problems. Looking at the family as the main object of care in the current proposal for reorganizing primary care and reorienting the care model⁵, the health systems organized by Primary Health Care (PHC) are superior to those that do not adopt it, and that the PHC models that the focus of the family is superior to conventional APS⁶ models.

Furthermore, when placing the priority centrality on the family, in the wake of what the FHS proposes, some questions are raised: What family are we talking about? Is there an understanding among the different actors involved in the FHS, health professionals, managers, educators, among others about the approach to the family in the context of primary care? And what place does it really occupy in this scenario?

The FHS is undoubtedly an innovative field, rich in potentials for assessment and intervention in family health, making it necessary to create a context in which professionals and families can establish a relationship of partnership, trust, regular communication and transparency.

The establishment of this relational totality "[...] depends on the perceptibility of the family concept, and on theoretical references and instruments that enable professionals to effectively address issues related to family dynamics"⁷. In reality, what is posed here is not necessarily the clarity of a "closed/standard" concept of family, but rather the perspectives of

families on the part of the professionals who are inserted in this context from their work processes.

In this way, studying about family assistance proposed by the ESF leads to seeking the conceptions that the service has of the family, and how this is translated into the focus of its interventions.

The search for an understanding of the professionals' perspective on families becomes important as, based on these issues, work processes are guided or an intervention in the FHS is managed, corroborating the continuity of basic medical-centered care residual and individualizing or as a counter-hegemonic movement to combat this situational framework⁸.

The aim of this study is to discuss the prospects for family(-ies) of professionals who are part of the Family Health Strategy in a Basic Health Unit.

METHOD

The research carried out with professionals working in Primary Care in the city of Teresina, State of Piauí, was characterized as an exploratory study⁹ - aiming at bringing the researcher closer to the theme, making him more familiar with the facts and phenomena related to the problem to be studied - and descriptive¹⁰, being used to describe the context in which the research object was enrolled, and the nature of the considered approach was qualitative.

The option for the qualitative method is based on the possibility of working with the universe of meanings, motives, aspirations, beliefs, values and attitudes, which corresponds to a deeper space of relationships, processes and phenomena that cannot be reduced. operationalization of variables.

The research took place in a UBS in the city of Teresina-Piauí, since during the 2018-2020 biennium, the aforementioned institution received a multiprofessional residency team in family and community health, which enabled team work processes and interventions with the registered population.

The participants were professionals from the Family Health Strategy (FHS), selected based on the following inclusion criteria: professionals who were inserted in the FHS, working in the UBS under study for at least 2 years and who agreed with the research terms.

Data collection took place from May to August 2019, and a semi-structured interview script was used that contained seven questions related to the understanding of family and the work process performed by professionals, namely: *What is family for you? How do you see the families regarding the work process within the FHS? How do you work with the families that make up the area you cover? Tell us a little about the care you provide to families at the BHU where you work. What are the main challenges that exist in working with families in their professional routine? Cite an action of your knowledge carried out by the ESF aimed at families in its entirety and the periodicity in which it occurs in the teams' daily work. In your opinion, what is the focus of FHS services? Is the priority aimed at the families or individuals that make it up?*

The sample consisted of professionals inserted in the FHS and was characterized by being intentional and built by saturation, causing the suspension of new participants, as the interview data started to show redundancy or repetition¹¹.

Data collection took place after direct contact with possible participants, in which the research objectives were explained, the methodology used, the guarantee of confidentiality of information and anonymity, the risks and benefits, as well as the freedom to withdraw consent to any phase of the study. The place and day of the interview were chosen according to the preference of the participants, being crystallized after reading and signing the Informed Consent Form (ICF). It is noteworthy that, with the participants' acquiescence, the interviews were recorded and later transcribed and analyzed.

The analytical treatment of the collected material took place through content analysis, which consists of a technique of analysis of information, in which one appreciates what was said in interviews or other means of communication, constituting the following phases: 1) pre-

analysis; 2) exploration of the material; 3) treatment of results, inference and interpretation. It is important to note that, in the analytical process, the authors took into account the validation of judges with expertise in the area in order to confirm categories of belonging and similarity¹².

In addition, we sought to identify, from the participants' testimony, the nuclei of meaning, considering the importance of finding in the communication, the presence and frequency of these nuclei, as they are an element of significance for the analytical object studied.

In the operationalization of the analysis, the following steps were followed: the empirical material was read thoroughly with the process of floating reading in the pre-analysis, seeking to identify the nuclei of meaning in accordance with the proposed objectives; later, representative tables of each nucleus were elaborated, complemented with the interviewees' testimonies.

The process of formation of the categories took place after the selection of the material, resulting in a coding process, based on the narratives of the interviewees, on the convergence of meanings and, from the initial categories, the intermediate categories emerged, with the intention of supporting the interpretations and inferring results were grouped into final categories.

Subsequently, inferences and interpretations of the material collected were carried out in conjunction with the theoretical framework adopted from the integrative and intentional literature review on the topic with the perspective of providing a basis for the study of the analytical categories of the work in question.

This research was approved by the Ethics and Research Committee of the Universidade Estadual do Piauí (CEP/UESPI) according to the opinion 3,316,226 of 2019, according to the ethical precepts of resolutions 466/12 and 510/16 of the National Health Council. To ensure anonymity, participants were given fictitious names.

RESULTS

12 professionals from the FHS participated (1 doctor, 3 nurses, 2 community health workers, 2 nursing technicians, 2 oral health technicians and 2 dentists).

After transcribing the responses, the categories were created, so that Chart 1 presents the initial, intermediate and final categories.

From the analysis of the data and after the extraction of the themes related to the object of study, the information was grouped into two empirical categories: "*Perspectives of family(-ies) under different points of view*" and "*Dynamics of everyday life in the work process*".

Chart 1. Summary of progression of the categories. UBS in Teresina / PI, 2019.

Initial	Intermediate	Final
1. Family as basis	I. Family as reference	I - Perspectives of family(-ies) under different points of view
2. Affection relationship		
3. Place of protection		
4. Family breakdown/disorganization	II. Family and established social roles	
5. Sacralization of nuclear family		
6. Extended concept of family		
7. Work process focused on the individual	IV. Limits to a work process effectively aimed at intervening with families	II - Dynamics of everyday life in the work process
8. Work process in the logic of individual production		
9. Reductionist academic formation in the family universe		
10. Little investment in permanent education	V. Critical look at the current work process	
11. Attempt to change work focused on consultation		
12. Idealization of FHS		
13. Challenges of working with family		
14. Network work		

Perspectives of family(-ies) under different points of view

Participants were asked about their understanding of the family universe. In this category, the reflections of the professionals run through countless perspectives, as shown in the statements below, in which the family is linked as a place of reference:

Family for me is the basis of everything! It is the nucleus from which we form, where we create an identity, where we learn to have a family culture, learn to have good manners, basic education. So, for me, it's a structural axis in people's lives, it's the family. (Maria)

For me, family is the basis of everything, in it... if you don't have a good family structure, you are a person... it becomes a little unbalanced, because family is our base, it is our ground I think so my way of thinking. (Santos)

The interviewees' statements also denote the connection of the family as an institution that must necessarily have affection as a basic structure:

Family is an aggregate of people who like each other, who have common goals, who fight, but who settle and try to move, have the same direction, consolidated in a union that leads us to create a stable environment, both psychological and financial as well. (Elisângela)

Professionals also conveyed the sense of family to the exercise of established roles as potential factors to consecrate the "ideal family". In this passage, they associate this way of thinking with the families monitored in their respective micro areas in the FHS:

I feel very sorry for them because you don't have a father or mother as a reference, it is really going through a very big ordeal... and looking in others... Sometimes you look in a colleague, you look in an uncle, in a person more next and maybe the reference isn't the cool one, the good one, maybe if you've already caught that guy that everyone thinks he's stirred up, but he's the one who uses drugs, that is, the reference ends up being another and the tendency is to get lost. I told you at that first meeting, that we need to seek the sense of family that many of them do not yet have. (Elisângela)

Most families are completely unstructured. They are either maintained by a grandmother or do not have a father, or have no mother, the grandfather is the one who raises the grandchildren. I already had a stepchild family to be married to a stepmother. So they are families where bonds of friendship, affection, where all feelings are mixed often developed. It is not very similar to the image I had of family, of the family I came from, where I had my grandfather, grandmother, father, mother and brothers, all mixed up. It is not the mother who takes care of a child, it is often the grandmother, often a neighbor. It is a family that needs very special attention. (Carlos)

So, because the child she... if the child has that relationship with the father, I already accompanied a teenager that the parents separated. Very difficult. When the child has a relationship with the father who separates, they have that shock of separation, it is rebellious I witness a lot here. There are parents who separate and are very welcoming, they welcome their child well and thus, there are mothers [...]. (Amanda)

Still, it is possible to perceive in the speeches a broader view regarding the existence of the diversity of family configurations:

I can't define a family profile. What we have are 550 types of family. We have a family of father and mother, two parents, two mothers, grandmother, mother, son. So, in my mind, I don't have a family profile! I do not have. Because our reality is so multiple, so dynamic, that we don't have that profile. For me there is no family profile! There are those people who are there. Sometimes there is a family of friends, a group of friends gets together and it becomes a family. But like this, I don't have a family profile. (Maria)

Dynamics of everyday life in the work process

The participants pointed out the factors that often make it impossible for them to carry out an intervention actually aimed at families in a more comprehensive perspective, factors that are condensed by the management itself:

We are still very much fixed in the consultation, in the individual consultation, understand? Even if we see this family portrait, try to look for it, talk to the patient, if we know that we have a problem and try to get around it... bring a son, bring a husband, and then try to hug the family, I don't I know, I can't see that we do this work focused [emphasis] on the family, I think it goes back to the individual even though it may have consequences within the family. (Maria)

No. So, just this consultation. Come, make an appointment, consult, talk to the doctor, but don't you have to, so call them to give a lecture, these things? No. There are no such meetings. We couldn't do it. (João)

It ends up being more for the individual. I as a person see more focused on the individual because, for example, this project that is being placed now [Singular Therapeutic Project]... I don't remember the name, but it was presented to us there at 114, should the PSF in my view, should work that way. (Vânia)

As they are intertwined in a work process aimed at the individual figure and linked to an outpatient care framework, there is a requirement for individual care productions, which in fact contributes to aggravating work in the FHS in the hospital-centered logic or focused on the disease.

Therefore, the work process is focused on the figure of the individual (sick) and linked to an outpatient care framework, corroborated by the demand for individual care productions, which in fact contributes to intensifying the work in the FHS in the curative and centered logic in illness as a personal hospitalocentric fact:

But in general, the search, the service itself is more centered on the individual, on that individual's response when seeking any health service, be it private or public. So, again, this is where the issue of ministerial and local ordinances comes in, that if you have this logic to be fulfilled, this goal to be fulfilled, the more difficult this becomes, you work in a family context. (Sandra)

The productivist logic was imposing itself during the process, individualizing the professional doing, because in the beginning, the process was different, with greater autonomy of the professional to diversify the list of service offers:

I think that at the beginning of the FHP, because I am one of the first teams, there was not much of this consultation issue, that "the doctor had to make so many consultations, the nurse had to make so many consultations, there had to be production". In the beginning, the team was more open to doing activities, regardless of the consultation. Today, as this issue of consultation was brought up a lot, it became like an outpatient clinic, I don't think there was much family care. There is more family care for those most needy families, which we look at more. In general, only the family, no. The individual became more. (Carlos)

The bureaucratization and crystallization of actions aimed at the release of information in the "system" imposes itself on the needs of families, which constitutes more demands on professionals, which is also a factor that generates discomfort for professionals:

The FHP,, I'm coming here, my hands are tied, because I have to open the system, I have to put the patients' names, SUS card ... We end up getting involved and being charged for things that are not us leading to results. This frustrates us, and more and more demands, "you have to do this, you have to do that!". So these are situations that I don't feel comfortable with. (Elisângela)

Some professionals indicate that in the territories/BHU (Basic Health Unit) where there is a diversified list of teams and service offerings, a more powerful work process is possible, with differentiated offers, different from the panorama designed for places where only one team persists:

Why does it exist in some places, because there are some places where the Strategy is stronger? Where I have residence, where I have NASF, where I have PMAQ teams that work in the morning and in the afternoon. So in those places where teams have powerful support, a lot of cool things happen. Then you can work in a broader way, with different therapies, with different things. Now, the places where the team is alone, she can't handle it. It does not meet the current demands of the population. (Maria)

The presence and performance of the Residence collective in a specific BHU is taken as a parameter of how the FHS should be acting, configuring it as a mirror for some professionals, as described below:

There had to be a visit to this family first... a new family, who asks for the card, who asks to be seen at BHU. I think there should be a kind of visit to see the housing condition, the emotional condition of these people, to have a closer relationship. I know there are a lot of people for you to put everyone on your lap, but I think... the case of the Residence here, I think the Residence helps a lot this issue, which I think should be more or less than the way you work, welcoming everyone, the whole family. There is a family, then there is the elderly, only the elderly who go to the health clinic, hardly any other family members go and I think everyone should participate, be encouraged. (Vânia)

Networking is seen as a guideline for a more comprehensive intervention in biopsychosocial aspects related to families:

All this work, working with a family, seeing what are the problems that are conflicting within this family, because it is not just the question of a pathology, but those conflicts, those conflicts also cause a lot of [emphasis] illness in a family. We aim to avoid this. But it is difficult to work because we cannot live alone, we need these other services to help us. Because nursing, for example, what we can do, we can see, prevent diseases and infections by working, educating and providing, for example, condoms, contraceptives to prevent pregnancy, guiding the use. But when an area arrives, a psychiatric problem, an emotional problem, a financial problem, that's where the limit, our limit, comes. That there we need these other resources, these other institutions to be able to help and we can reach this level of health that we seek so much. (Samara)

DISCUSSION

The Family Health Strategy (FHS), was designed to reorganize the health care model, seeking a diversified space for professionals, aiming to guarantee comprehensive care for each family involved in this work process¹³.

The first step that must be established when proposing to study the theoretical universe of the family is to denaturalize multiple concepts that involve this analytical category and to think that it must start from a genesis or necessarily from a historical event.

This time, understanding family is not a very simple process, for that you need to know its history, what facts were important over time that caused the implications of the contemporary family, who is part of the family and what is their role in society.

In the category "*Perspectives of family(-ies) under different points of view*" the question was raised that although it is a very recurrent theme in studies in the social area, the family brings within it various expressions and meanings that make this social segment difficult to define, explained and understood. Therefore, it is not easy to understand the complexity of the family institution, especially in contemporary times.

It was noticed that the participants scored different views on the family, based on their daily experiences, subjectivities and professional training that helped in the construction of the highlighted perspective in the study. The family was identified as a reference, relational basis, linked to the idea of established roles, but also composed of affection, in addition to blood ties, with an expanded perspective of configurations. However, strangeness was also observed due to the finding of grandparents raising grandchildren, neighbors, friends, since the work process implies a relationship between people from different social classes.

The family can be approached from three different and complementary angles: 1. As a domestic unit, which is primarily concerned with material conditions, that is, with the maintenance of life: eating, dressing, sheltering and resting; 2. As an institution, representing a set of norms and rules, historically constructed, that govern the relations of blood, donation and alliance; and 3. As a set of values, defined as ideology, stereotypes, prescriptions, images and representations about what the family is or should be¹⁴.

Thus, including among the basic social institutions, it can be said that the family has the role not only of maintaining the survival of individuals, but also of protecting and socializing its members, producing the feeling of belonging, transmitting cultural and economic, fostering solidarity between generations, first instance of living rights and duties, in addition to other functions¹⁵.

In the testimonies, it was found that the participants' perspective on the family institution and its conditions are also combined with the main understanding that the family is the constituent reference of beings and for this reason is formed by key elements that attribute their role in society^{14, 15}.

The family has been formed since the dawn of civilization and at no time has one family model been shown to be the same as another. Each family has its particularity far beyond its structure and function, but it is confirmed as fundamental for the development of the individual, as it is a space of coexistence where customs, values and also conflicts are created, regardless of their configuration¹⁶.

The family is a synthesis of multiple social, historical, economic and cultural determinations, constituting a dynamic and contradictory totality; a historically conditioned social institution, but also dialectically linked to the social structure in which it is inserted¹³⁻¹⁷.

The family, in terms of structure, is determined by a complex integration of economic, social and cultural factors, which refers, on the one hand, to a historical-structural determination and, on the other hand, to the specific form of internal organization of the family group¹³.

The historical-structural determination leads to the observation of the existence of a variety of family models that establish hegemonic models, such as the nuclear family, in

bourgeois society, spreading to other social classes, but it also includes a variety of internal patterns that differentiate families between classes, and even with variations within each class.

As for the internal organization, the family is not homogeneous, there are asymmetrical relationships between its members, with differentiation of gender, generation, hierarchy, but also marked by processes of negotiation, cooperation and solidarity with a reality, as if can observe, full of diverging interests¹⁸.

It is pointed out that it was possible to verify, through the interviews carried out, that some of the participants observe the family starting from an idealization that it must be formed by the consanguineous figure of father, mother and child, in a patriarchal relationship, in which, in the absence of this structural standardization, what is considered is the family "disorganization/disorganization".

These elements signal the belief that, for the group of professionals interviewed, there is still an ideal family composition, which should not be taken away from the traditional patterns of formation of the family nucleus, which can influence the molds of the action performed by them in their different practices in the FHS, resulting in possibly moralizing and harmonious actions.

However, it is worth mentioning that it was also found that part of the team, based on their personal experiences, points to the family's understanding considering the societal transformations, in the midst of a more comprehensive understanding that the family institution materializes in different configurations and needs.

A sociological conception¹⁵ of the family category¹⁹, shows that, family is one:

*[...] group of people linked or not by blood ties, kinship or dependence that establish relations of solidarity and tension, conflict and affection between them [...] and [are conformed] as a unit of individuals of diverse genders, ages and positions, who experience a constant power game that crystallizes in the distribution of rights and duties [...]*²⁰.

This concept aims to accompany the social, historical, demographic, political and economic changes of family organizations based mainly on the advent of societal transformations.

As a result of these changes, the family is identified by the communion of life, love and affection in the bread of equality, freedom, solidarity and mutual responsibility. Therefore, currently, the family is not only formed by ascendants and descendants, it also does not originate exclusively from marriage, but started to seek the full realization of its members, in all aspects, involving more affectivity than property²¹.

Nowadays, "[...] there is a new concept of family, formed by affective bonds of affection and love"²⁰. However, society is already going through a new phase. Today, everyone has become accustomed to the new forms of family that have been distancing themselves a lot from the model formed by the family organized in the patriarchal system, although this one still exists, it is a minority. The contemporary family has become pluralized, it is no longer restricted to nuclear families, today there are recomposed, single-parent, homo-affective families and yet another numberless ways:

[...] the advent of the Constitution of 1988 inaugurated a different analysis of Brazilian families. Another conception of family took shape in the planning. Marriage is no longer the sole basis of this entity, questioning the idea of a strictly matrimonial family. This is evidenced by the fact that formality should no longer be the predominant focus, but rather the reciprocal affection between the members that compose it, redimensioning the legal valuation of extra-marital families²¹.

With regard to the category that deals with the "Dynamics of everyday life in the work process", he considered the perspective that family is produced in a peculiar way in the midst of the participants' daily professional praxis, where health work implied the recognition of the object of work by its agents in a different way.

In the midst of organizations and decision-making processes, it is necessary to recognize diversity, the processes of formation of subjectivities, the unique form of care production and the power inscribed in the dynamics of praxis “[...] *it is necessary to problematize the question that the complex world of work is not a place of equality, but of multiplicity, diversity and difference, tension and dispute*”²².

It was noticed that the daily practice of the professionals who are part of the FHS influenced the look they have developed regarding the perspective of family(-ies), in which some points stood out for the teams, such as: management and their charges via “System” and the consolidation of practice combined with training, professional subjectivity and experience in the service.

When dealing with the work process of the FHS teams and how daily life influences professional praxis in the perception of the object of action centered on the family(-ies), as recommended by the ministerial documents, it corroborates with the thinking of another study²³ which expresses that a health care model should focus on the content of the health system represented by practices, and not just on the continent as infrastructure, management and financing.

In presenting the different techno-assistance models experienced in the country, another research²⁴ highlights: the hegemonic medical model with medicalization of the problems and privilege of the health/disease duality; the Family Health Program (FHP), with intervention focused on the poor and excluded; the health programming technology model; the model of territorialized actions; the risk and injury prevention model; and the Family Health Strategy (FHS), with an interface between the technological combinations of the organized offer, districtization, health surveillance and reorganization of work processes.

There is growth of the FHS in Brazil, but its feasibility is challenging with regard to professional practices that should be centered on bonding, accountability, integrality and teamwork; and often the bureaucratic management of the system, with norms and quantitative logic of production of procedures ends up causing a low capacity for managerial innovation, with a strong impact on assistance and social control, including workers, who do not feel they are participating in a work collective²⁵.

In the interviewees' statements, many demonstrated that the logic of the work performed is sometimes reduced to a technical, biomedical, outpatient and hospital-centric perspective, prioritizing a panorama centered on consultations and on the quantity of these and on a more individualized assistance due to the demands for results and to comply with what is punctuated by management, which leads to difficulties and challenges for the consolidation of a practice focused on the family context.

Management is one of the challenges for workers to implement models of health care within the scope of SUS, especially in primary care and specifically in the FHS, since the reorientation of existing models will be possible, based on the recognition that all workers are managers of their own work, exercising degrees of freedom in the organization and execution of their practices.

The nature of the relationship that is established between the worker and the user will determine the type of bond produced, which may be of power or fragility, since this meeting may be guided by the valorization of the actors' autonomy and protagonism, or on the contrary, be of power dampening for the action of these actors, in the sense that the user is objectified by a work process focused on biomedical practices and centered on hard technologies, as standards and equipment, and light/hard inscribed in the established knowledge²⁶.

The change in the service provided to the population in health services must include changes in the organization of work processes, the dynamics of team interaction, the mechanisms of planning, decision, evaluation and participation²⁷.

The FHS as a model of assistance supposes the involvement of team members with the population of their territory, so that a bond is created between the family and the team, so that

the teams can plan and execute actions that aim to bring about changes in the context of users' lives²⁸. However, for this to occur, the work process must gain specific outlines, the professional needs to be qualified and have a differentiated profile, since the emphasis of assistance is not on technical procedures, but on the interrelation between team/community/family and team/team²⁹.

Service management is sometimes used as a “thermometer” for the operationalization of a more effective and comprehensive practice regarding the reference of assistance care to family(-ies). It was possible to perceive, with a certain prevalence in the testimonies, that the professionals enhance the service provided by the FHS based on the support obtained by the management, in which it should be up to it to stimulate and provide spaces for reflection about the work process, which can go through organization, for the real actions that were taken to solve a new problem, or even collaborate with diversified experiences that contribute to the qualification of professionals.

The innovation of management processes is possible by overcoming problems related to communication and integration that are predominantly of a political-organizational nature, that is, coming from the most macro level of management, from the higher hierarchical levels of management. A coping strategy is the creation and strengthening of co-management mechanisms for work that enable spaces for dialogue and discussion, allowing the resolution of problems and the redefinition of established rules and the charging for results of what is prescribed in the rules on the process in the FHS²⁸.

In this context, it is through a differentiated practice within the FHS that allows new outlines for the execution of actions that it will be possible to develop a critical perspective in these spaces, that is able to understand and promote the expansion of the referential of care with a view to a reorientation of the care model and the aspects that involve family dynamics, its functioning, its development and its social, cultural, demographic and epidemiological characteristics.

This requires professionals to have an attitude and posture that is based on respect, ethics and commitment to the families for which they are responsible, through the creation of bonds and participatory action in the construction of healthier environments in the family space²⁷.

The professionals pointed out that a more comprehensive intervention in this sense must rely on networking, observed as a guideline in this process. All health work is a network work, formed by flows and connections established between workers, these with users and everyone with health services¹⁶.

Networking, in this context, can represent the sharing of acts and knowledge as a possibility of meeting power between workers, thus envisioning the resolution of demands in a skillful and effective way.

The important thing is that within the praxis, the professionals adopt a conception capable of ensuring the family's participation in the definition and planning of assistance, starting to act with a view to instrumentalizing it to make decisions related to health and the illness of its members. This involves informing, discussing, sharing and negotiating with the family the diagnosed aspects that interfere with their process of being/being healthy, as well as actions and strategies that can contribute to reversing, when necessary, the situation found²⁸.

CONCLUSION

The definition of the Family Health Strategy (FHS) as a guide for Primary Care in Brazil formalized the family as the focus of care for health actions, understanding that the approach of this construct enhances individual care, and that family and individual form an indivisible whole .

Family-centered care has been discussed as an efficient way to promote the well-being and health of individuals. The appreciation of the family for a new way of care arose because it is believed that it is the major influencer of the health-disease-care process of its members. Therefore, health professionals must offer subsidies to the family, in order to encourage their participation and collaboration among their members, offering them autonomy to achieve better living conditions, in which one is able to assist the other in the health/disease process.

It was noted that the conceptions of family have been changing over time. These new established family constitutions imply new attitudes by professionals in the assistance of FHS teams, in search of comprehensive and quality care. It can be inferred that this can be seen as a challenge to be faced by health professionals, given that it was still possible to observe that it is imperative to overcome the conservative view of this social institution by some professionals, in addition to highlighting the need to overcome the impositions experienced in the spaces that imbue health practices for a view, sometimes still individualized.

To assist the family, the professional needs to be aware of the family's own concept and understand that, currently, it has taken other forms. This is another factor that reveals the importance of getting to know the family as well as this one has presented itself with its limits and possibilities in contemporary society and, mainly, in the public health scenario.

In this sense, it is necessary to break with the concept of the ideal/standard family as a parameter for assistance, that is, to transcend the sacralized and idealized perspective based only on the love between its members, starting these discussions in the process of training professionals to apprehend and consider doing that develops a new look at the dynamics of the work object centered on the FHS, which concerns the family(-ies), their conformation, their different configurations and meanings.

For the participants of this study, even though the nuclear family plays an idealized role for some, the insertion of new family configurations is recognized in their daily lives, being one of the steps for the family-centered care to be expanded. In addition, assisting each family in its own dynamics is putting the basic principles of SUS into practice.

Communication between managers, health workers and families is also effective in building new ways of producing health, since it allows for articulations and changes based on the needs identified by everyone involved in the construction of health work.

Family-centered care can be considered a major step forward to replace the biomedical model, still established in the country, but it also depends on a part of the professionals who carry out the FHS and on the “demands” of the management, including promoting the autonomy and protagonism of the workers, to diversify offers.

As limitations, there was the difficulty of access to some professionals to conduct the interviews and collect information on the subject due to the schedules and work demands.

Despite this, the production of this material signals necessary trends to be addressed and debated in the scientific field, however, it does not intend to exhaust the discussion that this area involves. The intention of the work was part of the logic of contributing to dispel the theme, in addition to suggesting and punctuating the materialization of further studies in identified gaps as imperative.

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Antonio Rubens dos Santos Dias contributed to the study design, data collection and analysis and writing. **Sâmia Luiza Coêlho da Silva** participated in the study design, data analysis, writing and review.

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