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Original article

Families, sexual minorities and diversity from primary care professionals' perspective: concepts and approaches*

Famílias, minorias sexuais e diversidades na perspectiva de profissionais da atenção primária: conceitos e abordagens

Familias, minorías sexuales y diversidad desde la perspectiva de los profesionales de atención primaria: conceptos y enfoques

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Abstract

Objective: to understand the way in which Family Health Strategy professionals conceptualize and approach families, and the difficulties and facilities arising from this work process. **Method:** a descriptive-exploratory, qualitative study. Data collected through interviews and submitted to content analysis, thematic modality. **Results:** two categories revealed that the conception of family is centered on affective relationships, with the bond being a factor that facilitates assistance, while the lack of professional preparation for a welcoming and inclusive approach to families that deviate from the heteronormative standard is an obstacle in daily services. **Conclusion:** the concept of family is predominantly based on affection, with traditional ways of conception and action persisting within it. Professionals have difficulty dealing with non-heteronormative families and those who do not take co-responsibility during the therapeutic process. The bond between professionals and families is crucial to overcoming the difficulties and weaknesses of the care process.
Descriptors: Family Health; Public Health; Nursing; Family; Sexual and Gender Minorities

Resumo

Objetivo: apreender o modo com que os profissionais da Estratégia Saúde da Família conceituam e abordam as famílias, e as dificuldades e facilidades advindas deste processo de trabalho. **Método:** estudo descritivo-exploratório, qualitativo. Dados coletados mediante entrevista e submetidos à análise de conteúdo, modalidade temática. **Resultados:** duas categorias revelaram que a concepção de família é centrada nas relações afetivas, sendo o vínculo um fator facilitador da assistência, enquanto a falta de preparo profissional para uma abordagem acolhedora e inclusiva às famílias que fogem do padrão heteronormativo é obstáculo no cotidiano dos serviços. **Conclusão:** o conceito de família baseia-se predominantemente na afetividade, persistindo modos tradicionais de concepção e de ação junto a ela. Os profissionais têm dificuldade de lidar com famílias não heteronormativas e com aquelas que não se corresponsabilizam durante o processo terapêutico. O vínculo entre profissionais e famílias é crucial para superar as dificuldades e fragilidades do processo assistencial.
Descritores: Saúde da Família; Saúde Pública; Enfermagem; Família; Minorias Sexuais e de Gênero

Resumen

Objetivo: comprender la forma en que los profesionales de la Estrategia Salud de la Familia conceptualizan y abordan a las familias, y las dificultades y facilidades que surgen de ese proceso de trabajo. **Método:** estudio descriptivo-exploratorio, cualitativo. Datos recolectados a través de entrevistas y sometidos a análisis de contenido, modalidad temática. **Resultados:** dos categorías revelaron que la concepción de familia se centra en las relaciones afectivas, siendo el vínculo un factor que facilita la asistencia, mientras que la falta de preparación profesional para un trato acogedor e inclusivo hacia las familias que se desvían del estándar heteronormativo es un obstáculo en los servicios diarios. **Conclusión:** el concepto de familia se basa predominantemente en el afecto, persistiendo en él modos tradicionales de concepción y acción. Los profesionales tienen dificultad en el trato con familias no heteronormativas y que no asumen corresponsabilidad durante el proceso terapéutico. El vínculo entre profesionales y familias es crucial para superar las dificultades y debilidades del proceso asistencial.
Descriptores: Salud de la Familia; Salud Pública; Enfermería; Familia; Minorías Sexuales y de Género

Introduction

Over time, the conception of family has undergone significant transformations. Until a certain moment in history, the family adopted a patriarchal, nuclear logic, centered on blood and genitive ties, but, due to the combination of various social transformations and new cultural values, it gave way to family arrangements centered on affective relationships.[1] Thus, discussing family means talking about the union of people who seek, through coexistence, a mutual company that promotes moral and psychological support, factors that do not necessarily depend on consanguinity to come to fruition.[2]

The Federal Constitution of Brazil defines the family as a basic institution of society

and a special object of State protection. The law text discusses the existence and permanence of civil or religious marriage, as the basis of the family, however, it does not determine its exclusivity. For State protection purposes, it recognizes the family entity as one formed by the stable union of a man and a woman, and also formed by any of the parents and their descendants.[3]

However, to meet the demands of social transformations, a modern concept of family was established, infraconstitutionally, in the legal field, through Law 11.340/06, popularly known as "*Maria da Penha* Law", which presents as a definition of family the community formed by individuals who are or consider themselves related, united by natural ties, by affinity or by express will.[4] In turn, the Federal Supreme Court, when judging the Direct Action of Unconstitutionality 4277 and the Claim of Non-compliance with Fundamental Precept 132, decided to equate homosexual unions with stable unions. Thus, it guarantees all the rights conferred by the Constitution and other laws pertinent to unions among people of the same sex, provided that, obviously, they meet the requirements stipulated by law in the Stable Union. It thus demonstrates an openness to new family models, on the part of legislator, in the face of visible changes, both cultural and social, occurring in Brazilian society.[5]

Therefore, in addition to the varied types of unions that characterize families, the terms homoparenthood, single parenthood and transparency are currently being discussed, concepts that seek to describe the new family arrangements present in society. Such arrangements are increasingly accessible due to the adoption system and assisted reproductive technologies.[6] It is important, therefore, to highlight the discussions around issues involving gender, gender identity and sexual orientation which, in a generalized and summarized way, state that sex is an anatomical truth, while gender is a sociocultural construction.[7]

Something is certain: lesbians, gays, bisexuals, transsexuals, queers and all other sexual orientations and gender identities (LGBTQIA+) live in and form families, generically called plural families. However, studies carried out in Brazil,[8] in Australia[9] and in Sweden[10] indicate that this population encounters a series of problems/difficulties in health care, the main cause of which centers on the lack of preparation of professionals.

A systematic review corroborates pre-existing statements by showing that individuals belonging to the LGBTQIA+ community face disparities within the health system, mainly due

to discriminatory experiences perpetrated by some professionals, a factor that fosters feelings of distrust and concern among these individuals in relation to health services. This contributes to the persistence of high rates of mental health problems, substance abuse, risky sexual practices, self-harm and suicide within this community.[11]

Nationally, health care offered by the Brazilian Health System (SUS – *Sistema Único de Saúde*) must be guided by the principles that guide the Brazilian National Primary Care Policy (PNAB) implementation: universality, accessibility, comprehensiveness, equity, continuity of care, accountability and humanization, with the purpose of valuing users/patients as unique subjects, worthy of qualified and resolute care. And it is through comprehensive care that holistic, effective care that meets the enrolled community's health needs is provided.[12]

Holistic care for individuals, considering their uniqueness and complexity, requires trained professionals specialized in different areas of knowledge. Therefore, according to PNAB, for the effective functioning of Family Health Strategy (FHS), it is necessary to establish a multidisciplinary team.[13]

However, the civic, social and professional training of these individuals follows the cis-hetero-normative binary logic and, even though the concept of family has undergone countless readjustments over the years, an ideal of what a "traditional family" would be remains latent in society. This has the potential to be reflected in professionals' limitation in developing a view that is not prejudiced or discriminatory aimed at people who deviate from the cisgender and heterosexual logic, and also at families formed by these groups.[8]

Considering the above, the question arises: how do FHS professionals conceive the concept of family and how is it approached in the service's daily routine? It is important to obtain answers to this question, as these professionals work directly in providing assistance to Brazilian families and their understanding of what "family" is can influence the assistance process. Furthermore, due to a noticeable lack of information capable of answering this question and considering it relevant for the advancement and improvement of the work process in the health field, the objective of this study was defined: to understand the way in which FHS professionals conceptualize and approach families, and the difficulties and facilities arising from this work process.

Method

This is a descriptive-exploratory study of a qualitative nature carried out with professionals working in the FHS in the city of Maringá, Paraná, Brazil, which, at the time of the investigation, had 33 Basic Health Units (BHU), 78 FHS teams, four Family Health Support Units and Home Care Service.[14]

The municipality's health department authorized the study to be carried out in three of the BHUs that already constitute an internship field for the institution to which the researchers are linked. One of these BHU has, in its coverage area, a population with a profile of greater socioeconomic vulnerability, while in the other two the middle class predominates.

Three visits were carried out in each of the health units with the aim of identifying potential collaborators. The selection of professionals focused on health professionals who met the following inclusion criteria: working in FHS for at least one year. It is important to highlight that health professionals who were not present or who could not be contacted during any of the three visits carried out due to their occupational commitments were not included in the study.

Before the visits intended for data collection, the main researcher asked the BHU coordinator to indicate the professionals who met the previously established inclusion criteria. The researcher then made the most of opportunities to personally contact potential professionals. To this end, on the days established for data collection, they remained at the service for the entire period (morning or afternoon). The invitation to participate in the study was made in person, at which time the objective and type of participation desired were informed. In total, 15 professionals were invited and all accepted, with the exception of a dental surgeon, who claimed that he had no time available due to his appointment schedule. Whenever possible, the interview was carried out on the same day as the invitation to participate.

Data were collected in November and December 2022, through individual interviews, carried out in a private room at the BHU itself, on a day and time according to the availability of professionals. Only one meeting took place with each of them, lasting an average of 15 minutes.

The interviews were conducted by the same researcher (cisgender gay man, final year nursing student who was trained to conduct interviews and analyze qualitative data), during which a script consisting of two parts was used. The first of them contained questions related

to professional sociodemographic characteristics (age, religion, education, role held, length of work in the profession), and the second consisted of a guiding question: "What do you understand as family?". Some supporting questions were: how do you see your family today? In your opinion, who makes up the family and what are their roles? When you provide care in your daily life, are you able to address the family as a whole? What facilitates and what makes it difficult to approach the family within the Primary Health Care (PHC)?

The interviews were audio recorded, after professionals' consent, using an electronic device, and then transcribed in full and stored in individual files in Microsoft® Word for analysis. Transcripts were subjected to content analysis, thematic modality, which recommends the completion of three stages: pre-analysis; material exploration; and treatment of results.[15] Analysis operationalization was guided by a practical script.[16] In the pre-analysis, after printing each of the transcriptions, the material was read briefly, followed by an exhaustive reading of the entire content, identifying the central ideas. In the material exploration stage, central ideas were grouped by similarity, giving rise to meaning cores. Subsequently, the statements that best represented the central ideas of each nucleus were identified and, subsequently, the descriptive syntheses prepared were grouped into categories.

Finally, in the results processing stage, a general synthesis of the findings was carried out, which were discussed with relevant literature, followed by inference and interpretation. To guarantee the quality of the recording of this research, the COnsolidated criteria for REporting Qualitative research (COREQ) parameters were used. The study was developed in accordance with ethical precepts contained in Resolution 466/2012 of the Brazilian National Health Council and approved by the Research Ethics Committee of the *Universidade Estadual de Maringá* (Opinion 5.385.925/2020). Professionals were guided regarding the ethical precepts of autonomy, anonymity, secrecy, beneficence, non-maleficence and social justice. Everyone signed the Informed Consent Form in two copies.

Results

The 14 professionals under study were between 33 and 60 years old. All declare themselves heterosexual and cisgender, 13 of whom are female, 10 married, eight evangelical/Protestant, eight with completed higher education and 11 with more than five

years of experience in FHS. Four of them were community health workers; three were nurses; three, nursing technicians/aides; two were physicians; one was a dental surgeon; and one was a dental assistant. From data analysis, two categories emerged.

There are several types of families: "In my case, it is father, mother and children"

According to the perception of the professionals who participated in the research, the current family focuses mainly on affective relationships and their conjugation is not necessarily linked to consanguinity. In their statements, they recognize that contemporary families are no longer necessarily formed by a father, mother and their biological children, and that there are countless possible models for forming a family. Among them, people who love each other, who care for each other and support each other stand out as affective phenomena that define the concept of family.

> *Family for me is a set of people who love each other, who are taking care of each other, who are supporting each other, who are living together, living together, in a certain agreement, in the same vision* [...] *in my case, it is father, mother and children, but there are other types of families, families of just two, three, ten, men, women, children.* (Community health worker 03)
> *For me, family is a nucleus of people who have an emotional connection and also kinship* [...] *not only by blood, but more on the emotional side, nowadays we see the various types of family, not only those related to blood. It is a nucleus where people interact.* (Community health worker 02)
> *A family is a group of people who live in the same house, who have common goals in that house and who take care of each other. The connection does not necessarily need to be blood-related* [...] *today families are very different from each other, and if they live together and have a bond of union, a fraternal bond* [...] *it doesn't matter* [...] *that is family!* (Physician 01)

However, the statement of some interviewees reveals a perception of family directly linked to religious principles, a conservative view, in which the concept of family excludes the diversity present in today's society.

> *The family was formed there in the beginning by God, it is made up of a man and a woman.* (Nursing technician 02)

On the other hand, other interviewees who present statements linked to a conception of family centered on religious roots, to which they feel they belong, demonstrate a concern to include plurality in their conceptualizations on the topic, mainly due to professional factors.

> *What family is for me, according to the principles of the religion I follow, which is Catholic, is made up of a man, a woman and children, one, two, three* [...] *that is up to each couple.* [...] *now thinking about basic care, what family is in*

> *terms of working in health, I think it goes a little beyond this concept of religiosity.* (Nurse 01)

The study showed that the presence and, therefore, assistance to plural families is a reality in daily health services.

> [...] *we assist any and all varieties of people, there are families, let's put it in quotation marks, as "standard", which are heterosexual couples, with their composition of children, but we also have and do assist homosexual families.* [...] *but for us, especially in the professional sphere, today in the face of access to information, in the face of everything that is published in the media, it is very natural for us, and they have also lost a bit of prejudice, in relation to of either wanting to hide or maintain secrecy* [...] *no, it is very natural today!* (Nurse 03)
>
> [...] *I've had children living with uncles, aunts, grandparents, homosexual couples, both women and men, for me if the child was fine, there was no difference, contact was good.* (Nursing technician 03)

As much as conservative and exclusionary concepts of the plurality of types of families existing in current society persist, these seem to be in the minority compared to statements that recognize the current heterogeneity. The reports highlight the existence of non-heteronormative families, including in health institutions' daily reality. When realizing the existence of so much diversity, the question arises: how is care provided and what aspects facilitate and/or hinder the progress of care? We seek to answer these questions in the following category.

Aspects that facilitate and hinder family assistance in daily life

As the statements reveal, trust, effective communication, demonstrations of support and, mainly, the bond formed between professionals and families who are assisted at BHU are the main facilitators for the success of assistance. In this context, it is necessary to pay attention to the fact that the majority of professionals interviewed have a long history of working in the teams they are part of, which is an important factor in making the bond effective.

> [...] *what makes it easier is that in primary care there is an organization of the territory. What team is he/she, when the patient is really referred to the team, we get to know him/her, we create a better bond.* (Nurse 01)
>
> *Communication that facilitates. Communication between professional and family. The professional will see the person's situation, the professional will guide and listen to what they have to say* [...]. (Dental assistant 01)

> *I've been here for five years, I didn't have a connection with PSF, I came from the hospital, nowadays I know the patients more by name. What makes it easier is that you know them, live with them, know about their lives, they have a certain trust in you, in the professionals who work with them, they have a certain openness to talk about a problem without being judged.* (Nursing technician 01)
> *I think it's demonstrating that we are there to help, "I came here to help you", "I came here to register, you won't need to go to BHU"* [...] *identify users' needs and monitor this need and always be helping in the best way possible in whatever way we can. I think this makes us create a bond, where they gain more trust in us, they know that "I can pass it on to her, that she will do her best to meet my need".* (Community health worker 01)

There is, on the other hand, an ambiguity regarding the bond, as it is considered one of the triggers for the high level of dependence of patients and families, who stop taking on the role of leading actors in the care of their loved ones, and even in self-care, delegating, almost exclusively, the responsibility for care, prevention and promotion actions to health teams.

> [...] *there are positive points of the bond and negative ones, of course, it creates a great dependence on us. Sometimes, we have to be careful with this, how far does this bond go so as not to create such a great dependence.* (Nurse 01)

In their statements, professionals revealed that the paternalistic profile, very present in society, hinders the progress of the service, given that families do not take responsibility for their health, showing resistance to self-care. This factor is aggravated when there is an older adult in the family.

> [...] *we still suffer from the welfare profile that we bring, and a little, if not quite, from the paternalistic profile, because, if we allow it, I have to take scales to the patient's house, I have to give the medication time to the patient, hold the patient's hand and say "Come on! Walk!".* (Nurse 03)
> *We notice people who want to delegate their obligations to us. During the pandemic, we brought a lot of prescriptions to prevent patients from coming to the BHU. Many thought it would be like this all their lives, "Oh, I need medicine", no, but now you have to see a physician* [...] (Community health worker 01)
> *There are some cases where they think we have to solve everything, the family thinks the work is ours,* [...] *I even do it, I take medicine, I take a prescription, but it's not my obligation, this is the family's obligation. In some cases, I stop doing it. I could do it, but I stop doing it so as not to take responsibility away from the family, because if you do everything, the family will move away and leave it to you.* (Community health worker 02)
> *I think the biggest difficulty nowadays, when it comes to families, is older adults, because the child goes to daycare, and where do older adults go?* (Physician 01)

> *Family is extremely important* [...] *but I experience many situations of neglect from family members, and this saddens us. When we have that older adult and the child arrives at my door and says, "Call the public prosecutor's office, because I'm not going to take care of them, it's not my responsibility* [...] (Nurse 03)

Some family groups do not take responsibility for the health care of their members. It is necessary to emphasize that the co-responsibility factor is provided for in the PNAB, but reports have shown that this is not a reality of services. If this factor is not implemented, the bond becomes a barrier and not a facilitator of the care process. The COVID-19 pandemic, according to the statements, contributed to this problem becoming even more significant.

It can also be said that, even though the presence of plural families is a reality in health services, some professionals' statement highlights the difficulty they have in approaching this population, mainly due to the lack of knowledge about universes that deviate from the heteronormative rule.

> [...] *in the approach, for instance, of people from the homoaffective part, that sometimes you have a certain difficulty in dealing with, in trying to understand this universe, because you are not part of it. This could be a difficulty that I have in coming in and trying to provide support. It would be one of the difficulties for you to be able to get there and give advice and talk, in short, that would be a difficulty, because in other psychiatric or pathological situations, I don't see any problem* [...] (Physician 02)
>
> [...] *because sometimes we even get embarrassed, we go to call the patient, it's a woman's name, when we look, the appearance is that of a man, and then what do we do? What is our reaction? Sometimes you call a female name, then you see it's clear that the person is no longer a woman. What is our reaction to this and our approach to the patient?* (Dentist 01)

However, even though they have externalized a series of difficulties in approaching and assisting these families, some professionals' concern in adhering to an inclusive attitude, using devices provided for by law, such as social name. The interviewees demonstrate concern about providing quality service to the clientele assigned to their operating unit, however they demonstrate a lack of knowledge to achieve this desire.

Finally, in addition to issues related to professionals, one of the statements highlighted the health services' fragility in dispensing treatments in response to the specific needs presented by this population.

> [...] *a homosexual couple came, they are two women, and she came to start her prenatal care, so I said, "Did you choose a donor and artificial insemination was performed?", "Yes!", "And how did you do it?", "At home!",*

> *then I said, "Huh, what do you mean at home?!"* [...] *they performed a homemade artificial insemination that I was unaware of until then, but she explained to me that there is even a way to teach it, they chose a mutual friend who collaborated, allowed himself to be the donor, without any legal obligation [...] "It worked, we got pregnant ". After a few days, "It's twins!", "Girl, what a home insemination that worked!", I said.* (Nurse 03)

The report exposes one of the difficulties faced by contemporary families, especially homosexual families, with regard to access to family planning. This causes this population to resort to conceptual methods that expose them to a series of health risks, indicating the need for professionals to be able to intervene and promote health guidelines that minimize risks to those involved, including the fetus.

Discussion

The analysis of the content learned showed that the concept of family focuses mainly on affective relationships and that there are countless possible models for building a family. Bonding, according to statements, is considered the main mechanism for reducing difficulties in access and approach, and the main means of obtaining successful health interventions. The fragility of carrying out a quality care process with family groups that professionals consider not aligned with the co-responsibility factor with regard to the therapeutic process was identified.

Professionals also reveal the difficulty in approaching families that deviate from the heteronormative standard. A similar situation was also identified in Sweden, where LGBTQIA+ people who sought reproductive health care revealed inadequacies and mistreatment in health care, which was linked to the consequences of heteronormativity.[10]

The results of this research demonstrate that for health professionals, currently the understanding of family is shaped, mainly, by affective relationships. Corroborating these findings, a Brazilian study states that biological connection is not a determinant of the form and intensity of the relationship among individuals in a family, but rather the bond that permeates the memories and experiences shared by family members.[17]

However, even though there are expansions of family concepts consistent with existing plurality, a model considered ideal for family formation still remains latent in society, which gains prominence mainly during waves of political and social conservatism, similar to those that occurred recently in countries such as Brazil and the United States,[18] or traditionally

in countries of Arab origin, where sexual orientation conversion therapy is used.[19] This conservative tendency was observed when some professionals interviewed revealed an exclusive view of diversity typical of contemporary times, mainly when reporting a perception of family linked directly and solely to religious principles.

Professionals' statements also highlight the difficulty faced by professionals in addressing, guiding and intervening in families' specific needs that deviate from the heteronormative standard. Corroborating the above, a study carried out in Santa Catarina, with the objective of describing transgender people's and nursing staff's experiences in healthcare at primary and tertiary level, pointed out that due to sociocultural circumstances, in which the hetero-cis-normative paradigm is considered natural, ideal and morally correct, health professionals' training process is deficient. This is because the knowledge imparted in academia is influenced by the current culture, meaning that there is not sufficient knowledge of the universe of possibilities of being in the world, directly harming the possibilities of equitable and effective care.[8]

This context reveals the importance of rethinking health professionals' training process. National research results highlight that, in Brazil, there have been considerable advances in implementing public policies aimed at human rights, sexual diversity and gender relations. In other words, what was previously done indirectly, through generalist phrases that preached the common good, free from any form of prejudice, as is the case with the 1988 Federal Constitution, today it has solidified with the implementation of programs and public strategies aimed at meeting a specific demand from a subjugated portion of the Brazilian population.[20-21]

As examples of existing programs and strategies, we have: the Brazil Without Homophobia Program; the inclusion of social name on the Brazilian National Health Card; the implementation and expansion of the transsexualization process in the SUS; a inclusion of the field "motivation of violence" by "homo/lesbo/bi/transphobia" in the Notifiable Diseases Information System (SINAN - *Sistema de Informação de Agravos de Notificação*); the Brazilian National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals, among others.[20-21] However, it is necessary that there is education aimed at meeting what is stated in these documents so that their assumptions are put into effect in professionals' care practice.

Brazilian, Spanish and Australian researchers[9,11,22] state that not only is it necessary to produce knowledge about the LGBTQIA+ population's health, but also to train health professionals to care for this population. In other words, professionals need to have access to the knowledge produced, and this must occur from the training process onwards for those who are still in the academies and also through continued training for those who are in services.

In the present study, it was shown that, despite the State's recognition of the right to family planning and sexual and reproductive rights, this is not a reality guaranteed to the population. According to a statement from one of the professionals, given the desire for biological motherhood, some families needed to resort to home methods. This is true of families who do not have the financial resources to undergo treatment in the private network, as assisted human reproduction involves a series of high-cost procedures. In this research, a successful situation was highlighted, although it deviates from the rule of most cases, because plural and even heteronormative families, which express the desire for biological motherhood/fatherhood, encounter a series of difficulties in realizing their desires.[23]

Studies support these findings by revealing that some countries, including Spain, have government incentives for assisted human reproduction, mainly due to the low demographic growth of their populations. However, this is not the reality in Brazil, where treatment is not covered by health plans and public access exists, but limited.[23-24]

However, despite barriers to accessing conceptional treatments, there has been a significant increase in the number of parents who self-identify as lesbian, gay, bisexual and transgender. However, a literature review that analyzed studies from Australia, Sweden, the United States and Finland revealed that, although many LGBTQIA+ parents have had positive experiences when using health services for their children, there are still numerous cases of homophobia recorded. Furthermore, according to the authors of this review, there remains a deep-rooted feeling of heteronormativity, manifested by the tendency of health professionals to make heterosexist assumptions and by heterocentric modes of health care provision. Because of this, researchers emphasize the urgent need to adapt the documentation used in healthcare environments, to raise awareness among professionals through training that allows these workers to identify and welcome LGBTQIA+ families in an inclusive manner.[25]

In the statements, for professionals, the bond is considered the main mechanism to

reduce difficulties in access and approach, and the means of obtaining a successful health intervention. This is highlighted in studies in Brazil, with emphasis on the field of public health, which show that the bond can be understood as a mechanism for coping with situations of vulnerability, as it increases the effectiveness of health actions. The researchers also state that the bond itself is an intersubjective encounter permeated by spontaneity, empathy and exchange, being an important element to effectively meet subjects' expectations, therefore being a health need.[26-27]

Professionals' unpreparedness for sensitive and welcoming action can be considered a barrier to bonding, and the lack of bonding, a barrier to quality of care. Such evidence was reported in research carried out in Brazil[8] and another in Australia,[9] which outlined a series of difficulties experienced by the LGBTQIA+ community when using health services, mainly due to the distance between staff and patient and negative experiences when using services. In line with these findings, North American research showed that sexual minorities have, due to unfavorable experiences permeated by prejudice, poor communication and disrespectful behavior by professionals, a negative perception of health care.[28]

The approach to families, if, on the one hand, is facilitated through the bond, on the other hand, professionals' statements converge towards a high dependence on patients and families, when the bond becomes very tight. This is mainly related to the co-responsibility factor, foreseen in the new PHC model. A Brazilian survey showed that the term is used in several official documents that deal with PHC and FHS, however, while health professionals have their responsibilities well defined, families do not. The rights, obligations and resources necessary for the family to take responsibility for care are not entirely clear. Moreover, the same research states that professionals do not pass on the necessary information to families for the care segment and the effective functioning of co-responsibility.[29]

Thus, qualified health professionals prepared to assist the plurality of families existing in the current social situation as well as the implementation of public health policies that are a distant reality from Brazilians' daily lives constitute a challenge for the health system. In this regard, there are notes from researchers indicating that continuing education is provided for in SUS documents and is fundamental in updating and exchanging knowledge between the various Health Care Network members, including users.[30]

Possible limitations of this study may be related to the fact that the interviews were

carried out during professionals' working hours and place, which may have restricted the time for participation and even inhibited more in-depth statements about some issues. Added to this was the occurrence of unplanned interruptions, which hampered the progress of some interviews. To overcome these issues, future studies could aim to observe professionals' performance in the exercise of their role, in order to identify how professionals actually act in their daily lives.

In any case, the results of this study are relevant and can contribute substantially to care practice, by pointing out that traditional and heteronormative training needs to be overcome. This change will enable health professionals to be prepared to work in the most varied scenarios and capable of meeting different population groups' health demands.

Conclusion

It was evident that conceptions of family, from the perspective of Family Health Strategy professionals, addressed in this study, although based on religious ideals, encompass, in a certain way, the plurality of family compositions present in contemporary society, with emphasis on single, intergenerational and homosexual parents. The approach occurs mainly based on the bond built and established over time, with respect, trust and dialogue being the preponderant factor for its implementation.

Professionals demonstrated in their statements that they recognize the importance of having the family as a partner in care. In line with this, they highlighted the difficulties they face when implementing a therapeutic process when they consider that the family does not take co-responsibility in treatment and care of members. This fact is stated to be more common in families with older adults, especially those who are dependent on basic activities of daily living.

Some professionals also expressed difficulties in approaching and assisting families that deviate from the heteronormative rule, which reveals the urgency in implementing changes in the training process so that professionals can be trained to assist all social groups.

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