The bond as a soft technology in the daily routine of the Family Health Strategy: perception of the user

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Objective. This study aimed to analyze the production of a bond between users and health care professionals in a Family Health Unit (FHU). **Methods.** This was a qualitative, descriptive study, with 33 hypertensive and/or diabetic users. Interviews were transcribed, analyzed and data were compared to the literature. **Results.** The users who have been accessing the FHU for years stated that the bond with professionals has grown weak, it is a fragile bond. When it does exist, it is directed toward some professionals in the team. A disruption in the bond was also mentioned in some situations, owing to individual issues. Establishment of a bond between the user and the health care professionals in the reference FHU consists of a soft technology. Therefore, it impacts quality of health care and the prevention and management of chronic diseases. **Conclusion.** Establishment of a bond is essential for health care professionals to become references for the users of health care services.

Key words: primary health care; delivery of health care; chronic disease; interpersonal relations.

El vínculo como tecnología leve en el cotidiano de la Estrategia de Salud de la Familia: el mirar del usuario

Objetivo. Analizar la producción de vínculo entre los usuarios y los profesionales de salud en una

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Unidad de Salud de la Familia (USF). **Métodos.** Estudio descriptivo de abordaje cualitativo realizado con la participación de 33 usuarios hipertensos y/o diabéticos. Se hicieron entrevistas que fueron transcritas y analizadas. **Resultados.** Los usuarios que utilizan la USF desde hace varios años dicen que el vínculo con los profesionales se ha fragilizado y, cuando existe, es direccionado por algunos profesionales del equipo. También, mencionaron el rompimiento del vínculo en algunas situaciones, debido a cuestiones individuales. El establecimiento del vínculo entre el usuario y los profesionales de la salud que prestan asistencia en la USF de referencia se constituye en una tecnología leve. De ese modo, tiene repercusiones en la atención de calidad y en el mantenimiento de la salud y en la prevención y control de enfermedades crónicas **Conclusión**. El establecimiento del vínculo con los usuarios es fundamental para los profesionales de salud; de esta manera, será una referencia para los usuarios que utilizan los servicios de salud.

Palabras clave: atención primaria de salud; prestación de atención de salud; enfermedad crónica; relaciones interpersonales.

O vínculo como tecnologia leve no cotidiano da Estratégia Saúde da Família: o olhar do usuário

Objetivo. Analisar a produção de vínculo entre os usuários e os profissionais de saúde em uma Unidade de Saúde da Família (USF). **Métodos.** Estudo descritivo de abordagem qualitativo realizado com a participação de 33 usuários hipertensos e/ou diabéticos. Realizaram-se entrevistas que foram transcritas e analisadas. **Resultados.** Os usuários que utilizam a USF há anos disseram que o vínculo com os profissionais está fragilizado. Quando existe, é direcionado por alguns profissionais da equipe. Também foi mencionado rompimento do vínculo em algumas situações devido a questões individuais. O estabelecimento do vínculo entre o usuário e os profissionais da saúde que prestam assistência na USF de referência se constitui em uma tecnologia leve. Desse modo, tem repercuções na atenção de qualidade, na manutenção da saúde e na prevenção e controle de doenças crônicas. **Conclusão**. O estabelecimento do vínculo com os usuários é fundamental para os profissionais de saúde serem referências para os usuários que utilizam os serviços de saúde.

Palavras chave: atenção primária à saúde; assistência à saúde; doença crônica; relações interpessoais.

Introduction

The Family Health Strategy (FHS) has been proposed by the Brazilian Ministry of Health (MoH), as a strategy to reorganize primary care and reorient the health care system model in the country, incorporating principles of the Unified Health System (SUS), which are: universality, decentralization, comprehensiveness and community participation. The FHS is characterized as the first contact within the Brazilian Health System for care, and it is structured inside Basic Health Units (BHU), which are located close to where people live.[1,2] The BHU with FHS should respond to social needs, including the health needs of the community in the area in which it is integrated. As they perform their daily practice, health professionals include among their work goals and objectives the satisfaction of needs related to the health-illness process.[3]

One of the fundamental principles of the FHS is the bond between health professionals and users, to ensure the continuation of health actions and health care.[2] Promoting features for its establishment are: a workload of 40 hours, coverage area for the population, community participation, work with families, and the presence of community health workers. This enables the client and the professional to be closer to one another. [1] In this regard, it is noteworthy that the word "bond" comes from the Latin, *vinculum*, meaning connection, a link. It is a concept that suggests interdependence, relationships of exchanges, and comprehensiveness of care.[4] The bond is essential for treatment adherence and continuity of care[5], and it goes beyond simple access to a health service by a user; it is also an ongoing and personal relationship, which is not transferable, i.e., a meeting of subjectivities.[6]

In addition, it is based on affection, acceptance, trust and solidarity between health professionals and users, and it is an essential element for quality of care.[7,8]

In this context, we observed the importance of the development of soft care technologies, such as promoting elements that strengthen the link between health professionals and users, as an essential factor to ensure the maintenance of health.[8] The bond helps promote a new type of care, which involves humanization, accountability and empowerment of the user, resulting in changes in the model of care.[9] In contrast, the distance between health professionals and users can diminish the bond, and consequently may encourage the abandonment of the therapeutic process.[8] In this respect, the relationship between the healthcare provider and user of services provided by the BHU, who have the FHS, is a challenge for the implementation of humanized practices in health care.[10] In addition, it is among the most challenging issues for reorganizing practices that must be provided by SUS.[5] Based on the above, this study aims to analyze the establishment of the bond between users and health professionals in a Family Health Unit.

Methods

This study used a qualitative, descriptive approach, and was part of the research project entitled, "Chronic condition and therapeutic itineraries: efforts to establish lines of care for health services users in the municipality of Pelotas, Brazil", developed by professors and students of the school of nursing from a Federal university in the southern part of the country, along with users and families living with hypertension and/or diabetes mellitus, living in the coverage area of the Family Health Unit. The study included 33 patients with hypertension and/or diabetes, enrolled in the *HiperDia* program, selected through a random drawing based on registration forms, from April to September of 2011.

Initially, users were invited to participate in the study, and then were informed about the objectives and ethical precepts of the study. Afterwards, agreement was given, by signing two copies of the Terms of Free and Informed Consent. All participants were guaranteed anonymity, the possibility to withdraw from the study at any time, and free access to the data when it was in their interest. Interviews were conducted at a previously scheduled date and time, so they did not intrude on the care routine. The use of a semi-structured questionnaire with open-ended questions allowed the user to discuss the issue subjectively. The same questions were asked in the residences of hypertensive/diabetic users, which was the scene for an extension project related to the study. Privacy was ensured during the study. Data collection allowed for recording of the sessions, which initially underwent qualified listening, and afterwards, they were fully transcribed. Subsequently data passed through successive readings to capture the essence of the information, as well as to interpret the data and group them into themes, based on the study objectives.[11] Information was analyzed and were compared with the literature and with reflections of the authors.

Data will be archived for a period of five years, and may be consulted at any time by those users who participated in the study. Moreover, their identity will be kept confidential. Therefore, we designated participants by using the letter U (for user), numbered according to the order of interviews, for an example: U01. Importantly, the principles of the National Health Council Resolution 196/96 were respected, in order to fulfill the standards for research involving human beings.[12] The research project was submitted to the Ethics Committee of the Federal University of Pelotas School of Nursing, under protocol number 192/2011, in March of _2011.

Results

The analysis of the interviews made it possible to highlight the main issues raised by users in regard to the bond, such as the: time spent in the BHU, popular understanding of the word

"bond", type of bond established within the BHU, identification of those health professionals who provided care in the BHU, recognition of users about the work performed by health professionals, and, the negative bond with professionals and its disruption.

With regard to utilization of the BHU, some users reported that they sought care there because they lived in the coverage area, as noted in the statements by U24 and U07: *Look, I've lived here for 20 years. For 20 years I have been coming to this BHU* (U24); *I think that since the BHU opened and for the time I've been living here. Since the BHU opened, I've been seeking care there* [UBS] (U07). Other users did not compare the time of utilization to their period of residence. However, they also mentioned a significant period of use of the BHU, as depicted by the users U11 and U12: *That was a long time.* [...] *About what... about ten years, I think, but let's say about nine years more or less* (U11); *Since the BHU was here in the [district name]. I do not remember, but for more than 30 years already* (U12).

When questioning users about the amount of time they had utilized the BHU, there were few who said that their use of the services offered was recent - represented by U10 and U13 – in a time of five years: it will be already for four years (U10); three or four years (U13). When the users were approached about the bond they had with the BHU and with the healthcare professionals, many users made clear that they lacked understanding about the meaning of that word. Soon, they interpreted the bond in different ways: as the reason for seeking the service (U03), the status of the unit (U06) and empathy with a specific healthcare professional (U27): *I think my relationship is to the hypertension, because I seek the BHU to deal with this* [hypertension] (U03); *What do you mean by bond? I do not seek the BHU much, just when I need it* (U01); I think that [UBS] is very dirty, horribly dirty [...] (U06); I live there, my dentist, everything is there. My dentist is there, I love her (U27).

The researchers, after realizing the lack of understanding by the users regarding the concept of "bond", tried to replace this word with the alternative term, "relationship", in order to clarify the idea of its meaning. However, there was still no understanding, as noted in the speech by U12: *How is that again? There are some things that could improve, for example, the drug, there is enough failure with the drug thing* (U12). At the time users were asked about the type of relationship established with the BHU, the stated reference was positive. However, they did not seek to deepen the way the relationship was set up, as it can be seen in the statements of U05, U09, U25 and U12*: It's good, very good, I can not complain* (U05); *It's good for me, it i*s good. *It is that way for me, so I have nothing to complain about* (U09); *For me it has been very good. I have nothing to complain about. I can not complain about them* (U25); *It's good, it is a possibility for people who need it most* (U12). Even being assured that their anonymity was guaranteed during the interview, most users merely said that the service was good: *It is good, the bad one is me, actually* [laughs]. *True fact, I can tell it. Most of the people complain, only see flaws, then I'm with them. But I am treated well, I cannot complain* (U07); *The bond that I have with the BHU started in my childhood, since they opened the unit here. The first of the medical records was ours, I have always been well treated here and always treated people well here. I never had any problem (*U33); *The service, to me, is very good, the only thing is that it's hard to find a doctor. Now it is organized by areas. Sometimes the person gets there, there is no doctor in your area and we can not see anyone. It's hard*! (U24). Some users reported having a negative relationship with the BHU, it was also emphasized by the participant, U13, that he only needed the service to pick up medication: *Terrible* (U18); *I do not like it there* [BHU]. *I go there because I am forced to pick up my medicine* (U13).

In the following statements, it is observed that most of the users were able to identify at least one of the health professionals who provided care in the BHU. This was especially true in regard to the medical professional, as they seemed to have a greater affinity for seeing patients in consultations. Secondly, the community health

worker (CHW) was mentioned, probably due to the greater number of home visits and the fact that they reside in the same territory. The nursing staff was also remembered in the speech of U12: *Their names?* [...] *I know the name of the doctor* [medical] from my area, Dr. [doctor's name]. [CHW's name], lives near that street (U21); *No, I just know the Dr.* [medical name], *who has seen me once* (U01*); [Name] is the community health worker. The medical doctor, Dr. [medical name], and the nursing [names of the nursing professionals], but the main one is the nurse [name of the nurse]. Look, it's one of the things I was never really into it, but now I like to observe how the care is delivered* (U12).

With regard to the identification of those professionals who go to their homes, some were unaware, such as U25, U19 and U16: No. *Who is seeing me most of the time is Dr.* [doctor's name]. *There was never a doctor for area two, now we have this doctor I do not know* (U25); *I do not know, before there was this guy from the BHU visiting me here at home, but for some time there is no one coming. I do not know, no one from the BHU is coming here* (U19); *Now I'm not going. Oh, I remind the nurses from there! They come here but I do not remember the name* (U16). It is noted that there is some difficulty on the part of some of the users in identifying the professionals working in the respective BHU, and many identified them by their profession, as in the U02 and U03 speeches: [...] I *only know they're* [BHU] *nurses, I am used to going there* [BHU] (U02); *No, I only know the nurses, I'm used to going there* [UBS] (U03).

Although there are difficulties in the identification of the health professionals, the recognition of the users about the work done in the BHU was mentioned. As shown in the statements of U10 and U26: *You are kind of well received, about that there is no doubt. The employees have nothing to do with it. That's it, what really matters is your health, not the employees, when you go, there is no one else to blame* [...] (U10); *Only the nurse* [name of nurse] *and the doctor* [medical name]. The doctor [doctor's name] saw me in November. *Then she [referring to her daughter] was there and consulted the same doctor and she was admitted by the PIDI* [Homecare Interdisciplinary Hospitalization Program]. *It was when I was hospitalized from home, that time I could not even walk* [...] (U26).

When questioning about the status of bond that users had with health professionals working in the BHU, a weakness or the lack of such a bond was noted in the statements of U06 and U01: *No, when I go there* [BHU], *only you* [referring to the interviewers] (U06); *No, no* [referring to the bond with professional] (U01). In addition to the lack of bond with the professionals, as highlighted in the previous two testimonies, the statements by U33 and U24 expressed the disruption in the bond with the professionals who provide health care in the BHU [...] *I had a bond with the doctor, the one that left area two. I forgot her name now. They sent her away* [...]. *Well, the new doctor who is there... I do not know if there is a doctor to attend area two, I did not search anymore for care* (U33); *Look, I think it's great so far, he treats me well. Only once in a while, you get used to that doctor, then they change their doctor. This* [doctor name], *who saw me, I consulted with her, she did lectures, she organized meetings for the hypertensive patients, I attended those meetings. She always tried to do things. Now, these others are already different. Now, the [doctor name] never did a meeting with her patients, she never did* (U24).

Due to the change of medical professionals, as noted in the previous statements, we noticed another disrupting factor to the bond: fragmented care, as represented in the statement by U07: *No, right now it is a mess, both of them are attending, there is no one in charge because the doctor left, I do not know what happened* (U07); The report of the wife of U07 exposed a situation that contributed to the weakening of the bond, which is the loss of trust with the CHW, as quoted: *The health worker was very nice, but now that I asked her to make an appointment, I asked for the remedies of [spouse's name] and she did not bring it to us. Then I asked her to mark a record*

for the elderly, she said that she would do it but she didn't (Wife of U07)

Discussion

In this study, considering the analysis of interviews with users who mentioned a significant utilization of BHU even before these units were rearranged as FHS, this factor ends up being part of their lives in a certain sense, favoring the development of bond. This fact is corroborated by the findings of a study conducted in a BHU, located in a neighborhood of São Paulo City - SP. The proposed objective was to identify the opinions, perceptions and needs of users, and we soon found that these subjects were using the services offered by BHU for a long time. Possibly, this leads to an understanding that people have a greater chance to really know the quality and the problems observed in the health unit they attend.[13] Another aspect observed in the study findings was the lack of understanding of users about the meaning of the concept of "bond". Even when relating it to the word "relationship", it was noted that during the interviews, users expressed positive and negative situations, whether with the BHU itself, or with the professionals. Often when reporting such situations, users end up providing the way in which the bond was established in a subjective manner.

It is important to highlight that the lack of comprehension lays not in a lack of understanding of the meaning of the word. In fact, the conceptual and academic sense is not actually a domain in the popular context; however, the use of other words is easily understandable, allowing them to express an existing relationship with the BHU and the health team. Even ignoring the definition of terms adopted by the interviewees, it is worthwhile highlighting that understanding constitutes a conquest, not an immediate event. The more appropriate the bond, the better the results, and the greater the exchange of knowledge between health professionals and the community.[14] In order to understand its meaning, we highlight that the bond constitutes the development of affective and reliable relationships between users and health professionals, enabling the deepening of the process of co-responsibility for health, established over time, in addition to having a therapeutic potential in itself. [2]

In this study, the observation that most users expressed the type of relationship with the BHU as good might be a modal esponse, since people could be avoiding complement your answers to avoid not compromising themselves. By the analysis of the statements, we inferred that, because the service provided is "free", people tend to consider it a favor and avoid questioning the care offered. In addition, there is a fear that a more detailed evaluation of the results could involve them as complainers or witnesses of the health care model practiced by the unit. In this context, primary care as a strategy to establish a better relationship for the demand might facilitate the development of bonds, providing teams with a possibility to increase flexibility of work processes and focus on finding satisfactory answers to the needs of users. This fact makes these services unique and distinguished in the manner of receiving the users, understanding them, tending to provide greater promptness and resolution for those who seek care.

When there is an appropriate bond, it strengthens user adherence to the service, inasmuch as there are needs to be addressed. The problem is when the relationship with the BHU is seen as inappropriate. Thus, the statements that demonstrated dissatisfaction with the care provided by the BHU become worrisome, as they may lead to disruption of the bond and the consequent discontinuation or withdrawal from treatment. Considering this, there is a need to establish greater contact between professionals and users, in order to allow them to know each other, to maintain a relationship, and have follow-up of the care.[14] It is important to know the user's perception about the care offered by health professionals, since the team can become aware of situations experienced, and understand whether the actions taken have been effective in improving people's quality of life.[15]

The establishment of a bond is intensely related to caring practice, demonstrated in attitudes of concern, interest and attention.[8] During the provision of care, it is necessary to have empathy between the health professional and the user, as this can ensure adherence to maintenance of good health.[16] In this sense, it is necessary to determine the cause of the disinterest of the enrolled population and the dissatisfaction with care, as well as to invest in soft technology with professionals who deliver care in BHS. The adoption of soft technologies in health care, and in partnership with primary care, permeates the first contact for care, the bond, and comprehensiveness. This is especially true for the health actions to be more adequate to enable that first contact with care to be able to address needs and involve the exchange of knowledge between users and health professionals.[14]

In addition, the principles adopted by the FHS, such as the prioritization of promotion, prevention and recovery of health in a comprehensive and continuous manner, should prompt professionals to reflect on practices that need to go beyond curative care. Therefore, it is necessary to rethink the model of care proposed by the FHU, focusing on the use of important tools, such as soft or relational technologies, especially the bond, as it helps in improving the care offered by public health. Thus, care that is offered with adequate listening and professional performance provides for the possibility of a bond between the user and the health service. This bond also allows professionals to identify the characteristics of the users who attend the health service, considering the priorities of each one of them. Furthermore, the provision of comprehensive care for the user enables the patient to feel safe and strengthens his/her relationship with the health professional, contributing to improvement of the health of those who seek the health service.[15]

We highlight that the allowance for users to express themselves, showing the most diverse opinions, contributed to the construction and negotiation of what is important for both the health service and the community. In this regard, it has allowed the implementation of the abstract guidelines for participation and social control, responsibility and ascendant planning, providing for the bond, and thus contributing to the consolidation of SUS.[17] Another aspect highlighted in this study was related to some factors that might have contributed to interrupting the establishment of the bond between the user-professional-service, including the frequent exchange of professional staff, constituting a relevant factor for the breach of trust in relationships. Although health care can occur with a different professional, this causes discontinuity of care and the need to start over again in terms of the process of forming a bond.

The establishment of a bond is essential, as it is a basic element in the health area. Thus, the bond developed in health care takes place in the context of caring relationships. The strengthening of the bond between health professionals and users promotes the production of care, through trust and shared commitment. [8] The health care actions should be planned collectively between health professionals and users, contributing to the establishment of a bond and co-responsibility, in order to build appropriate and effective methods for it to be achieved.[18] The FHS has contributed to the production of care by using the establishment of a bond between health professionals and users, through listening to patient's needs and individual participation in the planning of intervention and measures to be taken. The FHS uses health technologies that contribute to the autonomy of that individual, thus replacing the mechanical act of care usually performed by health professionals.

The study findings also showed that users recognized the work performed by health professionals, which is an essential observation to (re)think practices developed in BHU with FHS, aiming to increasingly improve the quality in care. This health care work perspective, in which one shares the recognition of the work of the other, requires the establishment of a relationship between those involved in it.[19] As well as this study, we highlight another research study that sought to know the users' perception of the performance of FHS professionals, demonstrating

that users realized nuances inherent in the working dynamics of this strategy. This factor constitutes an important aspect in analyzing the care produced by health professionals in the context of FHS.[18]

The bond is related to the proximity between the user and the health professional, thus becoming a key element in the work of FHS. Its presence enables the development of human relationships aimed at effective actions to care for their health. The findings of this study lead to an understanding that the establishment of a bond between the user and health professionals who provide care in the FHS constitutes a soft technology. Thus it has repercussions for improved care, for the maintenance of health, and the control of possible relevant chronic diseases such as hypertension and diabetes. Finally, it is noted that the establishment of a bond is essential for health professionals to be references for users who use health services, especially for those people who have chronic diseases such as hypertension and diabetes, as these diseases present high incidence among the population, with the possibility of leading to serious consequences if not treated or monitored properly.

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