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The family concept in the field of Brazilian health: a theoretical and reflective essay

Noção de família(s) no campo da saúde brasileira: ensaio teórico-reflexivo

Concepto de familia en el campo de la salud brasileña: ensayo teórico-reflexivo

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ABSTRACT

Objective: to discuss the term family in the field of Brazilian health through: 1) the historical review of the concept and family arrangement in Brazil; 2) the recapitulation and problematization of the term in Brazilian health; 3) the discussion in the Brazilian National Primary Care Policy. **Method:** this is a theoretical-reflective study. **Results:** the text was divided into: "Historical rescue of family transformations in Brazil", "First Basic Health Unit: the family" and "Brazilian National Primary Care Policy: which family are we talking about?", which helped in the argument about the problem of (non)definition of family. Amidst the concern about allocating family-oriented care, it becomes necessary to rethink this polysemic term, proposing the denaturalization of crystallized definitions that can emerge in professionals' work, which can produce actions based on (pre-)concepts and negligence to non-hegemonic families. **Final considerations and implications for practice:** it is necessary to discuss which conception of family is considered in the field of health and its repercussions, especially in Primary Health Care and in health policies, as in the Brazilian National Primary Care Policy, to minimize possible difficulties that may arise in professionals' actions when faced with the plurality of family realities.

Keywords: Primary Health Care; Family; Health Policy; Family Health; Health.

RESUMO

Objetivo: discutir o termo família no campo da saúde brasileira por meio: 1) do resgaste histórico do conceito e configuração da família no Brasil; 2) da recapitulação e problematização do termo na saúde brasileira; 3) da discussão na Política Nacional de Atenção Básica. **Método:** trata-se de um estudo teórico-reflexivo. **Resultado:** o texto foi dividido em: "Resgate histórico das transformações familiares no Brasil", "Primeira Unidade Básica de Saúde: a família" e "Política Nacional de Atenção Básica: de que família estamos falando?", que auxiliaram na argumentação sobre a problemática da (não)definição do termo família. Em meio a preocupação sobre alocar o cuidado voltado para a família, torna-se necessário repensar esse termo polissêmico, propondo a desnaturalização de definições cristalizadas que podem emergir na práxis dos profissionais, o que pode produzir atuações baseadas em (pré-)conceitos e negligências a famílias não hegemônicas. **Considerações finais e implicações para a prática:** é necessário discutir sobre qual concepção de família é considerada no campo da saúde e suas repercussões, principalmente na Atenção Primária à Saúde e em políticas de saúde, como na Política Nacional de Atenção Básica, para minimizar possíveis dificuldades que possam surgir no fazer dos profissionais ao se deparar com a pluralidade das realidades familiares.

Palavras-chave: Atenção Primária à Saúde; Família; Política de Saúde; Saúde da Família; Saúde.

RESUMEN

Objetivo: discutir el término familia en el campo de la salud brasileña a través de: 1) la revisión histórica del concepto y configuración de la familia en Brasil; 2) por la recapitulación y problematización del término en la salud brasileña; 3) para la discusión en la Política Nacional de Atención Primaria. **Método:** es un estudio teórico-reflexivo. **Resultado:** el texto se dividió en: "Rescate histórico de las transformaciones familiares en Brasil", "Primera unidad básica de salud: la familia" y "Política Nacional de Atención Primaria: ¿de qué familia estamos hablando?", Que ayudó en la argumentación sobre el problema de la (no) definición del término familia. En medio de la preocupación por la asignación de cuidados orientados a la familia, se hace necesario repensar este término polisémico, proponer la desnaturalización de definiciones cristalizadas que pueden surgir en la praxis de los profesionales, que pueden producir acciones basadas en (pre) conceptos y negligencia de familias no hegemónicas. **Consideraciones finales e implicaciones para la práctica:** es necesario discutir qué concepción de familia se considera en el campo de la salud y sus repercusiones, principalmente en la atención primaria de salud y en las políticas de salud, como la Política Nacional de Atención Primaria, para minimizar las posibles dificultades que puedan surgir en la actuación de los profesionales ante la pluralidad de realidades familiares.

Palabras clave: Atención Primaria de Salud; Familia; Política de Salud; Salud de la Familia; Salud.

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INTRODUCTION

The term family, originating from the Latin *famulus*, whose meaning refers to the terms created, servant and domestic slave, has different uses in everyday life, encompassing different meanings and interpretations.[1-2] This polymorphic aspect arises from the varied cultural, social, political, ideological perceptions, and from the various theories present in the fields of studies focused on the family, which makes it difficult to understand the term in a single definition.[1]

The difficulty in universalizing the term family can be seen in a literature review developed in 2003, whose objective was to identify the most used theories in studies on the family. Sixteen theories that produced specific conceptions about the term were found.[3] Almost ten years later, another study was carried out by the same authors who identified an increase in the amount of the 2003 findings, with 51 theories dealing with the concept of family.[4] This increase follows a "trend" that the term has of several changes in its definition, often supported by social and cultural changes. Since the term family is organized from an intersubjective relationship in the world, it is based on the symbolic exchange between genders and generations, by the mediation between culture/nature and the private/public sphere, being a product linked to culture, time and specific contexts.[5]

In the trajectory of the term family, different interpretations emerge arising from historical events that modify the hegemonic social parameters and that make it possible to (re)build paradigms. Among these events, feminist movements' achievements in recognizing the multiple women's roles, the possibility of divorce and shared custody and the recognition of homo-affective families were some of the events that influenced the construction of the family.[6] Even with the absence of a consensual definition, the term family is used indiscriminately in different contexts with different purposes, such as in the context of Brazilian health, in which the term becomes a motto for the development of public policies.[7]

In Brazil, the relationship between health and family has proven to be far away. Whether in interventions based on the process of aristocratizing the population to bourgeois standards, as in the colonial period, the development of specialized fields, such as family medicine, or in the development of health programs that use the family as a key point, the family relationship/health remains constant.[8] Mainly after the Health Reform, which provided new discussions on the health/disease paradigm, using the family as the basic concept for different health care strategies that helps to rethink the health/disease process.[7]

In this context, since the operating logic adopted in the field of health is a fundamental term, a basic question emerges when discussing this theme: after all, which family are we talking about in the field of Brazilian health? In an attempt to contribute to the reflection on this theme, the aim of this article is to discuss the term family in Brazilian health through three aspects: 1) historical review of the concept and family arrangement in Brazil; 2) recapitulation and problematization of the term in Brazilian health; 3) discussion in the Brazilian National Primary Care Policy (PNAB - *Política Nacional de Atenção Básica*), due to its importance in structuring the family health strategy. To organize the discussion, the text was organized into three parts, with the themes: *Historical rescue of family transformations in Brazil*; *First Basic Health Unit: the family*; *Brazilian National Primary Care Policy: which family are we talking about?*

METHOD

This is a theoretical-reflective study based on discussions carried out by Archanjo[8], Trad[9] and Mioto[10] on the family role in Brazilian public health and on the authors' position on (re) thinking of notion of family.

RESULTS AND DISCUSSION

Historical rescue of family transformations in Brazil

Throughout Brazilian history, the family has been the institution that, since the colonial period, has represented the standards and norms of conduct established by society. From the family focused on patriarchy, which exacerbated power and the father figure, which was the focus of hygienist practices, aiming at developing behaviors considered adequate by the bourgeoisie. The one in which romantic love changed marital relationships, the family took on different identities and characteristics over the years. In this transformation, three major historical excerpts help to understand the trajectories of changes that occur in the family: the period of greatest duration of traditional family (until the end of the 18th century); modern family (between the 19th century and the mid-20th century); and contemporary or post-modern family (from the 60s to the current period).[8]

Traditional family: until the end of the 18th century

The traditional family model was marked in the history of Brazil by the social aspects in force in colonial society, demarcated by slavery and patriarchy.[11] The Brazilian economy was present in the northeast, where vast sugarcane plantations were the focus of production on plantations located in rural regions, characterizing the large estates where elite families resided in large mansions, surrounded by slaves and dependents.[1,12] The understanding of family was not restricted to consanguine logic, as the members who participated in the traditional family included those who shared blood kinship, such as wife and children, and also individuals who established relationships based on several other elements, such as the religious and sentimental - friends and associates. Everyone owed obedience to the figure of the patriarch, as everyone was under his protection and orders, regardless of the relationship established.[8]

The activities that each family member performed were well supported by customs and traditions supported by laws that legitimized the traditional model inside and outside the domestic sphere and that prioritized the national power, which is the traditional model's cornerstone.[11] The other family members just obeyed and feared the punishments coming from the patriarch and had different social levels - the wives were confined to

the house and the children played only an instrumental role in the family, and both had the same social status as the slaves. Marriages were understood as businesses between families, there was no place for romantic feelings between spouses, and inbreeding relationships were common, as they had the function of preventing the dispersion of the patriarch's assets/power. Family members did not have their own rooms in their homes and were overcrowded with employees, relatives and family members, which provided for the absence of intimacy and privacy between family members.[11–13]

The figure of the patriarch was supported by a lordly elite that based its power on the possession of land and slaves, which valued social structure conservation, with recognition of the patriarchal power being necessary for this maintenance. The family role structured in this logic had great influence in the political domain, as actions and political participation depended on the relationships established with the figure of the patriarch, who sought representatives who defended their interests in the formal space of power, legitimizing the domination of patriarchy.[1,11]

Different works addressed this family context, such as *Casa Grande e Senzala* by Gilberto Freyre (1900-1987), and, for some time, it was considered the only hegemonic family model; however, even under the traditional model, other forms of family existed with other models of organization. Families with few members, widows, single parents, with slaves or Indian women[a], concubinage (stable relationships without authorization from the Church), and illegitimate (children outside civil and religious marriage) are some examples of other types of families that occurred in in conjunction with the traditional model, but which occurred more frequently in the lesser classes (except concubinage), due to the characteristics present at the time, such as the high migratory flow to explore the national territory, bureaucracy and the financial problems that involved the performance of marriage (civil or religious).[16]

An important addition to be made is that the patriarchal model, emphasized so far, is found not only in colonial history, but in modern and contemporary ones; however, this model tends to be modified with the passing of history, modifying some characteristics. This model lost some of its strength at the end of the 18th century, when the Portuguese Court arrived in Brazil, bringing with it changes that would affect the structure of society and the social understanding of the family.

Modern family: from the 19th century to the mid-20th century

The arrival of the Portuguese Court in Brazil marks several changes in social, cultural, political and economic structures. Previously, the power of the province, even though still subject to Portugal, was in constant conflict with the noble elite and their demands, which caused discomfort for the Portuguese Court, but an inconvenience supported by the metropolis. However, with the arrival of the Portuguese Court in Brazil, the power of the province would have to be turned to the Court and not to the noble elite. For this, new rules were implemented so that the Brazilian elite could absorb the European ideals of life. At this point, it was no longer enough for the Brazilian elite to have possessions or any connection with local traditions, what mattered was the possibility of "aristocratization".[8,12]

The process of "aristocratizing" itself aimed at framing the settlers to bourgeois ideals, being marked by medical knowledge that provided the State with the scientific basis to carry out practices aimed at the social transformations desired by the ruling class.

> The introjection of the desired patterns of practices and behavior was intended to constitute a model of family organization more suited to the liberal-Portuguese ideal, having as a consequence (or cause) the patriarchal family disruption and the State power centralization promotion.[8:29]

The patriarch power needed to be re-signified in order to weaken family power and, consequently, the lordly elite power. Through the medical power, family relationships of the traditional model were re-signified; consanguinity between members of a family was placed as a key factor for family definition, removing kinship understood by religion or sentimental ties. The roles of family members were well defined and differentiated for "good family functioning", giving each individual a responsibility – the woman was responsible for domestic care and child rearing; the husband took on the role of provider; the children, once just little adults who would grow up to help the family, become the central figure in the family.[8,11]

The definition of family roles and the cleaning of behaviors produced marked changes in Brazilian social structures by removing certain privileges aimed at the patriarch and establishing rules to be followed.[11,17] Family cleaning accentuated the risk of social addictions, physical illnesses and moral violence and exalted the maternal influence in children's education. The family becomes more restrictive and smaller. Houses, formerly large and without private compartments, began to be structured thinking about specific rooms for each member and their family functions. Family individualization begins to occur aiming at the established family social roles and the weakening of the previously defined model.[8]

The relationship between individuals begins to be understood by the reciprocity of carnal feelings and desires, and is now understood as an important part of marriage and procreation. The family constitution is no longer just a business for the patriarch and now passes to the sphere of desire and feeling of the spouses, thus giving rise to the ideal of a nuclear family based on love, protection and care for childhood.[8,17]

However, the new family model was established only for the bourgeoisie structuring, which excluded a large part of the Brazilian population that did not have the same economic reality as the elite to follow the established hygienist rules (like having their own house with individual compartments, women turning only to domestic care and child raising), which would become a problem in the mid-twentieth century, when Brazil starts its industrialization process and the less wealthy classes find it difficult to follow the "progress". Several mechanisms were developed

in an attempt to overcome the difficulties established by family hygiene practices, such as the development of workers' villages in factories, where workers followed the stipulated rules and were able (adaptably) to be "sanitized".[8]

Contemporary or postmodern family: the 60s to the present period

From 1960 onwards, the understanding of what the family is has found new changes arising from constant social and cultural changes, such as the insertion of women in the labor market; the capitalist system strengthening and the economy dynamization; the spread of anarchist ideas and the countercultural movements that opposed the Europeanization of customs; the intensification of feminist movements; the legal changes on marriage, which influenced the development and modification of what is understood as family in Brazil and in the world.[8] The changes occur mainly in the form of family organization in which more egalitarian patterns begin to follow, in which men and women share an idiosyncratic identity position, based on each member's individual differences, becoming more nuclear and privatized, due to the fragmentation of meanings and the crisis of figures considered to be of authority.[17]

These changes provide a diversity of arrangements and relationships between members of the same family, developing different arrangements that propose different types of families and renew pre-established concepts, redefining the roles of each member of the family group.[8,18] In these new forms, there are families with separated parents (in which the children do not live with the maternal or paternal figure), constituted by homosexual couples with children (adopted or generated in the laboratory), formed by siblings and nephews, grandparents, grandchildren, among other kinships, single parent families (consisting only of children and a parental figure), families formed by unions of people with children from other marriages, and more forms of families to be defined. In this context, the contemporary definition of family ends up being based on affective aspects, proximity to loved ones and the opinion of members about what makes them part of a family.[18] Other arrangements emerge due to solidarity related to socioeconomic conditions (mainly from the poorest strata and who suffer discrimination), in which family members need to stay together in the same environment in order to survive the existing economic and social adversities, leading to an increase in the number of active family members.[19]

First Basic Health Unit: the family

Among the different types of knowledge that act on the family context, the knowledge arising from areas related to the field of health was continuously present in the family environment due to: 1) being one of the first contexts that individuals are inserted in; and 2) being one of the first areas of informal care.[5] In this care provided, it is expected that there is reception and the fulfillment of families' physical and psychological needs and, concomitantly with this process, the projection of cultural, ethical, moral and humanitarian values that perpetuate important social behaviors for life in society.[2,5]

It is in this understanding of the responsibilities that the family "must" exercise (the word must is quoted, since the activities assigned to the family undergo problems of definition and availability to be exercised), which takes over a central place in several health policies. Mainly after the Health Reform, which provided new discussions on the health/disease paradigm, providing opportunities for debates aimed at community and family care, remodeling health services that, until then, followed the logic of the paradigm centered on the disease, focused on individualizing aspects with predominant biological interventions. This, for the model advocated by the reform, is insufficient to understand the health-disease process in its entirety.[2,19]

In view of this context, the family is elected as the central theme of public policies from the Health Reform, because, when understanding and intervening in the family, social, political and economic determinants, such as labor, territory and biological aspects, emerge as important characteristics that influence the health and disease process, preventing the reduction of individuals into anatomical parts and exclusion from their social context.[2,10] The family:

> [...] cannot be disregarded when it comes to public policies [...] is characterized as a complex space, which is built and reconstructed historically and daily through the relationships and negotiations established between its members, among its members and other spheres of society and between it and other spheres of society, such as the State, labor and market.[10:54]

Under this premise, in 1994, the Family Health Program (FHP) ended up being constituted as a method of structuring and strengthening the ideals advocated by the new model of health care, enabling actions to promote health for individuals, family and community, comprehensively and continuously, serving users in the local health unit, at home and in existing spaces available in the territories.[2] Even over the years, the family remains the focus of public policies. The FHP ends up being structured and organized, starting to be named Family Health Strategy (FHS). On March 28, 2006, through Ordinance 648, the Ministry of Health published the PNAB, becoming a historic landmark for the national consolidation of FHS, aiming at the reorganization of Primary Health Care (PHC). In 2008, the Expanded Family Health Nucleus (NASF - *Núcleo Ampliado de Saúde da Família*) was implemented in order to increase the resolution of PHC actions and services.[20] In 2017, with the revision of the PNAB through Ordinance 2436, the NASF has its nomenclature changed to Expanded Nucleus of Family Health - Primary Care (NASF-AB - *Núcleo Ampliado de Saúde da Família e Atenção Primária*).

This continuity of family and health relationship is sustained by different aspects that permeate both social health needs and the State's weakness in providing the necessary elements for social well-being. There are three characteristics that place the family in the reference of public policies,[10] namely: 1) individuals are assessed more by the living conditions that the family has than

by the individual status they have in society; 2) when the family manages to provide informal care for its members, it ends up reducing a possible demand that the State may have in assistance services; 3) "[...] when considering health as a special good, a direct constituent of each person's well-being, and recognizing the leading role of social determinants in the population's health conditions, it is unthinkable to dismiss the family as an important reference in public policies".[10:54-55]

The possible gap in the assistance provided by the State, in the field of health, for the population in general and the use of family as a way to eliminate this shortage present themselves in the face of the deviation of public policies of a universal character in detriment of policies aimed at specific population segments, causing the strengthening of the market as a provider of well-being and civil organizations. In this context, the family uses other artifices that do not come from the State and that are available by other instances to support the care provided to family members, such as in the field of health, in which there is a recurrent participation of private initiatives to fill the gaps that occur in State provision.[10]

In the State's retraction, families adopt solutions that are based on the autonomy of groups, following the individualizing neoliberal logic, but they find it difficult to resolve them due to the social inequities present in everyday life (high unemployment rate, high cost of food and housing, etc.), which it generates the exhaustion of families to meet the requirements of social protection and setbacks in terms of social citizenship.[10,21] This vulnerability influences the reduction of members belonging to the family group and the development of processes aimed at the impoverishment and deterritorialization of families.[10] In an attempt to maintain its protectionist characteristic and promotion of well-being, the family group uses several devices, such as (re)arrangements of family roles, in which there is a change in roles in the family system, or solidarity between members.[21-22]

Another important topic to be highlighted in the possible problems in using the family as a key point of public policies is the characterization of family. After all, the term has different definitions that characterize a vast possibility of family arrangements that can signal different forms of care and that allow for a discussion about which family is being addressed in descriptive texts of public health policies. Based on this theme, it will be analyzed and discussed below how the term family is developed in Ordinances 2436, 2436 and 648 referring to the PNAB, due to the importance of this policy in Unified Health System (SUS – *Sistema Único de Saúde*) actions.

Brazilian National Primary Care Policy: which family are we talking about?

As previously shown, Ordinance 648 consolidated FHS, reorganizing PHC in national territory through the PNAB. The publication initiated discussions on the institutional organicity focused on the care network, providing recommendations for health services, guiding work processes, functions of professional categories, system financing, among other recommendations, incorporating and disseminating the attributes of primary care in health.[23] In 2011, the Ordinance was revoked by publication 2488, on October 21, establishing the review of guidelines and norms that organize PHC in FHS and the Community Health Workers Program. In this new change in the PNAB, the points addressed in the previous edition are reaffirmed, but medical workload was made more flexible to make up for the lack of professionals in the teams.[23]

Subsequently, in the publication of Ordinance 2436, promulgated on September 21, 2017, a review of guidelines for PHC organization within SUS is carried out, bringing changes in the relativization of universal coverage, in the definition of different service standards, in team arrangement and work process reorganization.[24] Reading these ordinances is shown to be necessary, as: 1) they present the transformations in the theoretical and practical aspects of FHS during the reviews carried out; 2) are historical and official records of changes in the guidelines used; 3) are present in several teaching subjects that aim to clarify the FHS guidelines.

In the search for the definition that supports the notion of family by FHS, the full documents available on the internet were analyzed, looking for possible definitions for the term family and identifying probable characteristics that are being included in the term. The results found are that the ordinances together present the repetition of the term family 359 times (Ordinances 648 - 106, 2,488 - 161, 2,436 - 92), associated with the word strategy or used in order to classify the target audience, but they do not address the definition that supports the PNAB guidelines, which differs from the descriptive and conceptual care that the policy has on other elements that compose it.

The versions of the document objectively and clearly describe the various responsibilities that must be exercised by the PHC teams, covering various financial activities, implementation and continuing education, which underlie the management responsibilities to the activities that must be carried out by professionals working in Basic Health Units. The same detailed information appears in the description of basic concepts for understanding the PNAB, such as the definition of PHC and NASF-AB, in which the functions, necessary actions and justifications for these proposals are explained, specifically, the definition and fundamentals belonging to the PHC, which, throughout the editions, ends up being more detailed and composed of more features. However, the same accuracy of description does not occur in the definition of family.

In the term family recurrence, throughout Ordinances referring to the PNAB, there is a gap regarding the perspective used to support the idea of the family as a motto of public policy and what concept of the term is being adopted. Furthermore, there is also no indication of any official document that can be consulted on the aspects mentioned elsewhere, leaving the interpretation that suits them to the readers. In this aspect, a plurality of understandings regarding the family arises from the particular ontogeny of each individual, which may be in accordance (or not) with the elements and guidelines present in public policy, in this case, the PNAB.

In the absence of a formal definition (or guidance) and the possibility of subjective understanding of family, an unrestricted space for conceptualization emerges, especially for health professionals, who can allocate individual interpretations about the understanding of family in their practice. Above all, these conceptions are recurrent in the health field, as the understanding of family from the life cycle, or as a domestic unit in which people reside and are divided by biological characteristics,[11,25] conceptions oriented on specific aspects that restrict family plurality. This scenario can be seen in a study carried out with 24 professionals working in FHS, whose objective was to try to understand the meaning of family.[26] It was found that the professionals participating in the research had difficulties in conceptualizing the term family, presenting vague descriptions that excluded non-hegemonic arrangements, based only on biological aspects that provided a curative action focused on the disease, not promoting real health promotion actions, causing harm to the health of a portion of the population.[26]

The lack of assistance from non-hegemonic family arrangements, whether in the omission of their needs or recognition of basic rights, or even in the family arrangement disqualification, they do not align with the ideals proposed in the Health Reform, which comprises the breadth of the health and disease process beyond specific characteristics, which makes it necessary to constantly problematize family relationships to:

> [...] a comprehensive health care, focused on the family, both with regard to the proper forms of health care and diseases used by families, as well as with regard to the implications of family relationships in the process of falling ill, within what intends to be an expanded understanding of the so-called health-disease process, which takes into account the biological, psychological and social dimensions of these processes.[25:94]

This constant problematization must also occur due to historical[b] and everyday processes that are intertwined and part of the family constitution, such as marriage, pregnancy, birth, death, orphanhood, emancipation, among others that affect the elements of the family arrangement and attribute (or modify) different roles to group members. As shown, family (re) arrangements are multi-determined. The family (re)configures itself based on the possibilities present in its environmental and historical context, breaking with crystallized perspectives of purely blood and/or genetic relationships, also organizing itself in affective and survival relationships (e.g., single parent, grandparent, pluriparental, anaparental, simultaneous families, etc.). In this context, thinking about a concept that encompasses the plurality of factors that involve the family can prove to be an arduous task.

However, the problematization of the concept and the indication in official documents about the plural aspect present in the term presents itself as an initial possibility to develop a discussion or search for a concept that encompasses possible family arrangements. After all, when we are addressing public health policies, such as the PNAB, we seek to develop universal policies that are not exclusive, i.e., "public policies aimed at the family must address all families".[11:355] The concepts used in the construction of public policy undergo processes of redefinition and production of social meanings, amplifying and propagating possible ideals and forms of sociocultural perceptions, which can generate important changes in the social fabric.[27] Therefore, it is necessary to pay attention and be careful with the propagation of ideals that can generate exclusion or non-definition processes, as in the case of the term family.

In the end, the answer to the question "which family are we talking about?" in the context of the PNAB does not exist, as the policy does not address which family it is about. It addresses and describes the importance of a family in the health and disease process, but does not assume its description, leaving a field to be explored on the beliefs and practices that arise in the vagueness that the policy produces.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

One of the central terms in the functioning logic of SUS, the family was placed as a key part in the rethinking of health/disease paradigm in Brazil, being celebrated as a differential in health care. The centrality attributed to the term reverberates in different ways, whether in the development of strategies to the elaboration of campaigns, the family becomes the target of actions that value the population's health. Guidelines are developed to guide care involving this term, guiding health professionals towards the best application of the activities described. However, from the discussion developed elsewhere, there is a pending use of the term family in health with regard to theoretical reflection.

There is an organization of information in practice that involves the family in the field of health that fill the PNAB's various editions, but the same does not occur in the reflection on the importance and polysemy of the term family, despite addressing the importance of the term in PHC actions. As demonstrated by the family's historical rescue in Brazil, the term undergoes several transformations that change the arrangements, functions and roles established within the family, with a temporal/changeable character that allows for the plurality of interpretations and signals for care regarding the application of the term.

The lack of any element that signals, or a definition, or a discussion about the plurality of the term can contribute to a divergence between the ideals proposed by the PNAB and professionals' work. It becomes a subjective criterion for professionals about their understanding of family, which can lead to different biases and ethical questions for their daily practice. This occurs mainly when the individual understanding that professionals have about the term family diverges from the reality that emerges in daily life, which can enable actions of negligence in the care of families that diverge from hegemonic arrangements and in the perpetuation of stigma and discrimination on relationships.

Despite the theoretical-reflective study limitations, which is based on authors' unique theoretical and practical perceptions and experiences, in an attempt to contribute to this discussion, we can think of possible options on how to handle the problem presented in the field of health. First, to bring up the discussion (or, at least, signal) to official texts the plurality of family and the importance of its recognition for the health/disease paradigm, pointing out the possible forms that this term can take. Second, to develop studies on the different beliefs and practices that can arise in the field of the family, in the context of health, both in theoretical and practical terms. Third, to train, through continuing education in health, professionals who address this issue in their daily lives.

These possibilities do not cover the totality of ways that can help in the discussion of the term family, and other contributions to this field are still necessary. However, they can minimize the difficulties and conflicts that arise in the work of professionals when faced with the plurality of the family reality and, at the same time, apply the precepts established by the Health Reform model, in understanding the various aspects that influence individuals in their health/disease process.

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[a] The indigenous and African population (in colonial Brazil) was influenced by European logic, but there was no total loss of certain characteristics, such as polygamy, practiced by indigenous peoples (which also influenced Europeans). However, over time, these populations were forced to follow the notion of family established by the government and the Catholic Church, which placed (monogamous) marriage for the whole society, minimizing impure relationships. The African population, as slaves, had the possibility of forming a family within the conditions established by their masters (who had the guarantee of rights over any child born from the union of slaves).[14,15]

[b] When using the term historical processes, we are referring to specific changes in the family context and facts that affect society as a whole (e.g., changes in the roles of gender and sexuality, economic and political events, etc.).