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Situations related to health risk in families living in an urban sector of Pereira Risaralda, 2020

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Abstract

Introduction: Risk conditions for family health in the community of Pereira were identified in 2020. ***Methods*****:** a quantitative, descriptive study of 107 families with prior informed consent. Family assessment instruments were applied, considering the feasibility of identifying and interviewing the families. Given that the pilot sample consisted of 10 families, which was larger than the size suggested by the calculations. ***Results:*** The total number of people in the 107 families visited was 538. Seventy-five percent of the people visited came from the department of Risaralda, 10% from municipalities in Antioquia, 12% from Chocó and 3% from Venezuela. Their distribution according to gender corresponds to 56% women and 44% men. Fifty-four percent and 30% have primary and secondary education, respectively; 12% have technical education, only 3% have an undergraduate degree, and 1% have postgraduate studies; the largest number of people per family nucleus is between 4 and 5 people (37%), followed by 40% between 2 and 3 people, the remaining 23% corresponds to the most significant number of members between 6 and 9. ***Conclusion:*** In the families, risk conditions related to educational level, family composition and, therefore, changes in family typology are identified; occupation is related to informal employment**.** Communication difficulties are evidenced in the families, which implies the need to design an educational strategy that allows their intervention.

Keywords: Community, Community health, Community health, Family, Family risk, Family Health, Family Health, Community Health

Introduction

This article is based on the Systemic Organization theory of Dr. Marie Louise Friedemann. The phenomenon identified for the present study is family health risk conditions. The study is useful for family health because it provides information for the nursing care of families faced with risk factors such as individual risks by age group, biological-family risks, environmental risks and risks of health services and family; in the same way, it allows to propose programs and projects of integrated health care for individuals, families and the community, to improve the quality of life of these families. Finally, the results contribute to the training and care work of health professionals and other workers for the timely, adequate and integral provision of health services, considering the family.

Objectives

General Objective

To identify the risk to family health in family groups residing in La Laguna and La Florida neighborhoods in a commune of Pereira-Risaralda, in the first half of 2020 to formulate health promotion strategies aimed at minimizing the family risks found.

Specific Objectives

Describe the family typology and sociodemographic characteristics of the members

of the families residing in the commune selected for the study.

To identify the characteristics of intrafamily relationships, family dynamics, functionality and coping strategies in the participating family groups.

Methodological Design Framework

This chapter contains the following aspects: type of study, the universe, population, inclusion criteria, exclusion criteria, sample, study setting, ethical and legal aspects, description of the instrument, data collection, procedures and approach to the analysis of the results.

Type of study

This research is a quantitative, descriptive study. It is a descriptive study because through the data obtained from the information provided by the selected families, the data obtained from the instruments are described, which allows the interpretation and analysis of a situation of a population group that is in evident vulnerability concerning others (Hungler and Polit, 1997). Furthermore, the quantitative design implies a systematic collection of the information obtained through the application of family measurement instruments, which makes it possible to classify and analyze the research results, supported by statistical methods that organize and interpret the data obtained.

Population

Corresponds to all families residing in the commune Boston, Municipality of Pereira Risaralda, who meet the inclusion criteria.

Sample

Consisting of 107 families living specifically in the neighborhoods of La Laguna and La Florida, in the municipality of Pereira Risaralda, between February and March 2020, who meet the inclusion criteria. The pilot sample of 10 families, randomly selected, was planned and carried out in order to obtain preliminary information as a preamble and to carry out the calculation of various sample sizes following eligible levels of maximum admissible error and confidence. The estimated standard deviation in the pilot sample for the degree of family organization scale and the degree of family satisfaction scale, as a measure of their variability, was 5.02081 and 4.1605, respectively. In order to have a sample with as much slack as possible, the numerically larger deviation, i.e., 5.02081, was accepted, and an infinite population was assumed. With these considerations, the simple random sample size for this work was calculated using the usual expression for estimating averages since, within the description of the results, these will be a means for it.

Where $100(1-\alpha)$ % corresponds to the confidence level, expressed as a percentage; the corresponding percentile of a standard normal distribution; the estimate of the standard deviation in the pilot sample and the maximum admissible error in the estimate of the average of the dimension.

Given the feasibility of identifying and interviewing families, a simple random sample of size 107 was chosen, corresponding to a maximum admissible error of 1.5 and a confidence of 95 percent. Given that the pilot sample consisted of 10 families, larger than the size suggested by the calculations, a simple random sample of size 107 was chosen, corresponding to a maximum admissible error of 1.5 and 95 percent confidence.

Study scenario

The Boston neighborhood is located southeast of the city of Pereira; it is made up of 39 neighborhoods and has an area of 173.48 hectares and approximately 269 blocks. In the 1960s, the municipality ceded some land from the Boston farm and the first neighborhood was created with 339 homes, which is called the same name as the commune. Five years later, the El Vergel neighborhood was created, and in 1967 the San Luis Gonzaga neighborhood was created; INURBE created these neighborhoods. In 1999,

the commune was modified and separated under agreement 002 of January 4, 1999, the sectors of the town and Samaria. The Boston commune is bordered to the north by the center, and San Nicolas communes; to the south by the El Rocio commune; to the east by the commune, the town, and part of the El Rocio and El Jardin communes; to the west by the university commune, the Boston neighborhood bears its name because there was a hacienda called Boston located there. In 1960 Mr. Alberto Grisales and his family arrived in this neighborhood; these people were in charge of taking care of the construction materials, at first they did not have public transportation service to enter the neighborhood because the bus only reached the Providencia neighborhood, then Mr. Luis Arias, Mr. Leonardo Flórez and Mr. Hernando Álvarez met to talk to the mayor and transit to solve the transportation problem and that is how the Pereira urban route began to operate. The neighborhood, formerly called "Morro Bajo" because it is located in a hollow, was created by Mr. Perchides in 1990 and was built under collective work. the neighborhood is located on a creek and a guayaba, which is why its founders had to take stones from the river to cover the water filters. At first, access to the neighborhood was on bridle paths built by the founders because there was no main road. This neighborhood has a diversity of cultures; people from different parts of the country inhabit it, coming from Tolima, Santa Cecilia, and Pereira, among others. Informality was present in the Boston commune; the neighborhoods of La Platanera, La Laguna, La Florida and Travesuras correspond to settlements that originated as invasions and were later supported by the state to become neighborhoods.

The company la rosa donated the health post, and the Santa Teresita school began to function in the place where the health post is today, and its first nurse was Mrs. Etelvina Restrepo. The police post functioned for the first time where the vulcanizadora Tolima is today and was inaugurated by Mr. Edgar Castaño for hitting a police corporal in the face, which occurred during a party in the community action booth of the Boston community, data taken from memorias urbanas Pereira (2001).

Data collection

Considering the availability of the researchers, 107 family visits will be made, and informed consent was requested from the head of the household or his/her representative. Informed consent was requested from family members over 18 years of age; parental authorization was requested to allow them to participate for children between 7 and 18 years of age. For children 7 years of age or younger, only their age, gender, and morbid events present at the visit will be recorded.

A survey was applied containing the following variables: 1. Sociodemographic characterization of each family member; 2. Neighborhood mapping was available. To ensure a homogeneous distribution, up to 53 families were surveyed from each neighborhood, previously marked on the cartography. In addition, as a quality control mechanism, 10 records were randomly subjected to telephone validation processes. For the analysis of the information, an Excel database was created and analyzed in SPSS, using relative frequency measures. The purpose is to generate actions, recommendations and formative strategies that inspire the adoption of measures to mitigate family health risks.

Description of Instruments:

The measurement of family health and its conditions was carried out through the application of instruments validated worldwide. Following the MIAS Integrated Health Care Model, these instruments allow the diagnosis of the family's health status. In addition, the survey includes the variables of family composition and sociodemographic characterization of the members of each family group.

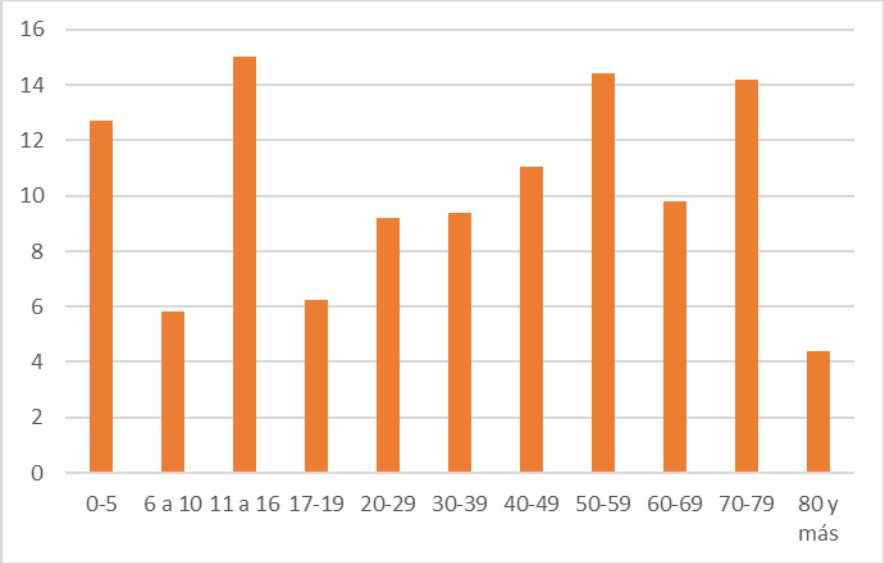
Analysis of results

The results were obtained using the family visit technique; the total number of participating families was 107. Therefore, the total number of people in the 107 families visited was 538.

Seventy-five percent of the people visited came from the department of Risaralda, 10% from municipalities in Antioquia, 12% from Chocó

and 3% from Venezuela. Their distribution according to gender corresponds to 56% women and 44% men.

Figure 1. Age

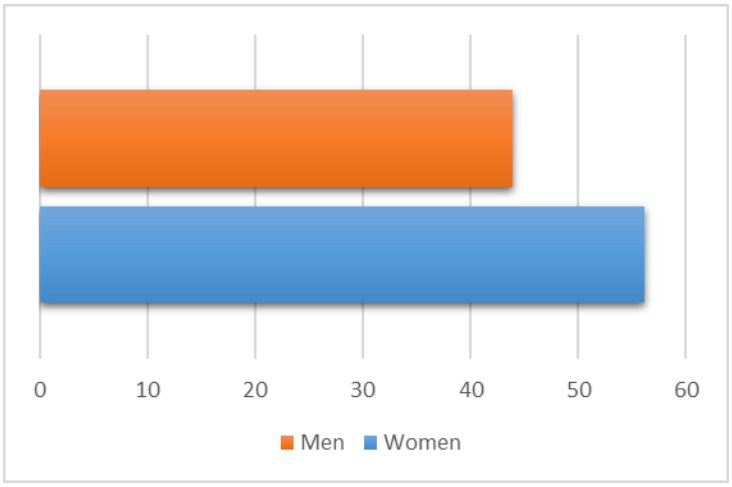


Source: Family Assessment Instrument

There is a percentage of 27% of people with the role of parents, uncles, aunts, brothers, cousins, and grandparents ranging between the ages corresponding to the range of 40 - 59 years with 25%. Followed by a percentage of 18% in the age range of 20-49 years and 28% for people over 60 years. Sixty-five percent are people over the age of 20.

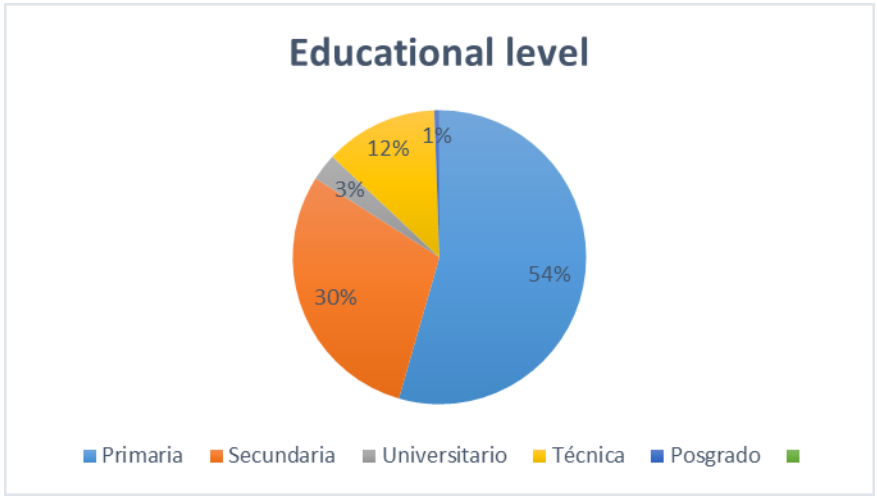
In this way, the family structure thickens in people over 36 years of age, a period in which people of potentially productive age are located. The ages of the adolescents that make up the family nuclei are recorded in the age range of 13-19 years with a percentage of 19%; children between 0 and 5 years and between 6 and 12 years correspond to 13%; periods where the relationship of economic and social dependence generates greater demand to the potentially productive group from the variable in question. Although Colombia's population and demographic pyramid currently shows a transition because the dependent age population - children and adolescents - that must be supported by the adult population is decreasing, the results show a significant percentage (32%) of children and adolescents that make up the structure of families.

Figure 2. *Sex*



Source: Family assessment instrument

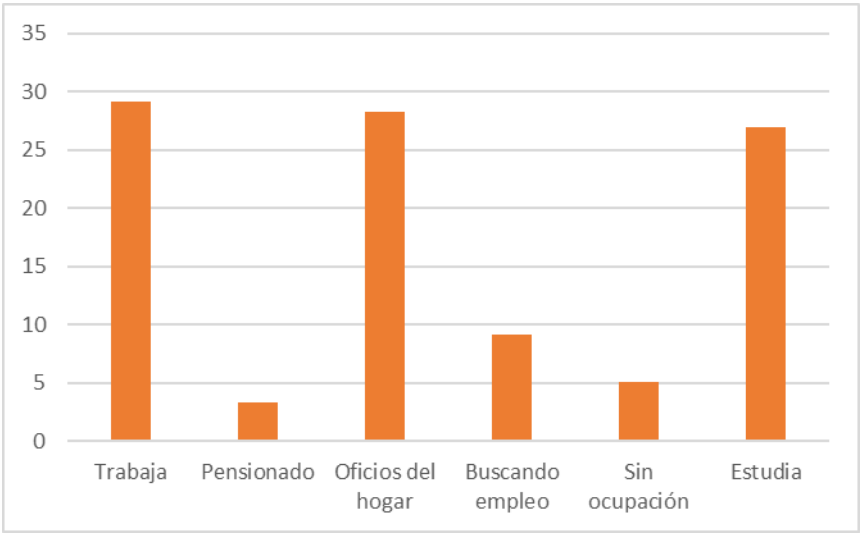
Figure 3. Educational level



Source: Family assessment instrument

Regarding educational level, 54% and 30% had primary and secondary education, respectively, 12% had technical education, only 3% had an undergraduate degree, and 1% had postgraduate studies. It is noteworthy that despite finding that most family members only reach secondary school, it is important once the new generations come to the educational training.

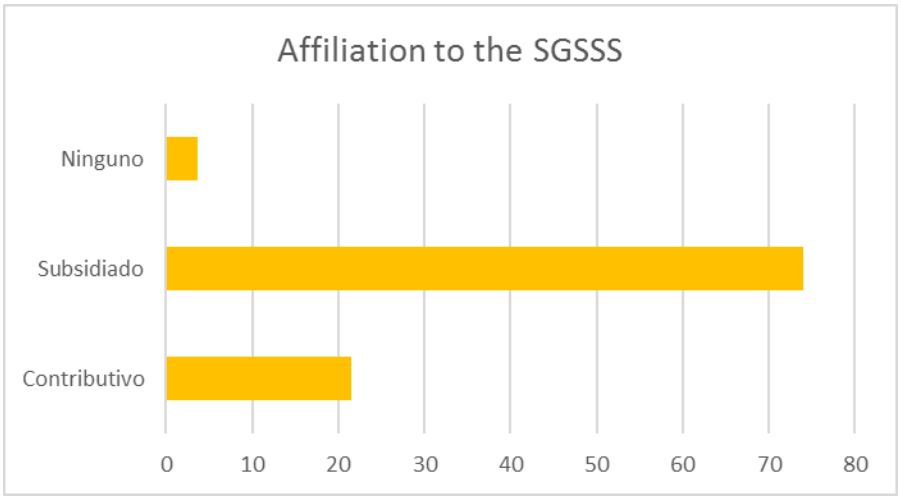
Figure 4. Occupation



Source: Family assessment instrument

Concerning occupation, the activity they perform was evaluated, finding that 29% of the family members are employed, 28% are engaged in housework, 9% are looking for work; however, 27% are studying, and the remaining 5% are unemployed, which for this report was defined as those who do not have a productive activity but are not looking for it either. As for the employed persons, they declare themselves as dependent (29%) or independent (71%); the area of productive activity is in order Commerce, Construction, Other, Agriculture, Health and Education (31,25, 22, 12, 5 and 4), a situation directly related to the educational level discussed above.

Figure 5. Affiliation to the SGSSS

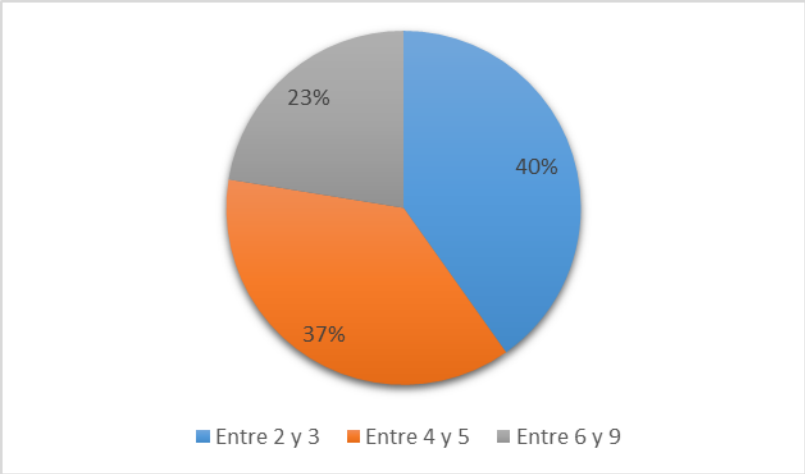


Source: Family assessment instrument

Regarding affiliation to the health system, 22% are contributory, and 74% are subsidized; a significant 4% do not have such affiliation, and it is necessary to explain the benefits and obligatory nature of being part of it. Although affiliation to the system is not synonymous with health, it facilitates access to care for illnesses, their early identification and treatment.

2. Family composition

Figure 6. Number of members per household



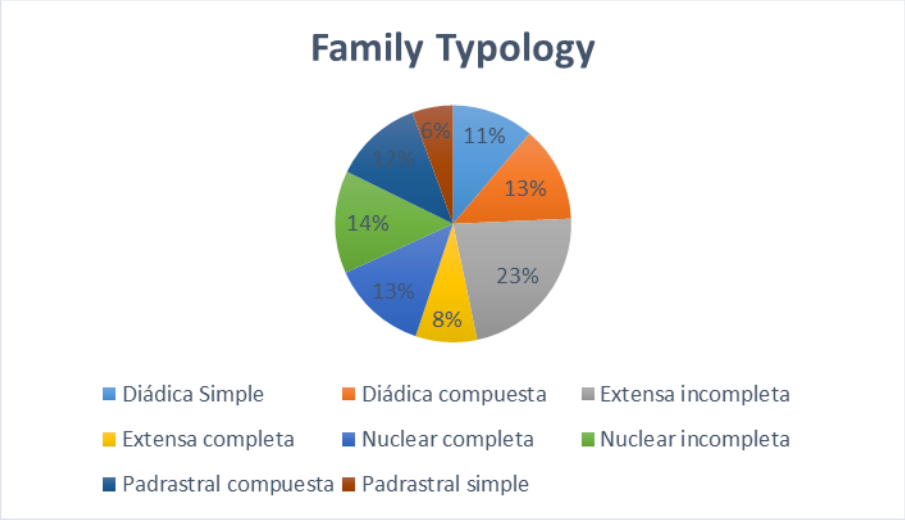
Source: Family assessment instrument

Family composition is a dynamic, changing process in which the moment or situation in which the family is studied intervenes, as well as the life course of each of its members. The composition refers to the number of members that make up the family nucleus and the structure refers to each of its members, the position they occupy, the roles they assume and, of course, the relationship between them. Therefore, through this, subsystems can be recognized: 1. Individual subsystem, which is formed by each of the persons, 2. 4. Sibling subsystem, formed by the set of siblings.

For the present work, and in terms of members per family, the largest number is located between 4 and 5 people (37%), followed by 40% between 2 and 3 people; the remaining 23% corresponds to the largest number of members between 6 and 9, the above is consistent with the situation in Colombia, where according to the National Demographic and Health Survey (ENDS) the number of people per family is at 3.5. (ENDS, 2015).

b. Family typology

Figure 7. Family Typology



Source: Family assessment instrument

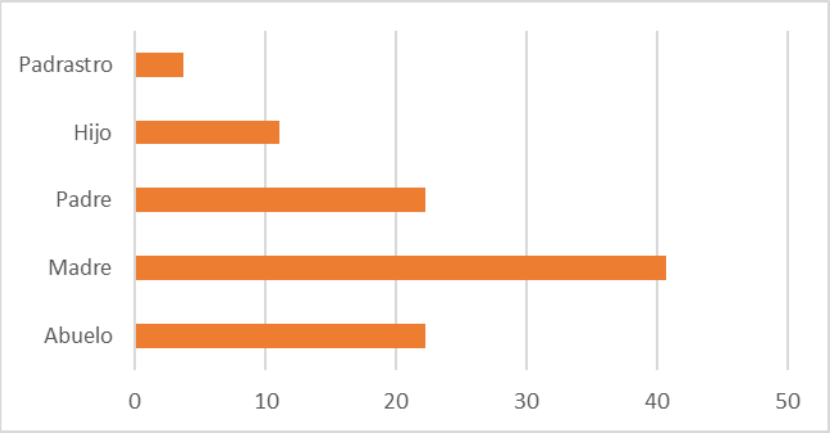
The typology of family structure allows the classification of families, considering the relationship between its members, and implies identifying the integration of families. When analyzing the information, it was found that 13% are nuclear families, that is, those in which there are parents and children; this type of family is the most prevalent in Colombia and is considered the most stable for the children. Of these, 50% are biparental (presence of both parents), the remaining 50% originating from the death of one of the spouses or divorce.

As a result of separation or divorce, 6% of families are identified as reconstituted, in which there is the presence of a stepfather or stepmother; the literature suggests that this type of family should be considered with special care; the insertion of a person from outside the family nucleus implies the reorganization of tasks and the assignment of roles. Considering the family as a primary source of socialization, it is evident in the direct observation of the family views the priority of the parents in their life projects for the educational formation of their children and the support that the children receive in their formative stage. Furthermore, the connotation of study in the medical area is a motive for the families' collective achievement and improvement of the educational level in their family nucleus.

In the same way, there are single-parent families known as simple dyadic (11%) and composite dyadic, in which the children are cared for by people other than their parents (23%), in this case, grandparents or uncles, which is explained by economic reasons, death, youth or perhaps by the migration suffered by Colombia in previous decades, in which the economic situation influenced them to seek a new path in European countries such as Spain or London. Finally, in the case of extended families, which correspond to 30%, they are defined by the coexistence with grandparents. They are characterized by the existence of solidarity in which there is support to the family nucleus either with the care of the grandchildren, by economic support or by accompanying the parents. Therefore, it is important to evaluate the typology to identify risks and thus make interventions in advance.

c. Illnesses of the family nucleus

Figure 8. *Role of the person with the disease*



Source: Family Assessment Instrument

When exploring the presence of diseases, it is recognized that chronic diseases such as Arterial Hypertension and Diabetes are those that prevail (45 and 19%), respectively; also among them are diseases such as Fibromyalgia and Arthrosis, Obesity, Hypothyroidism and Epilepsy, there are also antecedents of breast and skin cancer. Although the people who present these diseases are mostly the parents, the mother has the highest percentage (41); it is noteworthy that both grandparents and fathers (men 22%), the children obtained 11% and the stepfathers 4%.

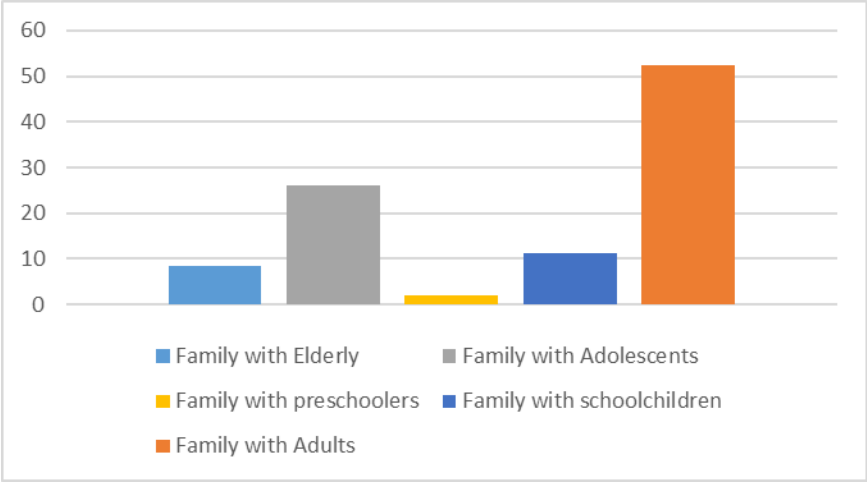
e. Norms and Values

Authority and control are exercised by the head of the household, who is represented in most families by the paternal figure, although very closely by the maternal figure. The rules are explicitly defined, allowing them to be clearly enforced; as for the limits, they are clear, although 2% correspond to diffuse limits.

f. Family Life Cycle

The life cycle is defined as the stages of progressive development, beginning at birth and ending at death. The life cycle facilitates the understanding of the individual's behavior, the normality of development and predicts problems and conflicts that may arise. Two types of cycles are distinguished: ***Individual Life Cycle,*** in which the age of each individual who is part of the family is recognized, aims to recognize promptly the crises they are going through. The Family Life Cycle: This cycle is recognized starting from the age of the eldest child. Families evolve with time; a development process involves successive changes in the different stages until they reach a sense of wholeness and purpose, which allows them to feel that they have lived fully and satisfactorily. Such changes include biological, cognitive, psychosocial and psychosexual aspects, which respond to individuality with their environment's social, genetic, environmental, cultural, economic and historical conditions (Gómez Urrego José F., 2014).

Figure 9. Family Life Cycle



Source: Family Assessment Instrument

In these families, the stage 5 family with adult children is characterized by the fact that the oldest child is between 20 and 59 years old, a situation consistent with the age and family typology (52%); the family with adolescents is 26%.

Conclusions

Young adults prevail, who are in the range of potentially productive ages since they are perceived as an expert, serious, committed, mature, disciplined, responsible and respectful of the rules.

Adolescents are registered in the family nuclei, being this a stage of development and changes where conflicts are generated that, as parents, they do not always know how to manage or solve adequately.

The predominant occupation is that of workers and employees, workers and, therefore, their families generally receive an income below the current legal monthly minimum wage with which they cover the essential expenses such as food and transportation, leaving aside what a family requires to have a decent life, quality education, recreation, sports, recreational activities, among others.

It can be observed that the educational level is mainly at the primary and secondary levels, respectively, which reflects the need to achieve better levels of social welfare and economic growth since education contributes to achieving fairer, more productive and equitable societies.

Improving employment levels, leveling economic inequalities, raising the cultural conditions of the population, expanding opportunities for adolescents and young people, and strengthening values that strengthen relations with society. According to the affiliation to the health system, there is a great demand for the subsidized regime taking into account that the population is attended the Boston Health Center that provides health services of the first level of attention, whose function is to promote the social welfare of the population of the municipality and the socioeconomic development of the region; through actions of health promotion, disease prevention and institutional and rural general medical care of recovery and rehabilitation of the disease; directed to the population affiliated to the various health regimes: subsidized, contributory and poor not affiliated.

The largest number of family members per family is between 4-5 people, with a greater frequency of two-parent families and, to a lesser extent, reconstituted families, where it is of vital importance to establish special care

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