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RELATIONSHIP BONDS IN SOCIAL INTERVENTION: A PARADOXICAL COMPONENT OF HOME ACCOMPANIMENT

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ABSTRACT. This qualitative study describes the insights of health professionals on the relationship component of an Advanced Home Visit Model (ViDA). The implementation of this model involved a training stage for professionals together with their participation in the execution stage. Qualitative data were obtained through phone interviews to 12 professionals, in-depth interviews to 6 professionals, being 3 of them directors of family healthcare centers, and the analysis of 85 individual reports from 34 professionals trained in the ViDA model in two districts of the Metropolitan Region of Chile. Data were organized by subject and analyzed through content analysis. Results highlight the relationship component of the model is perceived as a key aspect in the home visit schedule and is also valued by the professionals as a positive aspect. From such point of view, this component favors the bonding of visited people, increases a favorable attitude towards change, generates deeper transformations, facilitated the achievement of goals, and promotes women empowerment. Also, professionals remarked some challenges the training stage is not solving such as improvement in records, planning of interventions and development of visit purposes.

Keywords: Healthcare professionals; relationship, social intervention.

O VÍNCULO NA INTERVENÇÃO SOCIAL: UM COMPONENTE PARADOXICO DO ACOMPANHAMENTO DOMICILIAR

RESUMO. Este estudo[4] qualitativo descreve as percepções dos profissionais da saúde sobre o componente relacional de um Modelo de Visita Domiciliar Avançada (ViDA). A implementação do modelo considerou uma fase de capacitação dos profissionais e a participação deles na prática. Os dados qualitativos foram obtidos através de uma entrevista telefônica à 12 profissionais, uma entrevista em profundidade à 6 profissionais, 3 deles eram diretores de centros de saúde familiar, e da análise de 85 informes individuais de 34 profissionais capacitados no modelo ViDA, que pertencem a duas comunas da Região Metropolitana do Chile. Os dados foram organizados por temas e trabalhados usando a análise de conteúdo. Os resultados mostram que o componente relacional do modelo é percebido como um aspecto central na realização das visitas, sendo valorizado

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positivamente pelo/as profissionais. A partir da percepção dele/as, este componente favorece a vinculação com as pessoas visitadas, motiva uma atitude mais favorável às mudanças, gera transformações mais profundas, facilita alcançar os objetivos da intervenção e promove o empoderamento das mulheres. Além disso, o/as profissionais também percebem desafios que a capacitação não resolve: a melhora nos registros, a planificação da intervenção e a formulação dos objetivos da visita.

Palavras-chave: Profissionais da saúde; vínculo; intervenção social

EL VÍNCULO EN LA INTERVENCIÓN SOCIAL: UN COMPONENTE PARADÓJICO DEL ACOMPAÑAMIENTO DOMICILIARIO

RESUMEN. Este estudio cualitativo describe las percepciones de profesionales de la salud acerca del componente relacional de un Modelo de Visita Domiciliaria Avanzada (ViDA). La implementación del modelo contempló una fase de capacitación de los profesionales y al mismo tiempo su participación en la puesta en práctica. Los datos cualitativos se obtuvieron de la aplicación de una entrevista telefónica a 12 profesionales, una entrevista en profundidad a 6 profesionales, 3 de ellos directores de centros de salud familiar, y del análisis de 85 reportes individuales de 34 profesionales capacitados en el modelo ViDA, pertenecientes a dos comunas de la Región Metropolitana de Chile. Los datos fueron organizados por temas y analizados usando el análisis de contenido. Los resultados señalan que el componente vincular del modelo es percibido como un aspecto clave en la realización de las visitas, siendo valorado positivamente por las y los profesionales. Desde su percepción este componente favorece la vinculación con las personas visitadas, motiva una actitud más favorable al cambio, genera transformaciones más profundas, facilita el logro de los objetivos de la intervención y promueve el empoderamiento de las mujeres. Asimismo, perciben desafíos que la capacitación no resuelve: la mejora en los registros, la planificación de la intervención y la formulación de objetivos de la visita.

Palabras clave: Profesionales de salud; vínculo; intervención social.

Introduction

Home visits have proved effective in social programs oriented to childhood. This is an intervention strategy that offers support to families and/or individuals in their own home through meetings of varying frequency lead by a professional or non-professional visiting agent (for example, a community agent) (Olds & Korfmacher, 1997; Duggan et al., 2007). There is increasing evidence on the positive impact of home visits on childhood development, family wellbeing and positive rearing practices, when visits meet some criteria such as clear objectives, and visit frequency and intensity, among others (Sama-Miller, Akers, Mraz-Esposito, Coughlin, & Zukiewicz, 2018; García-Huidobro et al., 2021). Evidence and evaluations of programs using this strategy confirm that home visits are effective in the promotion of positive family relationships, child development, prevention of child abuse, school-admission preparation, health improvement (Duffee, Mendelsohn, Legano, & Earls, 2017), and building the relationship between families and networks that facilitate overcoming poverty (Duffee et al, 2017). Although there is a large body of evidence on the positive effects of home visits, "[…] it is still perceived as an underlying concern that home visits too often are of an insufficient quality to make a significant difference in the lives of vulnerable

children and their families" (Segal, Sara Opie & Dalziel, 2012, Euser, Alink, Stoltenborgh, Bakermans-Kranenburg, & van IJzendoorn, 2015 cited by Korfmacher, Frese, & Gowani, 2019, p. 382).

At the Latin American level, home visits have become a social intervention strategy widely used in early childhood protection programs, such as *Criança Feliz* (Happy Child) in Brazil, Cuna Más (Craddle Plus) in Peru, *Programa de Acompañamiento a la Política de Primera Infancia* (Accompaniment Program for Early Childhood Policies) in Nicaragua, *Infancia Mejor* (Better Childhood) in Ecuador, *Programa Infancia* (Childhood Program) in Uruguay, *Educa a tu* Hijo (Educate Your Child) in Cuba, and Chile *Crece Contigo* (Chile Grows up with You) in Chile, among others. These programs seek to increase parenting skills, improve the abilities of parents and caregivers to create a stimulating, loving and safe environment for children, and connecting families with health and other social services. These programs comprise variable frequency visits (from weekly to monthly), whose duration ranges from 45 minutes to 2 hours. Professionals and no-professionals are in charge of these programs, and intervention foci are preferably psychoeducational, addressing topics such as parenting skills, care of newborn care and child nutrition (Leer, López Bóo, Pérez Expósito, & Powell, 2016).

In Chile, child welfare relies on the Comprehensive Child Protection Subsystem 'Chile Grows with You' program (ChCC from the Spanish Chile Crece Contigo). The implementation of this program started in 2007 with the purpose of promoting the comprehensive development of children since their conception until they reach the age of 10 through universal services for the child population of Chile, as well as differentiated assistance directed at vulnerable children and families (Chile, 2018). According to the assessment conducted by Clarke, Cortés and Vergara (2019), Chile Grows with You has succeeded in improving neonatal health in Chile among participants of the program, with stronger effects in families from vulnerable areas (target population).

The Chile Grows with You subsystem uses the Comprehensive Home Visits (CHV) model. This visit model is employed mainly as a strategy for protecting early childhood, and seeks to improve emotional, language and cognitive development. This social intervention strategy aims to accompany women in vulnerable conditions and children's caregivers. Its implementation is associated to the specific stages of pregnancy and/or the development milestones of a child's first years of life, establishing the strengthening of prenatal development, the comprehensive progress of children and attending to children in vulnerable conditions as central pillars. Although the evaluation of home visits in the context of Chile Grows with You is positive, as these demonstrate to be "Effective for several key results but facing diverse challenges that reduce their impact" (García-Huidobro et al., 2021, p. 2). A relevant aspect identified is to "Reinforce or train professionals in relationship skills so visits fulfill their main objective, which is to establish a strong bond between the professional and the family" (González, 2018, p. 23). The study conducted by ICCOM (2013, cited by Saavedra, 2015, p. 73) about the implementation and operation of Comprehensive Home Visits of the Chile Grows up with You System indicates that the components to improve are "[…] the training of professionals (49% refers not having undergone training in Comprehensive Home Visits) and the intensity of the service in terms of the expected outcomes (51% of users only receive one Comprehensive Home Visit)".

Advanced home visit model: ViDA

Currently, there is consensus that the term home visit comprises a wide range of models, objectives, and types of intervention, with the common denominator being that they are conducted at the home of the participating families (McNaughton, 2004). The majority of them are models that tend to combine diverse conceptual frameworks, integrating intervention foci and strategies from different disciplines (Chile, 2009). Among the most recurrent models observed in works on childhood, mothers, fathers and caregivers is the model centered on access to services that aim to bring the benefited families closer to the community resources and networks, helping them satisfy the needs and lacks at home and reducing their stressors. A second model is based on providing information as a support and education strategy, focused on knowledge of parenting skills and stimulation, while a third model centers on support and behavior observation that seeks to guide parents and/or caregivers on responses to child behavior in order to improve their relationship with their children through the previous observation and interpretation of their behavior. Finally, a fourth model is based on the relationship between home visitors and the social service user, which employs counseling strategies (long-term accompaniment of families in specific life situations) and psychotherapy, which requires professionals trained in this specialty (Chile, 2009).

The ViDA model is focused on the improvement of the quality of primary health care programs through the strengthening of the competences of professional teams for social interventions at homes, with an emphasis on promotion and prevention through technology. Specifically, ViDA aims to (a) strengthen knowledge and develop professional skills for a social intervention centered on the resources or people and that enable a positive relationship with the families, (b) promote the development of supervision skills in professional teams, which contribute to strengthening their critical reflection upon the intervention they conduct, and contribute to their wellbeing and motivation for work, and (c) strengthen the m-Health skills of health professionals through the use of mobile apps (on tablets), in order to increase the effectiveness, regularity and quality of home visits.

The characteristic that differentiates the Advance Home Visit Model (ViDA) from other models is that it is made up of three elements that articulate and interact synergically, namely reflexive supervision for professionals conducting visits, use of technological tools to improve visit implementation and management, and focus on the relationship between professionals and whoever exerts parenting and caregiving, contributing to the strengthening of visit implementation and results[5].

In the ViDA model, reflexive supervision plays a relevant role for visiting agents. This supervision focuses on professionals so they can reflect critically about their intervention, having the possibility of reflecting upon "[…] how to build 'the case' and the subject who is 'a user of the service" (Taylor, 2020, p. 135, emphasis added). The supervisor accompanies professionals on their review, answering questions and helping them to look at all possible angles of the cases by encouraging visiting agents to broaden their perspective in order to have a better approach to them instead of providing them with solutions. Supervision requires regularity over time (at least once a month). This supervision model promotes self-awareness and self-reflection about work performance (Cerfogli, 2019) while contributing to identify elements to reformulate the policies sustaining the intervention, becoming an exercise for continuous improvement.

[5] To delve into this aspect, see García-Huidobro et al. (2021).

The technological component of ViDA is a mobile app that allows professionals to access intervention logs, work with people using diverse educational material (videos, datasheets, links to the Chile Grows Up with You website) and record the experience (Cerfogli, 2019). Five modules are found in the app. Module No.1 allows professionals to coordinate their visits. Module No.2 grants access to the history of the intervention and information about the family. Module No.3 supports the intervention during home visits by providing access to forms to log the intervention, test application, audio recording, educational material to use during the visit, writing of narrative texts and the scheduling of next visits. Module No.4 allows the professional conducting the visit to select, visualize, access video links or any other type of file corresponding to any of the visited families in order to inform and guide the intervention process. The system associates the case with the information contained in its history, from which it recommends the visiting agent some selected and embedded material. Module No.5 corresponds to the space professionals have to access their own personal information, visited cases, and confirmed scheduled visits (Cerfogli, 2019).

Likewise, the ViDA model gives great importance to the relationship built during home visits, as this is a central element of the work conducted with families. The visiting agent, in addition to providing information, should act as a change agent, maintaining an open dialogue to reach work agreements (Cerfogli, 2019).

The relationship: a strategic component of home visits

One of the fundamental aspects of home visits in the context of early childhood is the relationship between the professional and the adults responsible for the care of children (Korfmacher et al., 2007; Damashek et al., 2020; Laurenzi, et al., 2020). The evidence indicates that home visits are successful when they, among other aspects, focus on bonds (Sama-Miller et al., 2019). The generation of a positive relationship and a systematic accompaniment process over time improves parenting skills in families and program adhesion. “Current findings suggest that this relationship is associated with other aspects of the program’s process such as participation or overall satisfaction with the program” (Korfmacher, Green, Spellmann, & Thornburg, 2007, p. 477). The study by Damashek et al. (2020, p. 14) based on quantitative analyses, indicates that “[…] high reliability of cultural competence perceived from the service provider predicted participation in services”. Qualitative data from the study confirm the importance of reliability on the visiting agent, contributing information about important aspects to be considered by the visiting agent when conducting a social intervention in a home, among which are “[…] to establish a bond of trust; have good communication; provide information and be knowledgeable, be collaborative and flexible” (Damashek et al., 2020, p. 14). However, this relationship may be negatively influenced by some elements of the process, such as low frequency, intensity and total number of visits that are implemented per home, as well as the poor management of social skills by the visiting agent (Aracena, Krause, Pérez, Bedregal, Undurraga, & Álamo, 2013).

The ViDA model conceives gender as a dimension transversal to the relationship with parents and caregivers. Parenting cannot be separated from gender, as its practice is closely related to the way in which feminine and masculine subjectivities are formed, containing an identity dimension as parenting is not only a material work but also work on the self (Bachmann, Gaberel, & Modak, 2016). However, the notion of parenting usually conceals this dimension, since “[…] the practice of the parenting role does not seem to be

linked to one sex in particular nor to a specific status, and in turn, would be susceptible to transformation through experience and learning" (Bachmann et al., 2016, p. 65). Caregiving in the ViDA model is seen as a social responsibility in which the State, families, market, and communities participate (Lamaute-Brisson, 2013).. In the provision of care, "[…] the role of the state is central […] acting–or not– as a great leveler of opportunities– among men and women, and among social classes (Faur, 2014, p. 41).

Method

This study has an explorative and descriptive qualitative approach. This type of methodological design is consistent with the incipient development of the topic in Chile. The research reality is described and analyzed from the perspective of the individuals within it, as well as based on documentary evidence, which corresponds to a data collection and verification method, whose purpose is to access relevant sources of written information. In this study, documentary evidence was formed by individual reports of professionals trained in the ViDA model.

Instruments

The study comprised telephone interviews, in-depth interviews, and documentary evidence from individual reports by professionals trained in the ViDA model.

Participants

Eight professionals part of the Chile Grows with You program participated in the study. They were selected randomly and proportionally to the total amount of trained participants by municipality. Twelve of them were interviewed by phone and 6 in an in-depth interview (3 were directors of three family health centers and 3 were professionals trained in the ViDA model who participated in its implementation). Likewise, 85 individual reports were analyzed that were provided by 34 professionals trained in the ViDA model and from two municipalities of the Metropolitan Region of Chile.

The intervention

The training sought critical reflection upon caregiving in contemporary society and the challenges it poses for professionals in terms of implementation of health social programs directed at early childhood with a family approach. In addition, the study aimed to deepen the understanding of the importance of attitude in the relationship between visiting professionals and caregivers of children aged 0 to 6, which involves proximity, joint construction of objectives and the promotion of rights in order to develop personal and parental resources in pregnant individuals, and caregivers, of 0-to-6-year-old children.

Procedures and data analysis

Both telephone and in-depth interviews were recorded and transcribed after participants signed an informed consent form. In-depth interviews were conducted in the corresponding health centers of the interviewees. Reports correspond to analytical exercises written during the training process. All individual reports delivered during the

training were considered, which were written by trained professionals from the health centers of two urban municipalities.

For the analyses of individual reports, the training objectives for the relationship established by the professional with people and families during the visit were considered. A standard tool (analysis matrix) was created to capture qualitative data. Each examined report had the relationship component of the ViDA model and the perception of professionals about changes in home interventions after the training as pillars of analysis. Data gathered from the interviews (telephone and in-depth interviews) were organized by topics and analyzed used content analysis.

Ethical aspects

This study was approved by the Ethics Committee of Faculty of Social Sciences of Pontificia Universidad Católica de Chile (Protocol ID: 161219005).

Results

Qualitative data from the interviews of professionals who implemented the ViDA model, and the directors of family health centers provided information about the perception of participants about the relationship component of the model. Professionals made a difference between visits based on the ViDA model methodology and the typical visits from the health center in the framework of the Chile Grows up With You Subsystem, emphasizing that the focus on relationships make subsystem users more open to change. Conversely, the traditional visit model implies—according to the perception of health professionals - a much more superficial relationship due to the reduced number of visits and the frequent change in visiting professionals. In their opinion, this shifts the focus towards goal achievement (to conduct home visits) instead of addressing topics of interest to the family.

Professionals at family health centers report that the relationship component of the ViDA model gives the possibility of building a better-quality professional-pregnant woman/ mother/caregiver relationship, which is also more horizontal and facilitates the empowerment of women. On the contrary, traditional visits maintain the verticality of the relationship between those 'who know' and those 'who do not know'.

> […] there is a greater closeness, it is like giving tools but without solving the problems of people, but it makes them use the information and look for help themselves (ARIII, 3).

> […] it is a greater support given to the family. Without having to be too assistance-based. Because maybe at certain moments people are more used to assistance, to solving things faster, they have any given problem and come and want the solution immediately. Instead, with the program, in some way, we are making progress, but trying to give them tools they have but are unaware of […] it is like empowering people so they can do things themselves as well (ARIII, 4).

Likewise, in the eyes of professionals, the ViDA model promotes a relationship with pregnant women, mothers and caregivers that is based on increased trust and commitment, which facilitates achieving the objectives of the social intervention, as opposed to the traditional model, which creates a more formal and superficial relationship. "[…] people also like that one is there while […] not solving problems but being there. That they know they have someone they can count on that makes them feel welcome" (ARIII, 3).

According to the interviewees, the quantity and regularity of visits over time creates a relationship that promotes adherence to visits and health centers.

> […] Regarding the quantity of 8 visits, I think that no, it is not bad. Because, for example, a pregnant woman that starts at 7 weeks, 8 weeks, with one visit a month, I think it is good, because one follows the mother's process and also guides it. Make sure that she comes to prenatal check-ups, that doesn't skip checkups with the nutritionist, that is to say, there can be continuity (ARIII, 6).

From the perspective of directors of family health centers, it is also important to generate a bond through the ViDA model. In their opinion, focus on the relationship and accompaniment as a change driver produces a positive modification in the attitude of health center users regarding home visits.

> […] I think it is a very good objective to generate a bond, because if we finally generate one， we can try to change something […] if there is no bond, they are going to continue to see it as a simple formality: 'they came to see me and that's it' [...] that is, there has to be a relationship between the professional that conducts the visit and the person visited […] A bond needs to be built [...] if there is none, I think there will be no change (DRI, 11).

> […] Why do you come see me so often? Do I have any problem? Is there anything wrong with me? That stigmatization of home visits, hmm… I think that was… what was lost (DBII, 3).

Professionals also indicate that the visit model of ViDA has a preventive approach.

> […] that they see the center, ultimately, as a place to develop different preventive strategies. That they don't see it only as accompaniment because 'I'm pregnant' but see it as the place where they can go take exams, ask if they have any problems, if they have any questions (DBII, 4).

Information from documentary evidence (individual report) allowed for describing the perception of professionals about the changes in home interventions generated by the information received (Table 1).

Table 1. Changes perceived by professionals after training.

Without training	With training
1. Have relationship skills	Deepen and develop relationship skills such as dialogue, reflection, trust and understanding.
2. Only get involved with the pregnant woman	Get involved with the pregnant woman and other members of the family.
3. Are concerned about adapting to the person and her family in the current society.	They relate to the user through the acknowledgement of the particularities of the family and are aware of prejudice.
4. The objectives of the visit are not consistent with behavior changes	Pregnant women or caregivers perceive the help, which facilitates obtaining results in the intervention and openness to change.
5. Focus on the relationship between the visiting agent and the pregnant woman.	Transfer of positive bond between supervisor, visiting agents, visited person and her family.

Created by Dominique Jana - Mayra Martínez, FONDEF - CONICYT 'ViDA Project: Advanced Home Visiting Model, supported by technology, to strengthen biopsychosocial interventions with pregnant women and primary caregivers of children from 0 to 6 years of age, who receive care in the Primary Health Care system'. DNI16110278.

Regarding the relationship component, after training, professionals perceive that their relationship skills are strengthened, achieving more closeness, horizontality, and empathy.

> […] reflected enough empathy so the mother felt cared for and understood and I understood that in that moment, my technical skills was not what the family needed. She needed me to be a human-being and not the physiotherapist conducting an assessment visit (RD, Rep 1).

According to the professionals, the relationship-based approach helps improve the quality of the relationship between people and families, increasing trust, closeness, and horizontality (RD, RK, Rep 2). In their opinion, this allows for more receptivity, as well as for perfecting the quality of the information obtained, and therefore the enhancement of the intervention (BI, BH y BE, Rep 2). A relationship is established in which pregnant women positively perceive intervention and goals are achieved in sync with behavior changes (BI, Rep 1).

Professionals also perceive a strengthening of professional skills for the establishment of a bond not only with a specific person, but with their family. Participants indicated that, before the training, they almost exclusively engaged with the caregiver and the child during visits, without including other adults or children present. After the training, they included and related to other members of the family.

> […] Among the valuable elements of this model, above all in my opinion, is the formation of a bond not only with the child, but with the whole family. In general, we used to focus mainly on the child and the main caregiver, diminishing the importance of those who form the family (RD, Rep 4).

> […] in this recreation of a family visit, several aspects can be identified from the relationship dimension, for example, the co-construction of a therapeutic process, that the patient takes and feels part of his own intervention process, with emphasis on a mutual trust and commitment framework to achieve the objectives proposed by the parties, the consolidation of a relationship based on time, involvement of team and network work (RJ, Rep 2.).

Professionals also perceive challenges that are not tackled through training, which are related to improvements in planning, home visit goals, and record. While clear objectives and planning are the strengths observed by only some visiting agents (BI, BE and BF, Rep 1), they are also the challenges and concerns of other agents (BG, RM y RQ, Rep 1). The number of visits per family (8 on average), is mentioned as a concern (BD, BC BI, Rep 1).

> […] how to reconcile practice, required number of home visits and the fact that sometimes priority groups are not included, or else that an important part of the population may not be interested in home visits (BI, Rep 1).

> […] I'd like that the number of visits is not restricted, since there are reluctant families despite the bond generated by the professional (BC, Rep 1).

Discussion

The results of the study indicate that professionals trained in the ViDA model and health center directors highly value the model, underscoring benefits of the relationship component. From their perspective, the ViDA model improves the disposition of families towards change, enhancing communication and establishing a more horizontal and trust-based relationship. In turn, the model promotes increased commitment from people attending health centers, favoring adherence to visits and the health center, which facilitates preventive work with the population. Likewise, participants compare the ViDA model with the traditional home visit model. According to their perception, the traditional model used in interventions tends to generate a more defensive attitude in

users. The relevance professionals attribute to the relationship component confirms the findings of previous research on the professional-user relationship of social services, in which relationships appear as one of the key aspects for the quality of home visits and the achievement of positive outcomes in the context of early childhood (Korfmacher et al., 2007; Damashek et al., 2020; Laurenzi et al., 2020). Professionals perceive that the reinforcement of their relationship skills through the training received, improves the disposition to change of caregivers, achieving even deeper changes. Their perception is aligns with the evidence, which indicates that the relationship between families and visiting agents is one of the main change drivers in the participation of families in childrearing (Nygren, Green, Winters, & Rockhill, 2018). However, following Haramoto and Verdugo (2016), this perception of change improvement reveals a perception in which only some conditions are required to improve the quality of children's life, namely educational content and information, empowering them to finish schooling and emotional stability, ignoring the fact that "[…] unfortunately, many times the lack of wellbeing, health and education experienced by children is an active decision of the caregiver, which is caused by a lack of common sense instead of a lack of conditions or information" (Haramoto & Verdugo, 2016, p. 4). In this line, it should be noted that, although relationships are relevant to the social interventions conducted by professionals, they need to be encompassed by other key elements such as clear objectives and planning, which are still challenging for some participants of this study. These results provide some guidelines on home interventions with families conducted by psychologists, social workers, nurses, physicians, and health sciences professionals. In fact, the results reinforce the need of considering the history and experiences of people in the interventions in order to achieve deep understanding of them. Becoming aware of their particularities implies to acknowledge that "[…] each subject is unique and one-of-a-kind and that therefore so are clinical interventions […] it is not possible to plan clinical interventions in series" (Ituarte, 2017, p. 33). Likewise, these results reveal the need that professionals consider that social interventions are never effects of a cause or direct results of the environment, that good planning is not enough as results always depend on the target system of the intervention (Mascareño, 2011). In other words, they should bear in mind that families make sense of the intervention proposal, observing whether there are possibilities to improve their life conditions and so as to prevent the intervention from becoming a prescription or a control mechanism but rather a proposal that they can accept or reject.

Both health center directors and visiting professionals observe that the strengthening their professional skill promotes adherence and commitment of caregivers to home and health center visits. Some studies link adherence to community-based home visit programs to other factors. In fact, the study by Chiang et al. (2018, p. 114) confirms that "[…] caregivers with better social support had higher possibilities of completing the program". These authors underscore that it is necessary to deepen the analysis of elements influencing adherence, since only when it is known "[…] what factors are associated with what participation level and how that impacts results, we are able to match strategies to make several family sub-groups participate for enough time, so they benefit" (Chiang et al., 2018, p.125). In this sense, although this study on the strengthening of relationship skills in professionals emerges as an aspect that favors the adherence of families to home interventions, as well as their attendance to health centers, it is still a challenge for professional teams to continue deepening the

analysis of other elements different from relationship quality that could influence these results.

It is noteworthy that a smaller number of professionals perceive that improvements in the relationship facilitates the empowerment of women, as this gives them tools for solving the situations women face. The idea of empowerment mentioned by participants is consistent with public policies from a neoliberal state like the Chile, in which this notion is reduced to "[…] the capacity for individual action that lies in making rational, useful, effective and intentional choices" (Bacqué & Biewener, 2005, p.143). Social interventions would leave aside, "[…] the construction of critical awareness about the structural conditions of domination […] facilitating a realization that allows for resistance and radical subjectivities" (Bacqué & Biewener, 2025, p. 143). According to Matus (2018), a neoliberal social policy conceived for merely compensating poverty and inequality mechanisms through transfers will not be designed nor implemented to generate competences or skills that lead people to have a set of tools for becoming more autonomous. Social intervention does not only require accepting others but also consensus (Matus, 2018). Strengthening the relationship skills of professionals may paradoxically heighten an asymmetrical exercise of power and of possible manipulation of the people and family in the intervention. Therefore, the relationship process challenges health professionals ethically in terms of using power through the bond. In terms of Taylor (2020), it is possible to assert that professionals require a critical reflective practice that is responsible for the way the micropolitics of power operate through the relationship established with users from programs and social services.

Final considerations

The main contribution of this study, considering that its objective was to describe the perceptions of health professionals about the relationship component of the ViDA model, is to show the need for innovation in the traditional form for conducting home visits as well as the relevance of relationships for social intervention. This study reveals that health professionals value permanent training in key topics for the work they conduct, as well as having a need for reflection critically about their professional practice. In this sense, the relationship component of the model could serve as an induction procedure that facilitates interdisciplinarity for young professionals. Likewise, this study shows the importance in universities strengthening their education bond formation as one of the fundamental pillars in social interventions. In this way, the quality of interventions offered by public policies aimed at poor and socially excluded areas can be improved.

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