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Research Article

Community bonds in bereavement care in primary health care in Florianópolis/SC

Vínculos comunitários no cuidado ao luto na atenção primária à saúde de Florianópolis/SC

Vínculos comunitarios en el cuidado del duelo en la atención primaria de salud de Florianópolis/SC

Matheus Leoni Dultra Brasil[1], Carlos Alberto Severo Garcia Jr.[1]

[1]Universidade Federal de Santa Catarina, Department of Public Health – Florianópolis (SC), Brazil.

Abstract

Experiencing and expressing grief are deeply related to social, cultural, and historical contexts. In a society that tends to individualize the suffering of loss and suppress its collective spaces of elaboration, strengthening community networks and shared rituals plays a central role. Primary Health Care (PHC), due to its territorial insertion and its bond with families' daily lives, can be a strategic setting for supporting bereaved individuals. This study aimed to analyze how PHC in the municipality of Florianópolis/SC articulates community bonds in bereavement care. This is a qualitative, exploratory study conducted through semi-structured interviews with 18 Family Health team professionals and 4 users who experienced bereavement. Data were analyzed using thematic content analysis. The results indicate that strengthening support networks, promoting community groups, and territorially grounded practices constitute powerful approaches to bereavement care. However, weaknesses were identified in management and public governance, expressed by the discontinuity of collective actions and the distancing of Community Health Workers from the territory. It is concluded that, despite institutional and organizational constraints, the articulation of community bonds, the valuing of listening, and the reconstruction of collective spaces for processing loss emerge as promising pathways for strengthening PHC in comprehensive bereavement care.

Keywords: Community Participation; Bereavement; Primary health care.

Corresponding author:
Matheus Leoni Dultra Brasil
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Resumo

A vivência e expressão do luto estão profundamente relacionadas aos contextos sociais, culturais e históricos. Em uma sociedade que tende a individualizar o sofrimento da perda e a suprimir seus espaços coletivos de elaboração, o fortalecimento das redes comunitárias dos rituais compartilhados assume papel central. A Atenção Primária à Saúde (APS), por sua inserção territorial e vínculo com o cotidiano das famílias, pode ser um espaço estratégico no cuidado às pessoas enlutadas. O objetivo deste estudo foi analisar de que modo a APS no município de Florianópolis/SC atua na articulação de vínculos comunitários no cuidado ao luto. Trata-se de uma pesquisa qualitativa, de caráter exploratório, realizada por meio de entrevistas semiestruturadas com 18 profissionais da equipe de Saúde da Família e 4 usuários atendidos após vivência de luto. Os dados foram analisados com base na análise de conteúdo temática. Os resultados apontam que o fortalecimento das redes de apoio, a promoção de grupos comunitários e a atuação territorializada configuram práticas potentes no cuidado ao luto. Contudo, observam-se fragilidades na gestão e governança pública, expressas pela descontinuidade das ações coletivas e pelo afastamento dos Agentes Comunitários de Saúde do território. Conclui-se que, apesar dos entraves institucionais e organizacionais, a articulação dos vínculos comunitários, a valorização da escuta e a reconstrução de espaços coletivos de elaboração da perda emergem como caminhos promissores para o fortalecimento da APS no cuidado integral às pessoas enlutadas.

Palavras-chave: Participação da comunidade; Luto; Atenção primária à saúde.

Resumen

La vivencia y expresión del duelo están profundamente ligadas a aspectos sociales e históricos. Ante un contexto cultural que individualiza el sufrimiento por la pérdida, la red comunitaria, los espacios colectivos y rituales resultan fundamentales. La Atención Primaria de Salud (APS), por su inserción territorial y vínculo con la vida cotidiana de las familias, puede constituir un espacio estratégico en el cuidado a las personas en duelo. El objetivo de este estudio fue analizar cómo actúa la APS en el municipio de Florianópolis/SC en la articulación de vínculos comunitarios en el cuidado del duelo. Método: investigación cualitativa y exploratoria, con entrevistas semiestructuradas realizadas a 18 profesionales del equipo de Salud de la Familia y a 4 usuarios atendidos tras vivenciar el duelo. El análisis se realizó con base en el análisis de contenido temático. Los resultados revelan que prácticas como el fortalecimiento de redes de apoyo, grupos comunitarios y la actuación territorializada son potentes en el cuidado del duelo. Sin embargo, persisten fragilidades en la gestión y gobernanza pública, expresadas en la discontinuidad de las acciones colectivas y en el distanciamiento de los Agentes Comunitarios de Salud del territorio. Se concluye que, a pesar de los obstáculos, la articulación de vínculos comunitarios, la valorización de la escucha y la reconstrucción de espacios colectivos para la elaboración de la pérdida representan potentes posibilidades de la APS en el cuidado del duelo.

Palabras clave: Participación de la Comunidad; Aflicción; Atención primaria de salud.

INTRODUCTION

Although grief is a natural response to the loss of a significant person, its experience and expression are profoundly shaped by cultural and historical factors.[1,2] The progressive individualization of grief, driven by sociocultural transformations such as secularization, the medicalization of death, and the decline of collective mourning rituals, has contributed to the silencing of suffering, the lack of spaces for emotional expression, and the weakening of community support networks.[3–5]

The cultural experience of grief, once characterized by collective expression and shared support within social bonds, is currently marked by distancing and silence surrounding death and those who experience the loss of a loved one. This shift has contributed to the devaluation of farewell rituals, which play an important role in processing loss and coping with grief.[4-6,7] Furthermore, the absence of social sharing and community validation of grief-related suffering may contribute to the worsening of grief symptoms.[8]

Therefore, the importance of providing community-based spaces for the sharing and ritualization of grief is emphasized.[9] This scenario highlights the consequences of the absence of community support and the predominance of care practices centered on biomedical models, which may not only intensify suffering but also undermine the collective capacity to sustain processes of meaning-making following loss. In this context, revaluing and strengthening the social and territorial mechanisms that enable the shared processing of grief becomes essential, reaffirming care as a relational, community-based, and ethical practice.

Primary Health Care (PHC) plays a distinctive role in promoting population health,[10] primarily through the Family Health Strategy (FHS), which is structured around Basic Health Units (*Unidades Básicas de Saúde* – UBS) and outpatient care networks.[11] Among its main objectives is the capacity to address most health demands through the provision of comprehensive care that integrates clinical, preventive, and health promotion actions.[12] In this context, PHC represents a strategic setting for overcoming the hegemonic biomedical paradigm, which is often associated with the medicalization of existential processes such as grief.[7]

PHC can be considered fundamental in bereavement support, as it constitutes a multidisciplinary setting aimed at integrating biopsychosocial and spiritual dimensions within comprehensive care.[13] FHS, in particular, maintains close proximity to the community, enabling health professionals to understand the territorial context and actively participate in care throughout the life cycle. This closeness strengthens trust between professionals and patients and facilitates communication during critical experiences such as bereavement.[14]

The continuity of longitudinal care, a core characteristic of FHS, enables comprehensive follow-up of individuals before, during, and after experiences of loss, fostering strong bonds and providing targeted support to mitigate the emotional and social impacts of bereavement, as well as reinforcing the sense of support among grieving individuals.[14,15] Owing to its broad territorial presence and commitment to comprehensive care, PHC constitutes a strategic setting for addressing grief-related demands.

According to the National Primary Care Policy (*Política Nacional de Atenção Básica* –PNAB),[16] bonding refers to the establishment of relationships of trust and affection between users and health professionals, developed over time and grounded in shared responsibility for care. Considered a soft care technology, bonding is constituted through the interaction between health workers and users, enabling care to be produced collaboratively. This relational process carries significant therapeutic potential, as it fosters openness and mutual trust, thereby creating conditions for the expression and elaboration of profound experiences of suffering and life events.[17–19]

Thus, the concept of a support network may be understood as the set of bonds recognized by an individual as relevant and meaningful sources of support in situations of adversity or distress. Its primary sources include romantic partners, family members, friends, coworkers or classmates, as well as community and institutional connections.[19] In this context, the articulation between PHC and community and intersectoral networks enhances the effectiveness and preventive capacity of care, enabling the early identification of vulnerabilities and the development of actions aimed at minimizing the psychological and social suffering experienced by bereaved families.[20,15] Despite the existence of different approaches to bereavement care within PHC, there remains a need to strengthen the role of health teams as a reference and support point for grieving individuals.[21]

In PHC, the bonds established among health professionals, users, and the territory function as powerful relational technologies that contribute to the development of community support networks, promoting care beyond the limits of clinical practice and prescription-based interventions.[16,17] Through its longitudinal and territorial approach, closely connected to local dynamics, FHS enables not only the identification of losses experienced within the community but also the continuous follow-up of bereaved individuals, fostering practices of listening, welcoming, and sharing that restore the collective dimension of suffering.[16]

In addition to promoting comprehensive and humanized care, the approach to grief within PHC may contribute to the health promotion of bereaved individuals and the prevention of mental health problems,

while reducing the medicalization of suffering and expanding the possibilities for the symbolic and collective processing of loss. Despite its relevance, studies that systematically and qualitatively address bereavement care within the context of PHC remain scarce, revealing a significant gap in both the scientific literature and public health policies. This still relatively underexplored topic is of particular interest to the authors because it highlights a powerful yet often invisible dimension of care that requires critical reflection and investment in strategies integrating technical and community-based knowledge.

In this context, understanding how community bonds are established in bereavement care through the actions of PHC teams becomes essential for rethinking approaches to caring for the suffering associated with loss within the daily routine of public health services. This article aimed to analyze how PHC in Florianópolis, Santa Catarina (SC), contributes to the articulation of community bonds and bereavement care mechanisms. The study is grounded in the recognition that care for suffering resulting from death extends beyond technical intervention, involving a commitment to the transformative potential of relationships, the valuing of local culture, and the collective reconstruction of meaning in the face of loss.

METHODS

This article is derived from a qualitative, exploratory study linked to a master's thesis entitled "Bereavement Care in Primary Health Care in Florianópolis/SC," conducted within the Postgraduate Program in Public Health at Universidade Federal de Santa Catarina (UFSC). The methodological approach adopted proved appropriate for achieving an in-depth understanding of the participants' experiences.[22,23]

The study was conducted in the municipality of Florianópolis, the capital of the state of SC, which is recognized for developing successful experiences within this level of care.[24] The study population comprised professionals from Family Health teams — including physicians, nurses, nursing technicians, and Community Health Workers (CHWs) — PHC users who had received care related to bereavement experiences within the year preceding the interview.

The professionals were identified through referrals from UBSs indicated by the Municipal Health Department (*Secretaria Municipal de Saúde* – SMS), in addition to the use of the "snowball" sampling technique, in which participants themselves recommend other individuals who meet the established inclusion criteria.[25] To recruit users, the study was publicized through posters displayed in the UBSs and through direct approaches conducted within the units.

The inclusion criteria established for health professionals required affiliation with a UBS in Florianópolis/SC, as well as experience in providing care or developing practices focused on bereavement within the context of PHC. For users, eligibility required having received assistance from local PHC teams within the previous year in situations involving significant losses. Professionals with less than three months of experience at their current unit and users younger than 18 years of age were excluded from the study. In total, 20 health professionals and 4 users were interviewed.

In qualitative research, the sample should reflect the complexity of the object of study, prioritizing the depth of interactions and the construction of meanings throughout the investigative process.[26] Semi-structured interviews were developed using open-ended questions, allowing participants to freely share their experiences while guiding the dialogue toward the central themes of the study, thereby promoting greater depth in data collection.[27]

The interview guide was developed based on the study objectives and the relevant theoretical framework. All interviews were audio-recorded with participants' consent and subsequently transcribed.

The meetings were conducted in settings that ensured privacy and comfort, with an average duration ranging from 10 to 30 minutes.

Thematic Content Analysis, as proposed by Minayo,[28] was used for data analysis, with the aim of systematically and critically apprehending the construction and circulation of meanings, while avoiding approaches based solely on intuitive interpretations. The analytical process began with a preliminary reading of the transcribed interviews, allowing an initial familiarization with the material and the identification of relevant excerpts based on either their recurrence or their relevance to the study objectives. In the subsequent stage, these excerpts were organized into a spreadsheet and coded using keywords, enabling the grouping of similar codes, the identification of frequency patterns, and, consequently, the development of subcategories. In the final stage of data processing and interpretation, the subcategories were grouped and critically analyzed in light of the relevant literature. The study was conducted in accordance with the principles established by Resolution No. 466/2012 of the National Health Council and was approved by the Research Ethics Committee under opinion No. 6.923.378.[29]

RESULTS

The professional sample comprised 18 health workers, including 6 CHWs, 4 nursing technicians, 5 physicians, and 3 nurses, with ages ranging from 27 to 65 years. Most participants were female, except for 4 physicians, who were male. Regarding race, the sample was predominantly composed of White participants, with only one CHW self-identifying as Black.

The UBSs to which the professionals were affiliated are located in the following neighborhoods of Florianópolis: Tapera, Campeche, Saco Grande, Monte Cristo, Agronômica, Ingleses, and Barra da Lagoa, encompassing 4 health districts within the municipality. The group of CHWs ranged in age from 44 to 65 years and demonstrated considerable professional experience, with some participants having worked in PHC for more than 20 years. Among the physicians, time since graduation ranged from 6 to 15 years, with a mean of approximately 9 years, while length of service within the teams varied from 6 months to 10 years. All physicians reported specialization in Family Practice.

Within the nursing field, most participants had consolidated professional experience, with time since graduation ranging from 8 to 12 years and length of service within the teams ranging from 5 months to 2 years. Most nurses reported specialization in Family Health and in Emergency and Urgent Care. Among nursing technicians, length of service within the teams ranged from 3 months to 15 years, and the extended time since professional training was noteworthy, with most having completed their training more than 20 years earlier.

It should be noted that 20 interviews were initially conducted with health professionals. However, one physician was excluded from the study due to not meeting the minimum length-of-service criterion at the UBS, and one nurse was excluded for not having provided bereavement-related care or services, in accordance with the study's exclusion criteria.

The user sample comprised 4 participants aged between 27 and 56 years, including two men and two women. Regarding race, two participants self-identified as White and two as Black. In terms of religious affiliation, two participants identified as Evangelical, one as Christian, and one as Catholic. Family configurations varied, with participants living with children, parents, spouses, or mothers. The length of time linked to the UBS also varied considerably, ranging from 3 to 48 years, reflecting different levels of integration into and continuity of care within PHC. The participants were affiliated with the Agronômica, Ingleses, and Monte Cristo units.

It should be noted that the user sample comprised a small number of participants, which limits the generalizability of the findings. The disparity between the number of health professionals and users included in the sample resulted from several ethical and access-related challenges involving bereaved users, as the identification of individuals experiencing bereavement by health professionals was limited. In addition, difficulties were encountered in locating users who had experienced bereavement either within the health units or through other dissemination strategies adopted in the study.

The relationships with the deceased individuals that triggered the reported bereavement experiences included grandson, brother, sister, mother, neighbor, and wife, with one of the interviewed users reporting grief related to multiple losses. Finally, it should be noted that all four users had experienced the loss of a loved one less than two months prior to the interview.

Based on the data analysis, the findings were organized into three thematic areas: "The Role of PHC in support networks for bereaved individuals;" "Community groups as a care strategy;" and "Community Health Workers, Territory, and Grief." Code names were assigned to both professionals and users in order to ensure participant anonymity.

The role of PHC in bereavement support networks

Healthcare professionals reported initiatives involving not only individual support but also the encouragement of family and community ties, based on the understanding that collective support may play an active role in the grieving process. Nurse Cybele described a practice of raising patients' awareness regarding the importance of seeking support, emphasizing that many individuals attempt to cope with their pain alone, which, in situations of bereavement, may intensify suffering and social isolation. According to the participant, the professional's role may sometimes consist precisely in recognizing and legitimizing this need for support.

This movement toward recognizing the support network as part of comprehensive care also emerged in the accounts of other professionals. Nursing technician Minerva, for example, highlighted simple actions that may make a significant difference in coping with grief-related suffering, such as contacting a family member during the consultation. This gesture reflects the team's sensitivity not only in welcoming individual suffering but also in activating the affective environment capable of providing support during the grieving process.

Similarly, the importance of an approach extending beyond individual clinical practice was emphasized, aiming to connect users with relational ties capable of playing a protective role during the grieving process: "Perhaps strengthening the family network ties that can provide support at that moment" (Remu - Physician).

It is important to highlight that the strengthening of social bonds does not necessarily involve family relationships, which may sometimes become additional sources of suffering. This underscores the relevance and potential of collective spaces within the community as sources of support. User Vespasiano emphasized the importance of friendships in coping with the grief resulting from the loss of his wife, which helped him resume daily life after 30 years of marriage. The participant also reported that support from friends extended to assistance with bureaucratic procedures following the loss: "when it came to sorting out the funeral paperwork, things like that, the people in the community helped a lot too."

Community groups as a care strategy

Beyond mobilizing existing support networks, reports from both health professionals and users indicate that one possible strategy in bereavement care involves offering spaces that promote socialization

and exchanges with other members of the community. Dr. Ceres highlighted that she encourages bereaved users to participate in psychotherapy groups, as she perceives these spaces as welcoming environments. According to the participant, the open and heterogeneous nature of the groups facilitates emotional expression and functions as a means of emotional release. From the users' perspective, a positive perception of the groups offered within PHC was also evident. When asked about what she would have liked to have been offered in relation to her bereavement experience, user Venus stated:

> *"Maybe a meeting with people in the same situation, where each person listens to the other's story, like what they do in Alcoholics Anonymous. That kind of meeting might help other people, myself included" (Venus, service user).*

User Cedric reported his experience participating in a psychotherapy group:

> *"My grandma isn't here anymore. She passed away. So I've been going to the group, and there's someone there with a similar story, and I listen to them and think, well, technically I'm not alone in the world. And I also thought, it's a form of support, because I don't really talk much at home. […] And then when I start talking, I begin to feel lighter, it all starts to come out. I leave feeling light, like a butterfly flying" (Cedric, service user).*

Professionals also highlighted challenges in this process, particularly when bereaved individuals resist the idea of participating in group activities. Nurse Clio reported that, although referral to psychotherapy groups is available, this form of support is not always readily accepted by users. Similarly, professionals described careful strategies aimed at overcoming such apprehension, as illustrated by nurse Lucina, who suggested a gradual approach to group participation, without requiring individuals to speak, while respecting the personal limits and subjective timing of each participant. According to the professional, many users eventually report positive experiences after engaging with the group.

In some UBSs within the municipality, reports highlighted the relevance and effectiveness of psychotherapy groups for individuals experiencing bereavement. However, analysis of the interviews revealed an ongoing dismantling of collective practices within PHC, directly affecting health promotion and the strengthening of community ties. A reduction in therapeutic groups and community-based activities was observed, despite these initiatives having previously constituted a fundamental component of the collective health approach.

> *"The community aspect, I see it as something that concerns the entire municipality, but it's being left aside. We have a community garden group here, and it has been abandoned" (Proteu, physician).*

In addition to the community garden, the participant reported that other initiatives, such as groups for pregnant women and mental health support groups, had also been dismantled over the years and offered a possible explanation for this process:

> *"I attribute this to the municipal administration's way of thinking, in recent years, that primary care, organized in a territorial model, based on knowing the territory and knowing people's families, with community health workers, doesn't work. For management, this model is just a lot of unnecessary*

complexity, a waste of time, it generates few consultations, it's not productive. That's the kind of thinking" (Proteu, physician).

CHW Atena reported a shift in perspective that has affected the availability of therapeutic spaces, stating that, a few years earlier, she had participated in psychology groups and that there had previously been a greater number of group-based spaces that are no longer available.

When asked whether she had received support from the community following her loss, user Venus stated: "No, just a 'sorry, that's life, it happens to everyone.'" User Cedric, in turn, pointed to possible institutions that could provide such support: "Depending on the situation, maybe the church, but that's also very difficult."

Community Health Workers, Territory, and Grief

Based on the professionals' accounts, another aspect reflecting the weakening of the connection between health teams and the population is the recent transformation in the work process of CHWs. The interviews indicated that, over recent years, this dynamic has undergone significant changes, resulting in the progressive distancing of these professionals from home visits and the active follow-up of families.

"Lately, we haven't been doing home visits anymore; they've stopped. In the past, it was better. Doing home visits felt more welcoming, because it wasn't over the phone, we were actually in the person's home. With the pandemic, we couldn't do home visits anymore, and after that we haven't been able to resume them" (Jocasta, CHW).

This disconnection from the community has been intensified by several structural factors, including the reduction in the number of CHWs and the increasing burden of administrative work within health units.

"No new community health workers have been hired for a long time. Those who have been here for 20 years are gradually leaving, one by one, and they are not being replaced. They no longer go out into the territory; they've become administrative assistants, receptionists" (Proteu, physician).

Disconnection from the community also compromises the monitoring of sensitive situations such as bereavement. In the absence of regular home visits, health teams often become aware of a loss only when a family member seeks care at the health unit.

"The community health worker being out in the field is greatly missed. Before, we would inform the team about someone's bereavement. Now, we only find out if the family comes here in person" (Gaia, CHW).

Geographical distancing also compromises the understanding of families' lived realities. CHW Atena emphasized how community-based health monitoring work has been weakened:

"In the past, our work was really out on the streets, every day. The service used to come from outside inwards. Nowadays, it's more from inside out. If a person comes to the clinic, we get to know them. If they don't come, we don't even know they exist. Before, we knew much more in detail about people's lives, their street, their family. Today, we only find out through active outreach" (Atena, CHW).

DISCUSSION

Investing in support networks as a care strategy is aligned with the principle of comprehensiveness, as it assumes that suffering is not experienced in isolation but is shaped by the relationships and cultural dynamics surrounding the individual.[19,30] According to Koury,[31] Brazilian urban society demonstrates a progressive distancing from relational practices associated with coping with death, failing to incorporate both mourning rituals and bereaved individuals into social support networks. This stance reflects a broader collective tendency to deal with loss and grief in an individualized manner.

The shame associated with experiencing grief and the perceived need to remain silent in the face of others' suffering are characteristics of the contemporary subject, whose pain, fragmented and socially invisible, becomes a solitary and introspective process.[32-38] Nurse Cybele's account highlights a dimension of what has been termed "private grief." Luna[8] understands this way of experiencing grief as a result of a broader process of individualization embedded within the social fabric. According to the author, this process is associated with a mode of subjectivation grounded in utilitarian, meritocratic, and instrumental logics, which weaken the public expression of affections and relegate suffering to the private sphere.

Bereavement involves a tension between internalized suffering and the shame associated with exposing such suffering socially. As a consequence, bereaved individuals may tend toward isolation and the weakening of social bonds[8]. In this context, it becomes evident that individuals experiencing grief often require support in recognizing and legitimizing the importance of making visible the pain resulting from loss, as highlighted in the nurse's account.

The notion of biopower, in which biopolitical mechanisms operate as regulators of social norms and exert control over bodies and behaviors,[33] may be associated with the context of bereavement. Within this logic, pain tends to be repressed and suffering silenced in favor of maintaining docile and productive bodies.[5] However, it is important to emphasize that power is not exercised solely in a hierarchical manner; rather, it is disseminated throughout social relationships, operating in a capillary way and also being exercised by subjects upon themselves.[34]

From a contemporary perspective, Han[35] expands this discussion through the notion of psychopolitics. In his analysis, society is no longer primarily characterized by rules, prohibitions, or external forms of control, but rather by a logic of performance in which individuals become "entrepreneurs of themselves," driven by the constant demand for productivity. Within this framework, the subject simultaneously assumes the roles of exploiter and exploited. In this rationality, suffering associated with loss finds little space for expression; there is neither time nor social legitimacy for mourning, and the expression of grief to others becomes repressed by the individual themselves.

In this context of denial and silencing of suffering, support networks in the experience of grief emerge as a fundamental component within a health-promoting model of care.[36] Practices reported by professionals, such as the gesture of nursing technician Minerva in contacting a family member during a consultation, or physician Remu's guidance to strengthen family network ties, illustrate how team actions can catalyze interpersonal bonds between bereaved individuals and other people/institutions, thereby enabling spaces for expression and shared experiences of grief.

In bereavement situations, social bonds may provide cognitive and emotional support as well as practical assistance, including material support and the provision of services.[36] The characteristics of interpersonal bonds established between bereaved individuals and members of their network, such as

availability, reciprocity, the shared history within the relationship, and its multidimensionality, facilitate the sharing of bereavement experiences.[36] Furthermore, it is the responsibility of health professionals to foster the strengthening of community bonds in accordance with each individual's context, taking into account the uniqueness of these significant social networks. This implies that mediation with these bonds cannot occur in an inattentive or uninformed manner, requiring an understanding of the relational contexts of bereaved individuals that enable the expression and sharing of experiences.[8]

The experience of Vespasiano, who found essential support in friendships and the community following the loss of his wife, corroborates this perspective, demonstrating that the strengthening of social bonds does not necessarily depend on family relationships, which may, in some cases, even generate additional suffering. This underscores the relevance and potential of collective spaces within the community.

One way of providing these spaces is through community groups, which are valuable tools within PHC, as they promote the sharing of knowledge and practices rooted in the community, the strengthening of bonds, and the development of a sense of belonging.[37] Groups offered within PHC enable the emergence of alternative possibilities for discourse and interaction, articulating with the historical narratives produced within the family, school, church, hospitals, and health centers, while shifting the exclusive focus away from disease and allowing other dimensions of life related to health promotion to emerge.[38,39,40]

Regarding the mixed composition of these groups,[39] it is suggested that groups formed within PHC in the field of mental health should avoid "being organized according to specific types of mental health problems or forms of suffering. Instead, group diversity should be promoted." This approach seeks to counteract the standardization of care for users experiencing emotional distress.[39]

However, it is evident that support or therapeutic groups offered exclusively to bereaved individuals, more specifically to people who have experienced similar types of loss, may provide specific benefits. In group settings restricted to bereaved participants, individuals may recognize that they are not alone in their pain, which can reduce feelings of isolation and loneliness. Furthermore, the sharing of similar experiences allows participants to feel understood and supported in their grief experience.[41]

The statements of users Venus and Cedric, presented in the results, illustrate this phenomenon. The group, as a space for mutual support, sociability, and exchange, functions as a setting in which bereaved individuals may recognize that their pain is not unique, although it remains singular.[42] When Cedric listens to narratives similar to his own, he is able to understand grief as a shared human experience. The accounts of others lead him to the perception that he is not alone, implying an important shift from solitary suffering to an awareness of belonging.

The phenomenon described translates into a sense of universalization of loss, which may be reflected in user Venus's expressed desire to participate in meetings with individuals in similar situations. It is therefore noted that bereaved individuals often have a desire to talk about their loss, particularly with others who have experienced the same situation, and that participation in groups may serve as a way to alleviate loneliness.[21-32-41]

By stating, "I don't talk much at home," Cedric points to a common reality: the lack of spaces for sharing intimacy, in which suffering is silenced due to social, familial, or emotional constraints.[4,31] In this context, the group functions as a mechanism for the socialization of grief, serving as an intermediary space between the public and the private spheres, where it becomes possible to name pain without the censorship typically present in everyday environments.

This transition from private to shared grief is politically significant, as it challenges the logic of individualizing suffering that is characteristic of societies marked by meritocratic and utilitarian values, in which bereaved individuals may experience isolation and a lack of legitimacy to publicly express their pain.[8] Conversely, these groups create a space of care sustained by bonds, acceptance, and mutual listening, highlighting the importance of relational ties and their implications, thereby reinforcing a sense of political community. In this sense, such groups play an important role not only as emotional support but also as a political instrument and as a means of asserting the right to publicly express grief.[8]

Resistance to participation in groups, as evidenced in Nurse Clio's accounts and addressed through Nurse Lucina's strategies, may be associated with a fear of emotional exposure, whereby individuals may prefer to disclose themselves only within familiar or known relationships.[41] For some individuals, avoiding participation in group settings may function as a self-protective strategy, potentially contributing to lower levels of anxiety and sadness compared to those who engage in this type of support.[42] Therefore, it is important to recognize that not all bereaved individuals feel comfortable participating in such initiatives, as well as to acknowledge the limitations and possibilities inherent to each person's experience.

In parallel, the dismantling of collective practices evidenced in the data, including the reduction of therapeutic groups and community activities, may be associated with the guidelines of current funding models. An example of this is "*Previne Brasil*," established by Ordinance No. 2.979/2019, which redefined the criteria for federal transfers to municipalities based on weighted user registration, team performance, and the implementation of strategic actions. This approach introduces a logic centered on quantitative and individualized targets, prioritizing the number of registered individuals to the detriment of practices that consider the comprehensiveness of care.[43]

More recently, Ministry of Health Ordinance No. 635, of May 2023, established financial incentives for implementation, cost coverage, and performance related to the modalities of multiprofessional teams in PHC.[44] This further reinforces a results-oriented perspective based on measurable indicators, which may conflict with the principles of universality, equity, and comprehensiveness of SUS.[45] In view of this, it is assumed that recent ordinances governing PHC financing, when combined with municipal management strategies that prioritize quantitative indicators of care, may contribute to the weakening and reduction of community-based spaces.

This scenario is not limited to groups offered by health services but extends to the broader cultural logic in which the community is no longer perceived as a source of support and coping.[41] The statements of users Venus and Cedric, presented in the results, illustrate a process of erosion of collective coping with grief, characterized by the increasing social censorship and silencing of emotional expression[4].

It is observed that bereaved individuals seek formal support from the community.[36] Among the most frequently discussed forms of community support, farewell rituals stand out. Human life is characterized by rites of passage, and, in the context of death, funeral rituals constitute beneficial resources for the processing of grief. In this scenario, the privatization of grief directly contributes to the marginalization of farewell rituals, which, in many traditional societies, play a central role in validating loss and providing emotional support to bereaved individuals.[6]

Rites of passage enable the symbolic expression of grief, even when words are insufficient, while also fostering social and psychological maturation in the face of loss, reinforcing a sense of cultural belonging and collective understanding of death, and providing an emotional and mental record that helps prevent the forgetting of the deceased.[9] This is particularly relevant considering that the healthy processing of grief depends on the social recognition and validation of the memory of the deceased.[41]

It is noteworthy that, during the COVID-19 pandemic, farewell rituals were further diminished, with wakes and funerals being avoided or held under restrictions, contributing to the weakening of socio-community support for bereavement.[46,47] However, the image of the deceased needs to be shared, recognized, and re-signified through rituals and conversations. This highlights the profoundly collective and intersubjective nature of grief, as loss cannot be fully processed in isolation. Grief requires a safe and enduring space to integrate the deceased into the psychic and social life of those who remain,[41] a context that is corroborated by the territorial work of CHWs.

The work of CHWs has traditionally been closely linked to the territory and the community. The results suggest that the current shift in this perspective directly affects not only health prevention and promotion but also bereavement care and the support provided to individuals experiencing emotional vulnerability within the communities served by PHC.

It is observed that the precarization of the work of CHWs affects not only direct health care but may also compromise the management of psychological suffering and bereavement within communities. The absence of these professionals in the territory may weaken the monitoring of support networks and hinder guidance regarding available services, a context that leads many families to experience grief in isolation and without the necessary support.[48]

CHWs contribute significantly to the understanding of social determinants of health and to the identification of risk situations. Furthermore, their work through low-complexity activities conducted during home visits, such as the administration of oral rehydration therapy, the promotion of breastfeeding, and the provision of maternal and child health care, has had a direct impact on mortality reduction, particularly maternal and infant mortality.[48]

Among the most important responsibilities of CHWs are home visits, still considered a central activity in their work routine. This practice enables continuous monitoring of families' health conditions, facilitating the identification of needs, the early detection of health problems, and the provision of support. In the specific context of bereavement, the regular presence of CHWs in the community may contribute to coping with this process by ensuring active listening and the necessary support for bereaved individuals.[48,21]

The territorial scope defined by FHS enhances bereavement care through continuous and integrated follow-up. CHWs play a fundamental role in the early detection of mental distress, in referrals to specialized services, and in participation in therapeutic projects, expanding the possibilities of care within the community.[18]

However, PNAB 2017 introduced significant changes that directly impacted this care model. One of the main modifications was the flexibilization of the minimum number of CHWs per Family Health team, previously set at four and reduced to at least one, as well as the removal of the requirement for full territorial coverage. This guideline weakened the effective presence of these professionals within communities, resulting in a substantial reduction in the workforce and in their connection with the territory.[48,49]

As a result, PHC has become increasingly distant from its founding principles, which prioritize health promotion, disease prevention, and rehabilitation through territorial action and the establishment of bonds with the community. The hegemonic perspective, centered on quantitative targets and productivity indicators, tends to neglect territorial monitoring and weakens the relationship between the population and health services, rendering PHC less responsive to social demands, including those related to bereavement care and mental health.

This paradigm shift overlooks the fact that comprehensive care presupposes listening to the different "truths" circulating within the territory and articulating individual, collective, and institutional knowledge.[37] In this context, the acknowledgment of grief requires a broader perspective that recognizes bereaved individuals as subjects embedded in networks of relationships, whose psychosocial integration depends on mutual support, a sense of belonging, and the possibility of symbolically processing the loss.[36]

Therefore, it is incumbent upon PHC to reaffirm its commitment to providing support and attentive listening in the face of suffering, particularly in vulnerable communities, where the health team often represents the only available space for the symbolic processing of loss. This form of care is grounded in solidarity, dialogue, and the establishment of bonds as therapeutic resources, recognizing that no one should face grief alone.

FINAL CONSIDERATIONS

This study indicates that PHC in Florianópolis/SC has significant potential to welcome and support bereaved individuals, particularly when it mobilizes community ties and operates in a continuous, territorially grounded manner. However, a weakening of collective actions, a devaluation of spaces for social interaction, and precarious working conditions for CHWs were observed, all of which negatively impact comprehensive care.

Strengthening bonds among health care teams, users, and the community is a powerful strategy for ensuring recognition and support for bereaved individuals. Accordingly, the importance of practices that value listening, presence, and community ties as central technologies in bereavement care within PHC is reaffirmed. It is necessary to deepen and expand this discussion to inform new organizational public policies for health services, considering that recent changes are at odds with the principles of SUS and PHC.

The limitations of this study relate to the small number of users interviewed and the lack of in-depth analysis of specific types of grief, such as the death of children, spouses, siblings, or parents, which present distinct characteristics and require different possible care approaches. Furthermore, although race/skin color was included in the interviews, it was not explored in the analysis.

It should also be noted that the results presented constitute one section of a master's thesis, as indicated in the "Methodology" section, in which additional dimensions of care were explored, including listening and support from the health care team, as well as non-face-to-face forms of contact such as phone calls and messages. Finally, due to the limited sample size, the findings do not represent the entirety of the municipality of Florianópolis and are therefore not generalizable.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

MLDB: Conceptualization, Data Curation, Methodology, Writing – Original Draft, Writing – Review & Editing. CASGJ: Carlos Alberto Severo Garcia Jr.: Conceptualization, Methodology, Supervision, Writing – Original Draft, Writing – Review & Editing.

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