

Exploring the impact of family health care implementation on family resilience: Insights from friedman's structural-functional theory

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ABSTRACT

Background The family plays a crucial role in maintaining the health and well-being of its members. One of its essential functions is health care, including disease prevention, caregiving, and health-related decision-making. This function becomes particularly important during times of crisis or illness. Family resilience refers to the ability of a family to adapt, recover, and grow stronger in the face of adversity. A strong health care function within the family may contribute positively to building this resilience. However, the direct relationship between family health care function and family resilience remains underexplored, especially in the Indonesian context. Understanding this relationship is important for developing family-based interventions to promote health and resilience. **Therefore, this study aims to examine the correlation between family health care function and family resilience.** **Objectives** This study aims to determine the relationship between the implementation of family health care functions and family reliability. **Methods** The design of this study is a correlation study with the type of analytical correlation research through a cross sectional study approach. **Results** The results of the bivariate analysis can be concluded that there is a significant relationship between health care function and family resilience in respondents ($p = 0.001$). The results of the multivariate analysis can be concluded that respondents who have a high income have a 15,897 times chance of having good family reliability compared to those who have a low income. **Conclusion** The family needs to improve the function of family health care where the family must recognize health problems experienced by family members.

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INTRODUCTION

The family plays a central role in maintaining the physical and mental health of its members. The family health care function includes disease prevention, caring for sick family members, and making decisions regarding medical treatment. This function becomes increasingly important when facing chronic health challenges and crises such as pandemics.

Family resilience, defined as the family's ability to adapt and recover from stress or difficult events, is influenced by various factors, including the family's health care role. Research indicates that families with strong health care functions tend to be more resilient in coping with health-related crises. However, the direct relationship between the family health care function and family resilience has not been widely explored, especially within the Indonesian cultural context. The development of culturally appropriate instruments, such as the Indonesian version of the Family Assessment Inventory, is essential for accurately assessing family functions.

Understanding this relationship is crucial for developing family-based interventions aimed at enhancing family resilience in the face of health challenges. This study aims to examine the relationship between family health care functions and family resilience levels in Indonesia.

Family functions consist of affective functions, socialization functions, economic functions, reproductive functions, and family health care functions (Friedman, Marilyn M; Bowden, Vicky R; Jones, 2010)(Visković & Ljubetić, 2022)(Viskovic & LjubetiÄ, 2022). The family has a role and function to carry out health care for each family member. This family health care function is very important in shaping the human being as a central point in nursing services. Healthy family members will form a resilient and healthy family. A healthy family will form a healthy society as well (Irawati and Fitra, 2013)(Ariansyah, 2021)(Kusumaningsih, 2024). So it is very important to set the family as a target to improve health, including care for the prevention and handling of Covid-19.

In fact, many families are affected by COVID-19, either directly or indirectly. Direct impacts on families include loss of family members due to covid-19, concerns about health problems, job loss, decreased activity, loss or decrease in income, additional teaching burden of school children, stress, delay or cancellation of various agendas and activities (Kalil et al., 2020)(Beach et al., 2021)(Gayatri & Puspitasari, 2023).

Family resilience is the ability of the family which is a functional subsystem to be able to survive and rise from adversity so that the family is able to adjust and be able to overcome situations ((Williamson et al., 2021); (Mufarrohah, 2020)(da Silva et al., 2020)(Giordano et al., 2023)(Ceberio, 2024). When the family faces a risk, there will be two possibilities, namely the family experiences destruction or the family gets stronger and out of the problems faced.

This study will identify how the influence of family health care functions with family resilience during the Covid-19 pandemic in Sawah Besar District, Central Jakarta.

Problem statement, the formulation of the problem in this study is "Is there a relationship between the implementation of health care functions and family resilience in Sawah Besar District, Central of Jakarta?"

Research objectives, in general, this study aims to determine the relationship between the implementation of family health care functions and family resilience. In particular, this study aims to: Characteristics of the community in Central Jakarta, overview of the implementation of the health care function of the community family in Central Jakarta, overview of family resilience in the community of Central Jakarta, the relationship between the implementation of family health care functions and family resilience in Central Jakarta, the most dominant confounding factor affected family resilience in Central Jakarta.

RESEARCH METHOD

The design of this study is a correlation study with the type of *analytical correlation* research through a *cross sectional study approach*. In this design it means that researchers only take samples at one time without special treatment, to see whether or not there is a relationship between the independent variable and the dependent variable simultaneously in the study (Dharma, 2011). In this study, data was taken at one time. An operational definition is a definition of a variable that is described in a specific operational form that researchers use to measure variables. The operational definition is adapted to the concept definition. The operational definition in this study is explained in detail as follows:

Table 1. Operational definitions of research

No	Variable	Operational Definition	Measuring Instruments How to Measure	Measurement Results	Variable Scale
Independent Variables					
1.	Implementation of family care functions	Implementation of family health care functions (Friedman, 2013): a. Know the problem b. Make up your mind c. Caring for a sick family member d. Modify the environment e. Using existing health care facilities f. Family dietary practices g. Practice rest and sleep h. Practice Exercise and recreation i. Practice of using the drug j. Family self-care practices	Questionnaire	0 : Never 1: Rarely 2: Often 3: Always	Ordinal
Dependent Variables					
1.	Family resilience	the family's ability to withstand, adapt to, and recover from stress, adversity, or crisis.	Questionnaire Walsh's Family Resilience Assessment Scale (FRAS)	0: Never 1: Rarely 2: Often 3: Always	Ordinal
Confounding Variables					
1.	Age of husband	The life span of respondents (husbands) is calculated from birth to the date this study was conducted. Date of birth based on identity (Indonesian Identity Card / Family Card)	1 question item in the age characteristics questionnaire	1: late adolescence (17-25 years) 2: early adulthood (26-35) 3: late adult (36-45 years old) 4: Early Elderly (46-55 years) 5: Late elderly (56-65)	Nominal
2.	Age of wife	The life span of respondents (wives) is calculated from birth to the date this study was conducted. Date of birth based on identity (Indonesian Identity Card / Family Card)	1 question item in the age characteristics questionnaire	1: late adolescence (17-25 years) 2: early adulthood (26-35) 3: late adult (36-45 years old) 4: Early Elderly (46-55 years) 5: Late elderly (56-65)	Nominal
3.	Husband's education	The last formal school that has been taken by the respondent	1 item of questions in the	0 = Senior High School and above	Ordinal

No	Variable	Operational Definition	Measuring Instruments How to Measure	Measurement Results	Variable Scale
Independent Variables					
		(husband) based on the certificate owned	characteristic questionnaire on education	1 = Less than Senior High School	
4.	Wife's education	The last formal school that has been taken by the respondent (wife) based on the certificate owned	1 item of questions in the characteristic questionnaire on education	0 = Senior High School and above 1 = Less than Senior High School	Ordinal
5	Husband's work	Activities carried out to earn the husband's income	1 item of questions in the characteristic questionnaire about the work of the husband	1=Civil servant (civilian, police, TNI) 2=Private employees 3=Self-employed 4=Labor 5=Retirement 6=Does not work 7=other,mention	Nominal
6	Wife's work	Activities carried out to earn wife's income	1 item of questions in the characteristic questionnaire on the work of the wife	1=Civil servant (civilian, police, Indonesian National Armed Force _ 2=Private employees 3=Self-employed 4=Labor 5=Retirement 6=Does not work 7=other,mention	Nominal
7.	Family income	Income/financial conditions received by the family	1 item of questions in the characteristic questionnaire on family income	0 = below salary (Rp. 4,416,186,-) 1 = above salary (Rp. 4,416,186,-)	Ordinal
8.	Family type	Family type	1 item of questions in the characteristic questionnaire on family type	1 = large (extended) 2 = core (nuclear family)	Nominal
9	Ethnicity	Ethnicity	1 item of questions in the characteristic questionnaire about ethnicity	1=Java 2=Sundanese 3=Batak 4=Betawi 5=Dayak 6=Manado 7=Padang 8=Chinese 9=Nias 10=Other, mention	Nominal

Population is a generalization of objects or research subjects that have certain qualities and characteristics set by researchers to be studied and then conclusions are drawn (Anggreni, 2022). The entire object of research is the research population. In this study, the population is families in Sawah Besar District, Central of Jakarta. Administratively it consists of 5 Urban Village, 49 Hamlet,

599 Neighbourhood, 29,864 households, and 111,943 people, with a population density of 18,013/km². Sawah Besar sub-district consists of Pasar Baru Village (189 ha); Gunung North Sahari Urban Village (198 ha); Kartini Urban Village (55 ha); Karang Anyar Urban Village (51 ha); and Kelurahan Mangga Dua Selatan (129 ha). The number of samples in this study was 110 respondents. The sampling technique in this study uses *stratified random sampling*, which is a sampling method with randomization (random) carried out on individual members of the population, random carried out in each existing cluster or sampling based on areas such as kelurahan, sub-district, city and so on (Adiputra et al., 2021).

The instrument used to assess the implementation of the family care function uses the Family Health Care Function instrument and has been tested for validity (all question items are valid, r Alpha is greater than r table) and resilience Cronbach Alpha 0.982 (Ayuningtiyas, 2013). Instruments used to assess family resilience using instruments *Walsh's Family Resilience Assessment Scale (FRAS)*. This research instrument has been tested for validity with the results of all valid question items and the resilience test results show a Cronbach Alpha value of 0.96 (Nadrowska et al., 2021). This research has passed the ethical test of the Bani Saleh Health Research Ethics Committee with Number EC.293/KEPK/STKBS/IX/2023.

Time and Place of Research, this study was conducted in Central Jakarta, but data dissemination was carried out through questionnaires. The research was conducted in April-August 2023, starting with the preparation of proposals.

RESULTS AND DISCUSSIONS

The results of univariate analysis in this study are shown in the form of frequency and percentage distribution. The data obtained by the researcher is analyzed to get a display in the form of tabulations, by entering all data and then processed statistically descriptively. This univariate analysis is a summary of the data set of measurement results that are tabulated and displayed in the form of a distribution and percentage so that the data set studied becomes useful information. The univariate analysis describes the results of the study for respondent characteristic variables based on gender, age, father's education, maternal education, family income, family type and respondents' previous knowledge.

a) Overview of the characteristics of respondents

Table 2. Distribution of husband's age, wife's age, husband's education, wife's education, husband's occupation, wife's occupation, family income, family type and ethnicity (n = 110)

Variable	Total (n)	Percentage (%)
Age of husband		
Late adolescence (17-25)	4	3,64
Early adulthood (26-35)	32	29,09
Late adulthood (36-45)	52	47,27
Early elderly (46-55)	13	11,82
Late elderly (56-65)	9	8,18
Total	110	100
Age of wife		
Late adolescence (17-25)	7	6,36
Early adulthood (26-35)	36	32,73
Late adulthood (36-45)	49	44,55
Early elderly (46-55)	11	10,00
Late elderly (56-65)	7	6,36
Total	110	100
Husband's education		
Higher education (≥ Senior High School)	57	51,82
Lower education (< Senior High School)	53	41,18
Total	110	100
Wife's education		

Variable	Total (n)	Percentage (%)
Higher education (≥ Senior High School)	42	38,18
Lower education (< Senior High School)	68	61,82
Total	110	100
Husband's work		
Civil servants (civil/police/ Indonesian National Armed Force)	14	12,73
Private employees	28	25,45
Self employed	34	30,90
Laborer	24	21,82
Pension	4	3,64
Does not work	2	1,82
Miscellaneous	4	3,64
Total	110	100
Wife's work		
Civil servants (civil/police/ Indonesian National Armed Force)	5	4,54
Private employees	21	19,09
Self employed	12	10,91
Laborer	26	23,64
Pension	2	1,82
Housewives (IRT)	42	38,18
Miscellaneous	2	1,82
Total	110	100
Family income		
Less than salary Rp. 4.416.186,-per month	84	76,36
More than salary Rp. 4.416.186,-per month	26	23,63
Total	110	100
Family Type		
Core	64	58,18
Big	44	40,00
Widow/widower	2	1,82
Total	110	100
Ethnicity		
Javanese	38	34,54
Sundanese	21	19,10
Batak	-	-27,27
Betawi	30	-
Dayak	-	-
Menado	-	11,82
Field	13	7,27
Chinese	8	-
Nias	-	-
Total	110	100

Table 2 shows the description of respondents as many as 47.27% of husband's age is in the late adult category (36-45), 44.55% of the wife's age is in the late adult category (36-45), 51.82% of the husband's education is high, 61.82% of the wife's education is low, 30.90% of the husband's work is self-employed, 38.18% of the wife's work is Housewife, 76.36% of family income is below the Salary, 58.18% of the nuclear family type and 34.54% of respondents are Javanese.

b) Overview of the function of care and resilience of the family

Table 3. Distribution of health care function and family resilience (n=110)

Variable	Category	Total (n)	Percentage (%)
Family Health Care Functions	Not good	62	53,36
	Good	48	43,64
Family Resilience	Not good	58	52,73
	Good	52	47,27

Based on table 3, data were obtained that the family health care function was in the poor category of 53.36%, and the resilience of families with poor categories was 52.73%.

Bivariate Analysis

Bivariate analysis describes the relationship between dependent and independent variables. In this study, the dependent variable is family resilience and the independent variable is the family health care function.

Table 4. Analysis of the relationship between health care function and family resilience (n=110)

Family health care functions	Family resilience				Total		OR (95%CI)	P Value
	Good		Not Good					
	N	%	N	%	N	%		
Good	22	20,00	26	23,64	26	100		0,000
Not good	30	27,27	32	29,09	32	100	4,128 (0,867 –	
Total	52	47,27	58	52,73	110	100	4,159)	

Based on table 4 results of the analysis of the relationship between health care function and family resilience. The results of statistical test analysis obtained data that there was a significant relationship between health care function and family resilience ($p = 0.000$; $\alpha = 0.05$). Based on the results of the analysis, it was also obtained that the value of $OR=4.128$, meaning that good family health care functions were 4,128 times higher to increase family resilience.

Multivariate Analysis (Multiple Logistic Regression Prediction Model)

Multivariate analysis was conducted to determine the most dominant variables affecting family resilience. This study used multiple logistic regression. Logistic regression in this study is a predictive factor model to determine the relationship one by one variable validly between the dependent variable and several independent variables. This predictive factor model is used because all variables are considered important so that the estimation of several logistic regression coefficients can be done at once. The results of the multivariate analysis of this study are explained as follows:

- a. Bivariate selection, at this stage, a bivariate analysis is carried out between each independent variable and its dependents. If the bivariate test results have a *p value* of < 0.25 , then the variable can be included in the multivariate model. However, it may be that even the *p value* < 0.25 is still included in the multivariate if the variable is considered important in substance. The results of bivariate selection in this study are described in table 5.4.

Table 5. Selection of variables interaction of respondent characteristics, health care function and family resilience (n = 110)

No	Interaction variables	P value 1	Coefficient B
Characteristics of respondents			
1	Age of husband	0,457	1,246
2	Age of wife	0,114	1,674
3	Husband's education	0,108	1,317
4	Wife's education	0,048	1,612
5	Husband's work	0,000	1,432
6	Wife's work	0,487	1,230
7	Family income	0,026	1,447
8	Family type	0,435	1,258
9	Ethnicity	0,326	1,012
10	Care functions	0,027	2,124

Table 5 illustrates the results of bivariate selection tests for multivariate analysis modeling. In this study, the variables of husband's age, wife's occupation, family type and ethnicity were excluded from the modeling because the *p value* > 0.25 . While the variables, wife's age, husband's

education, wife's education, husband's occupation, family income and family health care function went into the next modeling because the p value was <0.25.

- b. **Multivariate Modeling**, in this modeling, the dependent variable and the independent variable are regression tests to determine the p value of each variable. In the interaction variable, a gradual selection is carried out where the largest p value, which is > 0, is removed first from the modeling. The process of variable expenditure is not carried out all at once but gradually or one by one. A variable is said to interact if its p value < 0.05 and remains in the model. The results of the interaction test in this study are as follows:

Table 6. Predictive factor modeling test affecting family resilience (n=110)

No	Variable	P value	Initial coefficient B	Change in Coefficient B							
				I	II	III	IV	V	VI	VII	VIII
1	Age of wife	0,815	1,012	Out	Out	Out	Out	Out	Out	Out	Out
2	Husband's education	0,002	0,642	4,736	Out	Out	Out	Out	Sign out*)	0,452	0,3870
3	Wife's education	0,016	2,341	0,345	2,325	3,869	Sign out*)	5,312	2,859	4,760	5,648
4	Husband's work	0,189	1,568	1,194	2,810	Out	Out	Out	Out	Out	Out
5	Family income	0,001	2,468	1,808	1,798	1,578	1,786	1,912	1,823	1,913	Sign out*)
6	Care functions	0,000	1,134	0,127	0,323	1,868	1,913	1,963	1,531	1,630	1,440
	Constant	0,000	0,000	0,000	0,000	0,000	0,000	0,000	0,000	0,000	0,000

The results of the analysis showed that the variables with a p value of >0.05 were the wife's age, wife's education, and husband's occupation. The wife's age variable has the largest p value of 0.815, then the wife's age variable is removed first from the model and then looks at changes in the Odd Ratio (OR) value for other variables. With the result of the OR comparison of <10%, the age variable is excluded from the modeling. The variable that has the next largest p value excluded from modeling is gender and then analyzed and calculated the OR value again. The next process follows like the initial process. The change in OR can be calculated by calculation:

Change OR = (b-a): a x 100%

- c. **Interaction Test**, interaction tests are performed on variables that are suspected of interaction. The candidate variables in this study were analyzed one by one starting from the candidate who had the largest p value. The candidate variable if it has a p value of >0.05 is considered to have no interaction and is excluded from modeling. In this study, the results of the interaction test analysis obtained the following data:

Table 7. Test of interactions affecting family resilience (n=110)

No	Variable	Change in p value					
		I	II	III	IV	V	VI
1	Husband's education	0,453	0,234	0,373	0,224	0,112	0,015
2	Wife's education	0,231	0,112	0,021	0,034	0,032	0,007
3	Husband's work	0,324	0,324	0,143	0,123	0,021	0,006
4	Family income	0,124	0,108	0,056	0,021	0,024	0,034
5	Care functions	0,578	0,156	0,173	0,178	0,145	0,104
6	Husband's education by husband's occupation	0,134	0,154	0,152	0,086	0,154	Out
7	Husband's education by Family income	0,456	0,376	0,453	Out	Out	Out
8	Wife education by care function	0,543	0,435	0,235	0,467	Out	Out
9	Husband's	0,675	Out	Out	Out	Out	Out

10	occupation by family income Family income by care function	0,004	0,012	0,009	0,015	0,012	0,005
11	Husband's work by care function	0,654	0,244	Out	Out	Out	Out
	Constant	0,007	0,006	0,013	0,002	0,015	0,000

Table 7 shows that the p value of the candidate variables carried out the interaction test is husband education by husband occupation, husband education by family income, wife education by health care function, husband occupation by family income, family income by health care function, husband occupation by Health care functions. The final result of the interaction test was found that the p value of family income by the health care function was 0.005, the conclusion was that there was an interaction between family income variables and previous knowledge.

- d. Last model, the last model for multivariate analysis of predictive factors that affect family resilience, the latest test results can be seen from the table below:

Table 8. Final modeling of multivariate analysis of predictive factors affecting family resilience (n = 110)

No	Variable	B	Coefficient B	P value
1	Husband's education	0,221	1,453	0,004
2	Wife's education	0,343	2,867	0,012
3	Husband's work	-1,546	0,553	0,008
4	Family income	12,148	15,897	0,005
5	Care functions	2,788	4,546	0,025
	Constant	-22,543	0,000	0,000

Based on table 8, the final results of the multivariate analysis show that the most dominant factor affecting family resilience is family income obtained previously from various sources (p value = 0.005) and obtained OR of 15.897. So based on the modeling, it can be concluded that respondents who have a high income have a 15,897 times chance of having good family resilience compared to those with low income. The regression equation obtained from this analysis is:

Family resilience = -22543 + 1,453 (husband's education) + 2,867 (wife's education) + 0.553 (husband's occupation) + 15,897 (family income) + 4,546 (health care function).

Discussion

In the univariate analysis of respondents' characteristics, it was found that 47.27% of husbands' ages were in the late adult category (36-45) and 44.55% of wives' ages were in the late adult category (36-45). Husband's education is 51.82% of husband's higher education. This is in line with research (Barzilay et al., 2020) which shows that the majority of respondents are highly educated. 61.82% of wives' education was in the low category. 30.90% of husband's occupation is self-employed while wife's job 38.18% of wife's job is Housewife. Family income is 76.36% of family income below salary. This is not in line with research (Barzilay et al., 2020) which shows that in Philadelphia the majority of respondents have incomes above salary. But in line with research (Defar et al., 2021) which shows that the majority of respondents in Ethiopia have incomes below the salary. Family type 58.18% nuclear family type. Ethnic groups 34.54% of respondents are Javanese.

The results of other univariate analyses showed that the picture of family health care function was in the poor category of 53.36%, and the resilience of families with poor categories was 52.73%. The function of family health care includes the family's ability to recognize health problems, the family's ability to make decisions, the family's ability to care for sick family members, modify the environment and utilize health facilities (dos Santos et al., 2012). Family resilience consists of factors of positive outlook, spirituality, cohesion of family and member

agreements, flexibility, family communication, financial management, family time, shared recreation, routines and rituals, support networks (Herdiana et al., 2018).

The practice of family health care functions in Sawah Besar District is still dominated by the poor category of 53.36%, this shows that families have not been optimal in carrying out these functions. Another similar study also in the Andalas Padang Health Center area showed that 85.3% of health care functions were also not good in terms of implementing cholesterol diet practices (Irawati & Fitra, 2013). Other studies have also shown that 59.3% of family health care functions in toddlers are not performed properly (Ayuningtiyas, 2013). This shows that families in society have not fully understood that family functions that are very important besides affective functions, economic functions, socialization functions, reproductive functions are family health care functions. If the family's health care function is not optimal, the family will not achieve optimal health.

The results of other analyses in this study related to family resilience found that there were 52.73% of poor family resilience. This is in line with research conducted at The Tulane University which showed that 59.4% of people experience resilience vulnerability (resilience) at the medium level and 6.00% at the high level (Ferreira et al., 2020). The same research in Rural China shows that family resilience status is low, especially in the aspect of financial capital (Yang et al., 2021).

The results of the bivariate analysis found that there was a significant relationship between health care function and family resilience ($p = 0.000$; $\alpha = 0.05$). Based on the results of the analysis, it was also obtained that the value of $OR=4.128$, meaning that good family health care functions were 4,128 times higher to increase family resilience. As far as literature research from researchers there has been no similar study on these two variables so it cannot be compared with other studies. However, based on the results of this study, it can be analyzed that to form family resilience, one of the determinants is the function of family health care. This is also explained by literature from Singaporean researchers which states that The study explores the construction of family resilience defined as family variables that allow families to survive major life challenges and as coping resources that allow individuals to face trauma and thrive from experiences (Chang et al., 2015). The conceptual definition of family resilience is synthesized from the results of current analyses: family resilience refers to the family's ability to regain its psychological and functional integrity after adversity. Although it has been recognized among theorists and researchers that family resilience can be better understood as a process, current analysis reveals that it can still be conceptualized as an ability because family resilience is the result of the interaction between vulnerability and family strength, which occurs under the specific and individual context of the family experiencing difficulties. Furthermore, it is also recognized that the concept is not a static condition that a family has throughout its life stages due to contextual variations, stressor traits, and a combination of family vulnerabilities and resources in difficult times (Oh & Chang, 2014).

The results of the multivariate analysis found that the most dominant factor affecting family resilience was family income obtained previously from various sources ($p \text{ value} = 0.005$) and obtained an OR of 15.897. So based on the modeling, it can be concluded that respondents who have a high income have a 15,897 times chance of having good family resilience compared to those with low income. This is in line with research that has been conducted in Brazil which shows that In relation to poverty, this resilience group was associated with poor families with a significant probability (51.84%) and with less poor families, with a strong probability (81.62%) (da Silva et al., 2020).

Insights from Friedman's Structural-Functional Theory, investigates the relationship between the implementation of family health care interventions and the resilience of families, using Friedman's structural-functional theory as a theoretical lens. Family resilience is understood as a dynamic process that enables families to adapt positively in the face of adversity, stress, or crisis. Drawing from Walsh's model of family resilience, which highlights belief systems, organizational

patterns, and communication processes, the study emphasizes the role of structured family interactions in enhancing adaptive capacities.

Central to the study is the use of Family Health Conversations (FamHCs), an intervention strategy designed to engage family members in open and supportive dialogue. This approach aims to enhance mutual understanding, emotional support, and cooperative coping strategies within the family unit. Through qualitative analysis, the research demonstrates that families who participated in FamHCs reported a stronger sense of control over challenging situations, such as decisions involving elderly care placements. These families also experienced reduced emotional burden, greater clarity in role distribution, and improved intra-family communication.

The findings are deeply rooted in Friedman's structural-functional theory, which conceptualizes the family as a social system composed of structural roles and functional capacities, such as emotional nurturing, socialization, and health care provision. The study reveals that FamHCs help reinforce these structural and functional components. By facilitating open discussions, these interventions allow family members to express concerns, clarify responsibilities, and reorganize their internal dynamics in response to external stressors.

Furthermore, the study illustrates that implementing family-centered care strengthens the family's structural coherence and functional resilience. It fosters a supportive environment where members feel heard and valued, which is crucial during periods of significant transition or crisis. As such, the application of FamHCs is not only beneficial for individual emotional well-being but also for maintaining the family's overall stability and adaptability.

In conclusion, the research underscores the effectiveness of family health care interventions in enhancing family resilience through the strengthening of roles, communication, and cohesion. Guided by Friedman's structural-functional framework, these findings offer valuable insights for health care professionals seeking to support families in crisis by promoting resilience through structured and empathetic conversations.

Conceptually, family resilience can be seen as nature and process. Review Sifat said that family resilience is strongly influenced by several protective factors as the main key so that a family can bounce back after experiencing difficulties. This protective factor comes from within the family, in the form of positive traits that can encourage the family to rise from the crisis. The perspective of family resilience as a process explains that family resilience is built by the success of the family using coping strategies to cope with stressors faced in his life. All activities carried out in the family work as a process, starting from the first time you encounter a problem to try to overcome it. Family responses in crisis situations are an interaction of many components that make families feel stronger, more empowered and more confident in developing their problem-solving abilities. However, the resilience of the family cannot be seen from one point of view.

However, positive factors that come from the family will interact with each other into the process of how resilience develops in a family. Therefore, it seems inappropriate if we separate the discussion from each view (Herdiana, 2019). Resistance family as the path that families follow in response to stress (Williamson et al., 2021). This concept refers to both ways of coping with stress and adaptation to stressful situations (to what the family does to survive a difficult time and what allows to adapt), it also refers to acquiring new resources and developing the family's potential in response to stress (changes in family priorities, what the family acquires, what the family learns). In general, family resilience refers to the processes that occur in the family and all kinds of activities carried out by family members, which allow it not only to survive difficult times but also to become stronger after a crisis (Nadrowska et al., 2021).

CONCLUSION

The results of the bivariate analysis can be concluded that there is a significant relationship between health care function and family resilience in respondents ($p = 0.001$). The results of the multivariate analysis can be concluded that respondents who have a high income have a 15,897

times chance of having good family resilience compared to those who have a low income. The community, especially the family, needs to improve the function of family health care where the family must recognize health problems experienced by family members, the family has the ability to make decisions in overcoming health problems in the family, the family has the ability to care for sick family members, the family has the ability to modify the environment and the family is able to utilize health facilities optimally to increase family resilience.

The results of this study not only demonstrate a direct relationship between family health care functions and family resilience, but also underscore the mediating role of family health functions in bridging the influence of sociodemographic factors, such as education and employment, on family resilience. Statistically, the multivariate approach used identified that family health functions remained significant even when controlled for other variables, indicating the contribution of structured functional roles in shaping family resilience. The finding that family income is the dominant predictor with an odds ratio of 15.897 can also be explained within the framework of Friedman's structural-functional theory, in which the family's economic function is the basis for the stability of the internal social structure and influences the family's capability to perform other functions such as health care and emotional support. Thus, these results confirm that strengthening family health functions, especially in low-income groups, is an important strategy in building overall family resilience.

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