Rev Saúde Pública 2010;44(1)

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Actions of health group coordinators within the teaching/care network

ABSTRACT

OBJECTIVE: To analyze the model for actions by health promotion group coordinators, in primary healthcare units with links to professional training.

METHODOLOGICAL PROCEDURES: A qualitative study was carried out in the municipality of Florianópolis, Southern Brazil, in 2001. Four groups were evaluated, over a total of 24 sessions at primary healthcare units. Participant observation was performed to start the fieldwork. The reports were analyzed by means of the technique of enunciative-pragmatic discourse analysis.

ANALYSIS OF RESULTS: The types of action among the coordinators that were congruent with the preventive model were: oppression, bench teaching, biologism and higienism, prescription of approaches, blame apportionment, infantilization, reduction of collective problems, denigration of group settings and use of monologue. The types of action consonant with the new promotion model were: facilitation of free expression and autonomy, empathetic communication, constructivism, receptiveness, active listening and promotion of overcoming of violence and alienation.

CONCLUSIONS: The coordinators acted primarily by means of the preventive model, without using technical and theoretical resources that allude to group methodology in the field of healthcare. The actions within the preventive and new health promotion models that were identified reveal characteristics that are grounded in, respectively, the ethics of oppression/subordination of users and cooperation/acceptance of users as free and responsible for their choices and consequences.

DESCRIPTORS: Teaching Care Integration Services. Health Knowledge, Attitudes, Practice. Health Promotion, manpower. Humanization of Assistance. Health Centers. Single Health System. Qualitative Research. Empowerment.

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Received: 8/31/2007
Revised: 5/26/2009
Approved: 10/14/2009

INTRODUCTION

Development of health promotion groups contributes towards cooperative interdisciplinary intervention actions for continuously transforming the health levels and living conditions of users of the Brazilian National Health System (SUS)[21] and, strategically, of users who are in situations of vulnerability and low autonomy, such as the elderly.

Studies within the fields of health promotion and healthcare for elderly people have reported that there is a need to develop planning methods, management and technologies directed towards improving the living conditions, health and healthy aging of the Brazilian population, within the context of profound social and economic inequality. These studies have envisaged a critical approach consisting of prevention, health education and health promotion, so that the system can meet the needs relating to the growing demands from elderly people.[2,4,19]

Health promotion groups link together knowledge, skills and attitudes based on a healthcare concept that simultaneously considers emotional, social and biological characteristics, among the various forms of approach that seek shared resolution of problems.

Improvement of the healthcare education process requires development of participative methodologies grounded in real situations, in which time, personal narratives and pedagogical resources are adapted to conditions of equalization of learning opportunities and individual and community empowerment.

Experiences acquired during the construction of the Brazilian healthcare reforms have identified group educational activities as a crucial factor for overcoming paternalistic and/or preventive educational models.[8,18]

Taking new public health[7] and the SUS guidelines as the reference points, there are two models for health promotion: preventive, in which the status quo is maintained; and new health promotion, in which changes in social organization are proposed.

The preventive model acts to prevent diseases and/or control illnesses through the biomedical model, which has the aim of changing individual behavior under conditions of alienation and oppression. It has a low policy density in that it does not make changes to social relationships, and a high ideological density in that it makes a theoretical-ideological construction that sustains the behavior of individuals who are passive with regard to their decision-making and ignorant of their possibilities.[2] This model is historically composed of the following tendencies:

The natural history model of diseases, proposed by Leavell & Clark in 1976;[15]

Behaviorist health promotion, expressed in 1978 through the Lalonde report,[14] which proposed that individuals should take greater responsibility for health issues and advocated "lifestyle changes" as a central condition for health promotion;

Health promotion for populations takes the paper by Evans & Stoddart[9] as its reference point. This considers income distribution, social development and individual reactions in determining health-disease processes. However, at the level of healthcare intervention, it still does not propose to reflect on and face up to the causes of inequality that are forged through capitalistic production methods.

The new health promotion model recognizes the complexity of the macro and microsocial factors that make up health-disease processes, and it acts towards creating environments that favor health through healthy polices and transformational processes grounded in critical reflection on healthcare problems under conditions of equity and empowerment.[7]

This model takes the Ottawa Charter[a] (1986) as its reference point. The Charter advocates increasing the technical and political power of communities for defining priorities and implementing strategies that aim to develop autonomy and improve living and health conditions. Thus, the following broad concepts are included as fundamental healthcare resources: peace, education, income, stable ecosystem, social justice, eating and equity.[5] Humanization of care is also a requisite of this model, as a condition for self-knowledge, autonomy and self-management for individuals and social groups. Partnerships between healthcare professionals and users that transform the ways of perceiving and providing services are fundamental for recognizing users as subjects with rights and duties.[1,20]

Considering the importance of group interventions for health promotion and humanization of care, the aim of the present study was to analyze the model for actions by health promotion group coordinators in primary healthcare units with links to professional training.

METHODOLOGICAL PROCEDURES

This was a qualitative study carried out in the city of Florianópolis, Southern Brazil, in 2001. Health groups conducted at primary healthcare units that were

[a] Carta de Ottawa: promoção da saúde nos países industrializados. In: 1. Conferência Internacional sobre Promoção da Saúde [event on the internet]; 1986 Nov 17-21; Ottawa, Canada. [cited 2009 Mar 10]. Available from: http://www.saudepublica.web.pt/05-PromocaoSaude/Dec_Ottawa.htm

participating in the university's teaching/care network were identified. One of the assignments of this network was to undertake theoretical-practical development of content material relating to group interventions. Thus, in selecting these units, the way in which training and improvement institutions for professionals committed to health promotion, humanization of care and the family healthcare strategy act within the context of SUS was considered.

Forms were used to obtain the following information about the units: number of groups, duration of existence of the groups, place where the groups functioned, number of participants, frequency of meetings and the coordinators' length of time in their positions and their training.

Out of a total of seven healthcare units, two of them were selected. These units presented the groups that had been in existence for the longest time, the greatest numbers of participants and their own rooms for conducting group activities. Twelve sessions in each of these units were observed, distributed equivalently between groups of pregnant women and groups of hypertensive and diabetic individuals, thereby making a total of 24 observations.

The observations were terminated when the amount of information gathered was deemed sufficient to meet the proposed objectives.

The technique of participant observation was used for entry into the healthcare units, without selecting preestablished analytical categories.[10] After familiarization with the field, the researcher was invited by the group coordinators to participate in these meetings.

The records of the group interactions were formed by continuous running descriptions of the verbal and nonverbal manifestations, using handwritten notes, recordings and subsequent transcription of the data.

The results were interpreted by means of discourse analysis, through identification of regular discursive features and latent content observed in verbal and nonverbal behavior.[3]

This study was approved by the ethics committee of the *Universidade Federal de Santa Catarina* and conducted in accordance with the principles of the Declaration of Helsinki. The coordinators and users were given explanations regarding the research objectives and they signed a free and informed consent statement.

ANALYSIS AND DISCUSSION OF THE RESULTS

The discourse analyses were grounded in constructing grouped categories relating to the preventive and new health promotion models.

Actions congruent with the preventive model

Oppressive form

Replacement of the ethics of cooperation with recognition of another form as legitimate, through imposition of normative approaches, institutionalizes contingent relationships of oppression.[16]

The democratic pedagogical dialogue in the health promotion groups related both to the content and to the way of constructing healthcare knowledge, which stimulated individuals to think and act critically. Differently, the coordinators reproduced authoritarian forms of relationship in the role of caregivers, through acting to delimit the collective elaboration of knowledge and devalue each individual's understanding of the issue.

The following situation illustrates the termination of the shared construction of knowledge, through intervention by the coordinator, who proposed postponing it, but without returning to it during the session of the pregnant women's group.

– (...) sometimes the baby still hasn't got the hang of sucking, so you've got to be patient. (Gerbera)

– A friend of mine gave NAN to the child at the age of three months. You have to try a bit more. (Rose)

– Let's continue with the group and leave this discussion for later. (Coordinator C - topic: breastfeeding).

Banking education

The imposition of approaches is compatible with the banking education.[12] The coordinators correlated the group dynamics with a class or the like. Under these conditions, knowledge was organized and evaluated through introducing as much information as possible, to assimilated passively, as illustrated in the following report:

"The next class will be on healthy eating (...)" (Coordinator B – hypertensive group).

Comprehension in terms of biologism and higienism

Education for health promotion presupposes knowledge of other people, their material and emotional conditions and the knowledge that they have.

Going against this affirmation, the coordinators prioritized information relating to hygienic care, to the detriment of the relational dimensions on which changes of approach are based.

The following is an example of discourse from the coordinators, with distancing from the emotional, social and material factors in the participants' daily lives and from their affective characteristics.

*"Today's meeting is on educating mothers about their babies' health. So I've prepared a class on proper personal hygiene practices for you." (*Coordinator B – pregnant women's group)

Prescription of approaches and blame apportionment

Through reducing the way of dealing with health-disease processes to cause and effect relationships, the coordinators used paternalistic attitudes to impose approaches and lay the blame on individuals for their health problems. Such comprehension explains coercion, legitimizes dehumanizing actions, impedes autonomy and perpetuates dependence through dividing individuals between asymmetrical poles of power:[6] those who know and who induce "correct approaches towards good health" (healthcare professionals); and those who do not know and must learn and/or obey the prescriptions (patients).

– My pressure became high after my mother died. If I get anxious, my pressure goes up." (Violet)

– I can't be bothered that my pressure goes up." (Chrysanthemum)

– Hypertension is a disease that can be avoided if you modify your lifestyle. You know that you have to stop smoking!" (Coordinator A – hypertensive group)

Infantilization of the individual

Through acting negatively in group communication, the coordinators infantilized individuals. They minimized doubts and anxieties by means of expressing words in diminutive form and with childish tones of voice. Dialogues conducted within this perspective revealed a lack of theoretical-technical awareness of the importance of way in which messages were transmitted. This indicated the possibility that the discourse would not be used by the coordinator for elaborating the content material needed for improving the users' living and health conditions.

– I've got a lot of nausea (...) so I'd like to know whether there's any medicine for stopping this nausea while I'm pregnant? (Polyanthus)

– This is how we do things: we'll look at this little doubt of yours later on (...). OK? (Coordinator R – pregnant women's group)

Reduction of collective problems to individual level

Group methodology should prioritize interventions at the collective level and at the time at which they develop. Shared perception of different management methods and possible identification among the individuals belonging to the group increase the possibilities for overcoming trauma and facing up to common health problems.

By not making use of such group resources, the coordinators reduced the processing of group members' collective problems to the individual level of understanding and dealing with these problems:

– Every month, we talk about something: today it's about the care that diabetics need to take (...). (Coordinator F)

– Yes, OK. Because I don't understand: perhaps I have a diabetes symptom, but I don't know whether it is or not. So, by talking, we'll try to find out. (Arum lily)

– On this point, we'll also have a separate chat, to give some guidance as well (...) (Coordinator F – diabetics group)

Difficulties in group settings

Among the coordinator's functions is maintenance of the group setting, i.e. the set of procedures that organize, standardize and enable the group process.[24]

The work process in healthcare units prioritizes actions relating to diseases that are individualized and centered on medical intervention, to the detriment of collective, educational and health promotion-favoring actions. Thus, situations in which the group setting was invaded by noise and movements of people external to the group occurred routinely, as illustrated in the following:

– Can the things we eat cause harm to the baby, or is this a myth? (Azalea)

– There are some types of foods that give child more colics if the mother eats them (...). (Coordinator C)

[At this moment, Gloxinia, her companion and Primrose arrived. They dragged over three more chairs that they had brought from another area. The discussion was restarted, but did not pick up the interrupted topic again. Five minutes later, a professional from the healthcare unit opened the door without knocking and, from outside the room, asked: "*Is Gloxinia here?... and Primrose? They have consultations!"* (pregnant women's group)]

Monologue

Motivated by personal dimensions, the coordinator conducted the group meeting by speaking for a long period of time, thus making it difficult to share and construct meanings mobilized through the members' free participation.

– My mother-in-law is great, too. My father-in-law (...), they're really great. (Carnation)

– We mustn't have any resentment about our origins. I think that people have to forgive their father and mother. So mothers don't have any doubts, because this way oh (...) (Coordinator M – pregnant women's group)

[In this report, the coordinator followed the reasoning by speaking uninterruptedly for more than nine minutes and then, because of the time, ended the group session.]

Actions congruent with the new health promotion model

Facilitation of free expression

After the content material has been presented to the group, it is especially the coordinator's task to stimulate dialogue, thereby constructing and strengthening complicity in seeking health promotion.[17] In this way, identification and cooperative achievement of real situations are facilitated.

This event is improved through free expression by the participants, when there is expansion of the conditions under which a word spoken by one person may bring the others to recall another word, thought and/or emotion.

In the example that follows, the coordinator facilitated understanding and facing up to real conditions, through taking opportunities from elaborations within the group that considered emotional, social and biological arguments.

– *Sometimes I just see the baby like it is here, you know.* (Lilac showed her belly to the group)

– *Lovely belly!* (Rose)

– *A pregnant woman is the most beautiful thing in the world...* (Coordinator I)

– *I get flirted more often...* (Daisy)

– *Do you know what this means? That you got it right...* (Coordinator I – pregnant women's group)

Favoring of autonomy

It is up to the coordinator to maintain an atmosphere that favors development of autonomy. The coordinator's mediation suggests attitudes directed towards achieving people's potential capacity to manage their life processes freely and knowledgeably.[11]

Group processing deepens discussions that are relevant to developing cognitive, emotional and social conditions that favor autonomy.

– *Why do you go to consultations?* (Coordinator K)

– *To be medicated.* (Camilla)

– *Medicines are one of the ways of treating high pressure, but what they're trying to say is that it's not just medicines that are going to bring this pressure down to normal. What else has to be done to look after yourself?* (Coordinator K)

– *Don't eat fat. Stop smoking.* (Camilla)

– *I'd like to put it to you that it's not the doctor, health clinic or hospital that's going to do this (...). There's another important part: to reflect on what you want and can do (...).* (Coordinator K – hypertensive group)

[At this moment, in parallel to the discussion, Anise invited Camilla to go for a walk.]

Empathetic communication and active listening

Addressing people by their names and listening to them as they speak about their ways of thinking, feeling and living are considered to be humanizing measures. They are related to the coordinators' capacity for empathy. However, the literature reveals that activities of listening and being able to take useful advantage from the users' reflections and sentiments are among the coordinators' most frequent difficulties.[23]

By following up how the content material presented develops and communicating empathetically, the coordinators stimulate attitudes of listening within the group setting.[23] In such circumstances, the purpose of group dialogue is not to standardize ideas and behavior but to enable convergence of different meanings.[23] This situation can be analyzed together with the next category.

Actions based on constructivism

Coordination has the fundamental task of taking on a relationship in which both parties (coordinator and group) grow.[22] The coordinators recognized group activities as a fundamental means for jointly learning and for critical reflection on reality as shown in the following statements:

"I'd like to say that the group meeting is a time for us to listen to stories, isn't it? Suddenly we get to know each other, listen, smile and learn different ways of feeling, seeing and doing things. It's at times like these that we get to grow, think and, who knows, find out how to live better." (Coordinator L – diabetics group)

Receptive actions

During the group sessions, individuals can express matters relating to unpleasant emotions. Thus, the coordinators need to act to receive this content material and help to construct meanings that are coherent with the psychological structures. In this way, the group unit is favored because the coordinator included the needs of each individual and of the whole group.[4]

– *I got pregnant, but I'm afraid.* (Jasmine)

– *When we express what we're feeling while we're here, we have the possibility of working on this: the fear that*

you feel and perhaps that others feel. (Coordinator Q – pregnant women's group)

Overcoming experiences of violence and alienation

Devices of power and violence that medicine wields on men and women's bodies may destabilize and alienate individuals and groups with regard to facing events in their own life cycles.[13]

One example of this can be seen in the increasing number of cesareans, which interferes through increasing morbidity and mortality among women and children. Within this context, the topic of the type of delivery can be seen as creating anxiety.

Such situations require coordinators to take positions directed towards overcoming practices that do not favor health promotion. These real situations need to be faced as results from a process that is still in progress and which depends on the development of these individuals and their technical-political context:

– What attitude should we take when the doctor wants to do a cesarean but we don't need it or want it? (Daisy)

– I'm going to throw the question back to you. If you've been to all the consultations and had all the prenatal tests, and everything's going well with you and the baby (...), what attitude should you take when the doctor wants to do cesareans indiscriminately? (Coordinator S)

– I think that natural birth is a better choice when everything's fine with the mother and baby. So, you've got the possibility of changing your doctor! (Rose)

CONCLUSIONS

Analysis of the role of coordinators of health promotion groups can be used as a practical resource to aid in constructing and improving services that are associated with a positive and expanded concept of health and humanization of health-related service provision. However, application of such educational approaches does not constitute, in itself alone, actions for health promotion or humanizing actions.

The analysis on the coordinators' actions within the preventive and new health promotion models that were identified revealed characteristics that were grounded in, respectively, the ethics of oppression/subordination that disrespected different individuals as legitimate parties living together, and reciprocal cooperation/acceptance of each other as parties that were free and responsible for their conduct and the consequences of their choices.

For health promotion groups to take shape within methodology that conceives of and promotes health through the new health promotion model, there has to be coherence between the aims and the ethical, political and pedagogical foundations through which the dynamics of health groups are organized.

Given that health promotion groups are resources for this purpose, they can be based on the pedagogical approach of problem-setting. From this perspective, the group methodology makes use of what people think, feel and say about their problems, as a resource for cooperative development of personal and social skills that enable autonomy and practices that transform individuals and the status quo.

In planning health promotion actions, they should be implemented under conditions of cooperation and mutual recognition of the subjects involved, as autonomous cooperative individuals who are capable of understanding daily life and producing strategies for mutually supportive participation and social control.

The coordinators acted primarily without using technical and theoretical resources referring to health-related group coordination. Their practices revealed lack of knowledge of the limits and possibilities of their actions. They minimized the potential of group resources for health promotion and humanization of care. They used linear arguments regarding health-disease processes and interventions that imposed approaches.

Although the coordinators had partially taken on board the presuppositions of new health promotion, it was seen that the emotional and social traits that influence health-disease determinations were rarely processed. Their practices favored conditions of spontaneity, through revealing a lack of theoretical-technical knowledge about conducting groups, and alienation from the work process. They wore themselves out in health group coordination that was developed with insufficient capacitation and requalification resources.

Projects for professional training and requalification in group methodologies committed to the guidelines of new health promotion and humanization of care are of fundamental importance. Professionals need to develop skills and knowledge within this new reference framework, thereby deepening the discussions on the roots of health problems and reflecting on the emotional content present within group participants' discourse.

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Paper based on the master's dissertation of Santos LM, presented to the *Programa de Pós-graduação em Saúde Pública* of the *Universidade Federal de São Paulo*, in 2002.