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Original Article

Continuing education in the family health strategy: rethinking educational groups[1]

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Objective: to analyze the experience of the family health team in resignifying the way to develop educational groups. Method: groups of discussion, with twenty-six biweekly group meetings conducted, with an average of fifteen professionals from the family health team, during the year 2009. The empirical material consisted of the transcription of the groups, on which thematic analysis was performed. Results: two themes were developed and explored from the collective discussions with the team: "The experience and coordination of the groups" and "The work process and educational groups in a service-school". Conclusions: continuing Education in Health developed with the team, not only permitted learning about the educational groups that comprised the population, but also contributed to the team's analysis of its own relationships and its work process that is traversed by institutions. This study contributed to the advancement of scientific knowledge about the process of continuing health education as well as educational groups with the population. Also noteworthy is the research design used, providing reflexivity and critical analysis on the part of the team about the group process experienced in the meetings, appropriating knowledge in a meaningful and transformative manner.

Descriptors: Primary Health Care; Family Health Program; Community Health Nursing; Education, Continuing; Health Education.

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Introduction

Primary Health Care in Brazil, since 1994, has been redirected by means of the Family Health Strategy with the challenge of developing actions of comprehensive individual and collective care for families, responding to the principles and guidelines of the *Sistema Único de Saúde* (National Health System – SUS)[1].

One of the resources to provide such integrated care can be the development of educational groups, especially if these constitute spaces of interaction and collective discussion between the team and community. In this sense, some authors[2-7] point out that, traditionally, in these educational groups, there is a predominance of information being provided, focusing on pathologies, with the predominance of traditional pedagogical conceptions being transmitted in a vertical form, weakening the integration and collective discussion. In general, they are also well developed with few material conditions and management support[6].

Thus, in order to meet the comprehensive health care that the Family Health Strategy wishes to operate, such actions require revision of the traditional perspective with which they have been implemented[3,6]. The so called *Educação Permanente em Saúde* (Continuing Education in Health – EPS) has been developed by the government and identified as a new perspective of learning at work.

It is a strategic educational policy for health teams[8-10] so that they can develop the working process including different knowledge and different voices that social actors bring into the health scenario in healthcare services.

However, we did not find studies that addressed the process experienced by the family health teams during the EPS, especially in regards to the rethinking and reflecting the work with educational groups.

Just one single study[11] approached the theoretical reference used here, and pointed to the high demand for training professionals from the primary health unit in working with groups, but it did not specifically address the EPS and the family health team. This specific study indicated the need to think collectively about meanings of groups and the demand for qualification of the teams, because their work might only focused at controlling the health behavior of the population. The scarcity of studies with the adopted theoretical reference, and about the theme, justified this research; it is noteworthy that only one article was published in this journal[12] in the last two years which addressed the course of facilitators for continuing health education.

The EPS states that work in healthcare should occur within a scenario of critical analysis and significant learning[8-9]. It has as its theoretical methodology the focus on the working process in health, the micropolitics of work, reflection, and innovative health educational practices[9].

This research innovates by adopting ESF as its theoretical and interventionist framework[9] as well as some concepts of the institutionalist movement, such as institutions[13], micropolitics[8] and those operative groups of the Argentinean School[14].

From this adopted perspective , the group practices are permeated by processes qualified as movements of resistance, cooperation, and dispute[15]. Therefore, even in the typical traditional informative groups provided by the family health teams, such processes currently occur.

The work of EPS can also occur within groups, and in these, members confront each other's knowledge, positions, power, feelings that can trigger subjectivities and changes in the work process, by undermining, questioning, wondering and also confirming the experiences that perpetuate institutions and can produce movements to modify them[8].

In this manner, the guiding question of this action research was outlined as[16]: How does the family health team reframe its work with educational groups in a process of Continuing Education in Health – EPS?

Objective

To analyze the experience of a family health team in reframing the ways in which they understand and work with educational groups during a process of continuing education in health (EPS).

Methodological course

This investigation used a qualitative[17], action research type of approach[16], that was characterized by processes in which there was a co-creation of subjects, of interaction and of senses. The research intervention was a device that went beyond the investigation and exploration of a theme, producing changes in the micropolitics of the institutions from the movements generated in the development of research[16].

Thus, there was an active construction of "an attitude of research" in which the binary divisions between researchers and the researched, subject and object, theory and practice were questioned and deconstructed, based on the premise that the integrated whole is more than the mere sum of its parts. The

provisionality of the findings is considered, as well as the movement and the multiple coexisting realities, where knowledge construction occurs in the spaces "between", in the dialogue and in encounters[16].

To perform the research, the research project was approved by the Committee on Ethics in Research, protocol n° 251/2007, as required by Resolution 196/96 of the National Health Council.

The inclusion criterion of the researched team was the desire and availability to participate in the research, and also belonging to the Western District of the city of Ribeirão Preto-SP, Brazil. The rationale for the choice of this specific study population the team of workers from the family health center of the district west of the city, was an agreement made between the Municipal Secretariat of Health and the University for development of research on this topic and in this area, and with this specific approach, which also requires a voluntary adherence to the process of joint research and analysis of the work along the lines of EPS.

Group meetings were conducted with the family health team using the methodological modes of the EPS[8] for analyzing their work with groups developed with the population.

There was systematic participation of the following professionals: one nurse, six community health agents, one physician, one team coordinator, two nurse technicians, two cleaning staff, two medical residents in family health. Also, there was the eventual participation of: a professor in the School of Dentistry, four interns in the course of nursing and of psychology. All participants signed the terms of free and informed consent.

There were 26 group meetings with an average of fifteen members per meeting, lasting one hour and thirty minutes each. The study intervention was made in the period from January to December of 2009, and the meetings were audio-recorded and transcribed.

The work started with raising expectations of the participants and also providing a theoretical trigger about groups. The subsequent encounters were prepared on the basis of listening and discussion of the recording of the previous meeting. After each encounter the researchers/coordinators of the group, the silent observer, and the technical scholarship holder linked to the project, gathered for an analysis of the work performed. It is noteworthy that the coordinator and the observer had training in coordination of operative groups.

The silent observer is a fundamental figure in the theory of Pichon-Rivière[14], who records the group vectors, body expressions and other information that enable the analysis of group movement, in addition to recording the words of the participants.

There were two movements of analysis: one that occurred during the research intervention, through the development of chronicles of the group encounters that were presented and discussed with the workers. And a second movement was made after the termination of the research work with the team, using content analysis of the transcripts of the encounters on the thematic strand[17].

The transcribed material were reread several times, grouping similarities and differences of ideas. The interpretation was made in light of theoretical references already presented, and of the objectives.

In the transcripts and the results presented here the participants were identified in numerical order attributed according to the order of speaking in every encounter, so the first participant of the first meeting is not necessarily the same in the other groups. This procedure was adopted to guarantee the anonymity of participants and is in agreement with the reference of the groups adopted, which is not proposed to emphasize the individual words, but the process of linking them[14].

Results

The results are arranged in two themes: "The experience and the coordination of the groups" and "The work process and the educational groups in a service-school."

The first theme expressed elements worked by the team in its process of EPS, indicating the way of resignification of the educational groups that they developed. The second theme encompassed elements of the work process linked to a service-school that interfered with the attainment of the educational groups.

The experience and the coordination of groups:

The health team develops groups in their work environment in order to create learning spaces, prevention of health aggravations, and also for interaction and socialization: *[...] the group of nutritional reeducation is formed by people who are referred by any member of the health team [. ..] the majority do want to lose weight, but also we direct the person to learn, for example, a dietary re-education to assist at times in various chronic diseases, such as diabetes, hypertension, also for the prevention of other diseases or the same, and also, some people come because they need spaces for socialization [...]* (G1).

In this way the team also conducts educational groups as a strategy for coping with problems such as

loneliness and social isolation. *[...] ... they are people who, or are housewives who had nothing, who had no activity for them, and other people who are alone, living alone, and had a need to have some kind of thing that was for them, and the group and the group is who chooses what you say[...]* (G2).

The groups are composed of residents from the coverage area, some are closed groups with a specified number of meetings such as those for pregnant women and hypertension, others are open and take place throughout the year as an experience group.

At the beginning of the research, in the group meetings, the team used to identify as necessary knowledge for the coordination of groups only the technical knowledge about the topic: *[...] what you need to do in the group, it is to know about hypertension and to try to bring the group to reflect about health, even being hypertensive, to understand the deprivations of eating without salt or not to eat certain things and still to live well* (G1).

With the development of the discussions, the need for knowledge about the management of the group process began to emerge. In line with this need, a text was prepared as a theoretical trigger for the discussion in one of the encounters and the workers were able to make an approach to the theme of the group process in relation to work of the group that developed. *Participant 2: I think that sometimes the mechanisms of resistance are those that are most obvious, they are! These are people who, for example, they somehow try to get the group's attention, at other times. [...] And also to sabotage the group. Participant 3: A person always has a counterpoint. You talk, or someone else brings up a subject, and the person poses the opposite* (G3).

Another aspect discussed was about what they considered as the results for the groups they conducted. In traditional scientific logic what is expected are numbers (indicators) that *a priori* categorize people and their normalized behavior by scientific knowledge. However, other possible outcomes were discussed by the team, such as the encounters, producing joy, relaxation, among others: *Participant 1: [...] I remembered a publication, a person set up a group of patients who had proposed to stop smoking and the Government wanted a response of how many effectively quit smoking. And that person commented in this publication, that what she managed to get out of the group was not to provide a visible way on how to quit smoking, but she managed to empower people, that was what she reported in the article, and we are talking about the same thing [. ..]* (G25).

The team, from the discussion of its own experience, can understand the complexity of group work, in that the group "converses" about a particular subject at the same time it also converses implicitly with the coordinator, and so it needs to be attentitve to this process, taking into account the "spoken and the unspoken"[12-13].

Exemplifying this fact, in the third encounter they discussed about the management of resistance and the subject arose about when the coordinator has one need and the group has another: *[...] I think it will vary, just like people doing the group of pregnant women, it is that ... they only wanted to talk about childbirth, and we were talking about the pregnancy itself, not talking about the delivery, that will be still in the future, then we have those diversions, so it was basically me and (name) that were in the group, he spoke a little something of what they wanted and then returned to the theme, because if not they wanted just to talk about the childbirth, they did not want to talk about the pregnancy itself, prenatal care, [...]* (G3).

This theme, management of resistance and divergence of needs, proved quite relevant to the team and appeared many more times in this meeting. In the fourth group meeting, when the chronicle of the third meeting was presented , the team again raised the theme, updated to the present team meeting, in a movement of expression with the present coordination (the researchers) saying that in fact they were expecting another kind of work in these meetings of EPS: *Coordinator: What do we do when we think a topic is important to address, and the group does not, they want something else? Participant 2: When you came the first time to present the project, I understood that, so ... it would be a more dynamic thing, there would be more exchange, you know, in my head, you would do so, find some experiences of other parts, or even just teach some dynamics that could be harnessed in the group; this group is very still, very lukewarm, it does not have productivity* (G4).

As a result of this meeting, there was a new agreement between the group and the coordinators/ researchers and some changes in the framework[13], such as starting the group with activities and games that intended to offer experiential work regarding a particular aspect that had been identified in the previous meeting. And the theoretical foundation occurred in the last fifteen minutes based on the more relevant theme experienced in that session.

It is noteworthy that the experience discussed and illuminated from theoretical perspectives produced movements of belonging[13], of engagement and of self-analysis[12] in the collective of the team: *Participant 14: I keep thinking, just as happens in groups when we are there and there is the role of the scapegoat, I think it happens here the whole time, you see?.* (G19).

The team also analyzed aspects related to coordination, when more than one professional has the

coordination of the groups with the population *[...] the coordination of this group is made up of a rotation within the responsible team, so the person responsible in the team in reality is Dr. (name), a medical resident, a fixed staff person, and an intern in psychology. Lately it has had this conformation, so there are four people* (G1).

In the conversational context of the theme co-coordination, it was also possible to articulate a theoretical discussion, bringing literature regarding group process[13-14], pointing out that shared coordination requires synchrony to be constructed by reflected experience and it should be guided by common theoretical, methodological frameworks. Also discussed was the problem of having a group with four coordinators of the different formations, without previous spaces of preparation, and without space afterward for analysis of the coordination and of the results produced. It was visualized that well coordinated groups can be traversed by interrupted communications, assignments not consistent with the directions of the group, among other aspects that do not collaborate with the production of a climate conducive to learning.

With the group discussions in this process of EPS, strategies could also be developed of calling of other users for renovation of the groups; there was the designation of one professional from the health team for coordination of groups and also an agreement for establishing a conversation that precedes the group session for planning, and also a conversation at the end of the group for evaluation.

The work process and the educational groups in a service-school

The health unit studied here had the dual task of caring for the enrolled population as well as to participate in the education of many health workers, such as medical residents in family medicine, nurses, psychologists, dentists, occupational therapists, physical therapists, among others. This dual task conformed and linked together certain work process that the group of continuing education (EPS) placed under analysis, and affirmed that interferences in the conducting of educational groups and other types of work occur.

The participants noted that the residents/students did not value the groups as a qualified form of care to be learned: *One other thing of resistance here, that I think this is something that happen to our team, more than the participant of the group, [..] when the medical resident invades the time of the group doing clinical appointments he does not realize that it is a form of resistance to this kind of work, "no ... but I had no other time to do the appointment". When he invades the hours that are supposed to be of his visit to the community, and replaced it with clinical appointments, he also does not realize that it is a movement of resistance" [...]* (G2).

The team identified that in some educational groups the invitation to participate was always directed to the same users, who "knew" how the groups functioned, making it easier to have their agreement and participation. An implicit agreement was observed, therefore, as if the groups were a scenario in which health workers and users were part of a particular "script" for the training of the students. This is known as traversing[12] of the service-school type of institution.

Another aspect of this type of health unity, the service-school, that was present in the discussions was the constant flux of students and the consequent exchange of the team members, splitting it between the "fixed team" composed of hired health workers and the "mobile team" composed of professors and students: *Participant 3: Can I say something ? [...] Because when you see it, it is the grieving stage, you know, because now two medical residents leave and two new arrive, we look and say: what a thing! ... [...] Participant 4: It's ... we end up wondering [...]* (G26). This process of exchange puts the population and some health workers in a state of constant farewell, which can compromise the necessary links to the care and teamwork.

During the group meetings it was possible to reflect upon the difficulty of communication, the devaluation of the opinion of employees such as community health agents and nursing assistants in the care of the people, the difficulty with spontaneous demand and overload with all the problems faced daily with the families followed.

To exemplify: *Participant 1: this discussion of the families, when we brought it up, we were afraid to say something [...], but sometimes we have an important point to make, because we do the visit, but we were afraid to talk, then we lay still. [...] Then the family goes to the physician and they verify the same things we did, but they bring it up, sometimes even with the same words ... and the team listens and goes after. Participant 3: And what does the community health agents bring? It is worth nothing!* (G5).

Discussion

The data presented in the first theme permitted us to affirm that the health team developed an understanding about educational groups as having the purpose of promoting conversational and learning spaces, which represents an advance in relation to the classical perspective of health teams in taking groups as

spaces of just passing information and prescription of measures for healthy living[4,6].

The understanding of health needs that considers loneliness and isolation also as a health issue indicates a broadened conception of the health-illness processes that corroborated findings from other research[2]. We emphasize that this aspect can bring the team to work in the direction of integrated care[10].

However, such a broadened conception questions the expected results with groups in health services, which no longer fit into traditional health indicators, because they speak to the production of autonomy, alleviation, empowerment. This discussion draws a question that can be problematized reflected upon and thought about within the teams: what kind of results are expected of a health education group?

Although studies[18-19] already indicate the effectiveness of health promotion groups from the traditional perspective, new technologies for evaluation should be investigated, considering the broadened conception of health proposed for primaryhealth care[10].

In order to develop educational groups as spaces of positive encounters, joy and knowledge exchange, some understandings are necessary, such as the understanding that coordinating an educational group demands different types of knowledge beside the traditional ones[15]. This other necessary knowledge surpasses the traditional field of health with its anatomical and physiological knowledge; they include, for example, the group dynamics and the pedagogical process.

We believe that this knowledge needs to be constructed with the health team from the perspective of meaningful learning. Thus, it appears appropriate to adopt the proposal from EPS, in which the experience of developing educational groups with the population together with placing the experience under analysis, understanding and explaining in the context of the group process is extremely valorized and recommended.

This was a device constructed during this process of EPS in this group, in other words, to experience and reflect in the light of theoretical frameworks. This manner of working with EPS is in agreement with the perspective indicated by scholars[8-10]. The advance of this proposal is in the production of specific devices for each situation, in context, based on the collective reflections.

The devices are artefacts proposed by the institutional analysis theory that permit the visibility and divisability of tensions between the forces of maintenance of a reality, and the modification of it[11,16].

When health workers viewed that they themselves "spoke indirectly" with the coordinator of the group, they could understand the presence of the implicit and how it is the task of the group to continuously negotiate those phenomena[14].

Probably many educational groups conducted in health are deflated because this negotiation does not occur, where the unspoken and the interest and desire of the coordinators prevail.

It is also probable that users of health care do not always tell their real opinion to health workers for fear of retaliation and of being improperly attended, therefore, the construction of the right to express dissatisfaction is a tool for the work of the primary care teams, and the fact is that experiencing this in the work of EPS allows reflexive learning.

Also in the first theme we saw that coordination and co-coordination of an educational group space was developed by several members of the team, but was little questioned by them. This seemed to us to be another important factor, as there is a naturalization of making educational groups as being restricted to face-to-face meeting, neglecting their planning and evaluation[7]. However, we highlight the advantages towards the possibility that professionals with diverse backgrounds can work together in educational groups composing a multi-professional work, desirable in the family health strategy[4,7,10].

In the second theme we saw aspects of the work process that traversed the performance of activities of the health team, including educational groups, and that could gain visibility in the space of continuing education (EPS). We highlight the presence of the traversing of the technical and social divisions in the institutions of labor and the institution of school/university, and issues of hierarchy and power which they bring with them, affecting the services[13].

Research conducted in France, found similar findings with regard to the presence and interference of the school institution in other establishments such as city hall, social services, among others. Such interferences are made by the crossing of potentially contradictory logics that result in conflicts[20].

In the present investigation, a public university participated in the management of the health unit being studied, and it coordinated with faculty in partnership with the Municipal Secretariat of Health. There was thus a question of hierarchy of power that was materialized within this dual management.

Studies[21] of institutional analysis in Brazil affirmed that: "The University as the school apparatus, is situated

at the apex of a hierarchical system of power, instituting places previously determined for the different social actors that occupy them. The location of knowing – the professor, the place of acquiescence of this knowing – the student, the place that will be attended to and "benefited" by the university knowledge – the community, etc. The machine of subjection is put to work for that, "oiled", serves the domination, the apprehension of the word and the impediment of the process of participation and decision"[21].

Thus, some agreements existed, and at the same time others were "erased", such as the conduct of educational groups designed indeed for the learning of medical residents and other students. A job that for them assumed a position of lesser importance in relation to individual consultations and home visits, which updated the health institution in its traditional matrix: occupying themselves with the ill individual patient.

In this way there was a concern with the learning of other tools of care such as group work, but, at the same time, there was not concern about the theoretical foundation of the same. It was hoped that students would learn to coordinate groups through doing the empirical only, which may reinforce the idea of educational groups as a "minor" and simpler form of care.

Another manifestation of the service-school type of institution in the process of team work is its division between the "fixed" and "mobile" team. The fixed is composed of contracted health workers who remain in service every day, the mobile are the students. The repeated passage of students, linking with them, then the separation and a new beginning can result in an overload for the workers. Another aspect is that they respond to a dual management: of education and of health, we even asked if the team can, due to overload and submission to academic power, end up prioritizing teaching to the detriment of assistance? How can they attend to two such complex tasks: teaching and attributes of primary health care, while committed to comprehensive health care?

These issues, with greater or lesser intensity, are being experienced across the country due to the implementation of curriculum guidelines for health courses[22] that indicate the need for training with a focus on primary health care. We point to the needs of further investigation about this issue.

Another present institution which was strongly manifested was the technical and social division of labor[12]. It was considered that the work process was performed through a division of tasks that were both technical and social, which made the work fragmented and piecemeal, and may lose the intent of work in health.

When workers of the team conversed about the work developed, they also conversed about the difference in power and knowledge between the components of the healthcare team[13]. Health workers with lower schooling and who were much closer to the population, such as the case with the community health agent, stated that they also bring to the team their perspectives on the need of the community, but that is often only vocalized if another health worker, usually higher in the hierachical structure, also does this.

Final Considerations

The analysis of the experiences of the family health team in the process of reflecting and reframing the way they develop educational groups showed advances with regard to more traditional practices of conducting groups, usually only focusing on informing the population, considering issues such as socialization. The need for theoretical support beyond the traditional, such as knowledge about pedagogy and the group process, was also evidenced.

In the process of ESP with the healthcare team it was possible to construct learning as to: working with groups in a participatory perspective, organization and coordination of the groups, approximation of its purpose beyond the educational dimension. This conversational group with the team became a space for discussion, learning by doing, and doing by learning, exactly as proposed by the EPS.

The research design of this study stands out as one of the important contributions of this research, in that the team analyzed the group process experienced during the encounters of EPS, embracing the knowledge and transfering to the groups that they conduct with the population, learning in a lively and significant manner.

It was concluded that, during the process of continuing education in health (EPS) about groups developed with the population, the team also analyzed its own relationships and its own work process, which was traversed by the institutions' technical and social division of labor and the school/university institution. This analysis can produce major changes in their practices.

Finally it is considered that this process evidenced for the team that the groups can be potent spaces of collective care, at the same time that they require space/time for review and analysis to indeed be spaces of collective discussion and practice change: moving from

the perspective of solely informing to the perspective of producing comprehensive care, encounters and engagement leading to positive impact.

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