DOI: 10.1590/S0080-623420130000300017

Original Article

Communication in the coordination practices of socioeducational groups in family health*

COMUNICAÇÃO NAS PRÁTICAS DE COORDENAÇÃO DE GRUPOS SOCIOEDUCATIVOS NA SAÚDE DA FAMÍLIA

COMUNICACIÓN EN LAS PRÁCTICAS DE COORDINACIÓN DE GRUPOS SOCIOEDUCATIVOS EN LA SALUD DE LA FAMILIA

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ABSTRACT

The purpose of this study was to assess the forms of communication used by coordinators in socioeducational groups in family health programmes. This qualitative, descriptive and exploratory study was conducted with 25 coordinators of groups in eight basic health units from Belo Horizonte, Brazil. Data collection comprised non-participant observation and semi-structured interviews with the coordinators. The theoretical basis for research was Bakhtin's formulations and references on communication and health. The gathered information showed that the body, health and disease triad was communicated in groups through different channels and at different levels of discourse. Our conclusion is that coordinators must adopt an approach that values the expression of participants, not just regarding the physical dimensions of health, but also the life of each participant, and should use various forms of communication to foster dialogical educational actions and means for interaction in groups.

DESCRIPTORS

Communication
Group structure
Family Health Program
Public health nursing

RESUMO

Este estudo objetivou desvelar a forma da comunicação do coordenador de grupos socioeducativos na Saúde da Família. Pesquisa qualitativa, descritiva e exploratória desenvolvida com 25 coordenadores de grupos distribuídos em oito unidades básicas de saúde de Belo Horizonte, Brasil. Para coleta de dados, utilizou-se a observação não participante e a entrevista semiestruturada com os coordenadores. O estudo teve como marco teórico as concepções de Bakhtin e referenciais sobre comunicação e saúde. As informações coletadas mostram que a tríade corpo, saúde e doença é comunicada nos grupos por diferentes canais e em níveis diversificados de discurso. Conclui-se que há necessidade do coordenador valer-se de uma abordagem que valoriza a expressão do participante, não estritamente da saúde em sua dimensão física, mas da vida de cada um, buscando diferentes formas de comunicação para efetivar a ação educativa dialógica e os espaços de interação nos grupos.

DESCRITORES

Comunicação
Estrutura de grupo
Programa Saúde da Família
Enfermagem em saúde pública

RESUMEN

Se objetivó revelar la forma de comunicación del coordinador de grupos socioeducativos en la Salud de la Familia. Investigación cualitativa, descriptiva, exploratoria, desarrollada con 25 coordinadores de grupos distribuidos en ocho unidades básicas de salud de Belo Horizonte-Brasil. Datos recolectados por intervención no participante y entrevista semiestructurada con los coordinadores. Se utilizaron como marco teórico las concepciones de Bakhtin y referenciales sobre comunicación y salud. Las informaciones muestran que la tríada cuerpo, salud y enfermedad es comunicada en los grupos por diferentes canales y en tres niveles diversificados de discurso. Se concluye en que hay necesidad de que el coordinador de valga de un abordaje que valorice la expresión del participante, no estrictamente de la salud en su dimensión física, y sí de la vida de cada uno, buscando diferentes formas de comunicación para hacer efectiva la acción educativa dialógica y los espacios de interacción en los grupos.

DESCRIPTORES

Comunicación
Estructura de grupo
Programa de Salud Familiar
Enfermería en salud pública

* Extracted from the thesis "Comunicação nas práticas de coordenação de grupos socioeducativos na Estratégia de Saúde da Família". School of Nursing at the Federal University of Minas Gerais, 2010. [1] Nurse. Master's degree in Nursing. Member of the Centre for Studies and Research in Human Care and Development at the School of Nursing of the Federal University of Minas. Belo Horizonte, MG, Brazil. ligemeasbh@yahoo.com.br [2] Nurse. PhD in Public Health. Faculty Member of the School of Nursing at the Federal University of Minas Gerais. Coordinator of the Centre for Studies and Research in Human Care and Development at the School of Nursing of the Federal University of Minas. Belo Horizonte, MG, Brazil. smsoares.bhz@terra.com.br

OnLine Português / Inglês
www.scielo.br/reeusp

Received: 11/10/2011
Approved: 02/05/2012

INTRODUCTION

In healthcare, socioeducational groups are commonly formed in order to provide community assistance. The aim of such assistance is to promote the participation of individuals who have gradually assumed the role of protagonists in the improvement of their living conditions[1]. Such actions consequently comply with requirements of Brazilian public policy directives in relation to educational activities that target the promotion, protection and recovery of health.

Because every act of education and learning is a continuous process of enquiry, reflection and questioning based on collective, articulated and shared activities[2], communication is thought to be a necessary skill for all group coordinators, and is an essential condition of fruitful intersubjectivity in the learning process[3].

However, the coordinator cannot always think of communicative practice articulated interactional and sharing mechanisms of the members involved. In these groups, there is also a tendency for vertical communication that focuses on the individual and biological aspects of a given disease or risk factors, which in turn promotes *naturalization* of states, situations and behaviour.

A previous study[4] showed that changes in form and manner in terms of group communication are probably slow and gradual. This study indicated that some coordinators prefer the dialogical model[5], which seeks participative learning based on activities that foster dialogue, and should therefore be better exploited.

The vertical communication model is now considered unproductive for group communication, and the mere linear and vertical transmission of messages no longer meets the new healthcare requirements, particularly given the urgency for new forms of discourse in the fields of health and communication[6]. The vertical communication model is also limited because, when applied to communication, it fragments participation by the various agents, simultaneously separating them and creating a relationship in which the communicator has power over the receiver, as if a hegemonic and necessary relationship of one over the other.

Consequently, the design of the current study was based on obtaining answers to the following questions: How do coordinators communicate in socioeducational groups in family health? What are the proximities and distances that interfere in the attainment of group objectives?

To date, research on groups has been limited to the technical and non-process aspects. Clarification of the impasses and potentialities that can occur in the involvement of people during self-help activities is still a huge challenge. Furthermore, the communication practices of group coordinators have rarely been explored in the scientific literature, and there is a need for critical learning in the realm of family health. The purpose of this study was to reveal the forms of communication used by coordinators in socioeducational groups in family health.

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METHOD

This was a qualitative, descriptive and exploratory study conducted with 25 coordinators of socioeducational groups in eight basic health units in Belo Horizonte, Minas Gerais, Brazil.

Participation in the study was voluntary. Inclusion criteria were that participants must be members of full family health groups (which include a physician, a nurse and two mid-level nursing professionals), and that they coordinated groups that target educational activities.

Data were collected from March to July 2009, by means of non-participant observation of the actual groups and semi-structured interviews with the coordinators. Key non-participant observation topics included: the content of the discussion at each encounter; message submission channels; forms of intervention used by the group coordinator; more important dialogues and relationships created between the participants, considering symbols, signs and discourses that distinguish places and speaking competencies.

In total, 33 encounters were monitored, and observations resulted in theoretical, methodological and content notes based on manual note-writing, as well as speech recording and subsequent data transcription. These notes were then used to create a field log with continuous and cursive descriptions of verbal and non-verbal communication within the group.

We made the decision to interview coordinators because, in practice, they are the group mediators[7], that is, they are the people who organize topics for discussion, and they intervene and lead the group by questioning, pointing out and interpreting group phenomena, which seems to contribute to greater or lesser involvement of participants with the proposed objectives.

Of the 25 participants, 14 were interviewed, including a physician, five nurses, two mid-level nursing professionals, five community health agents (CHA) and a social worker. The interviews were individual and were recorded in MP3 format and fully transcribed. The guiding interview question was *Tell me how communication occurs in the groups you coordinate – take into account the topics and manner in which these topics are explored*.

The observations and interviews were terminated according to the principle of 'information saturation', which

consists of interrupting data collection once the material becomes redundant or repetitive, and continuation is therefore unnecessary[8].

All collected information was organized and categorized according to the thematic analysis technique[9]. After field observations and interview transcription, the material was read through completely and exhaustively, initiating the pre-analysis and data exploration stage. Meaning units were recorded on systematically organized charts, with subsequent classification into thematic areas and meaning units.

We used Bakhtin's formulations to interpret the data, in addition to theoretical references on communication and health. Bakhtin's concepts allow reflection on the practices of coordinators, who must acknowledge the group as a social space for interaction formed by a plurality of voices. Meaning in these groups allows for several interpretations.

The study was approved by the Research Ethics Committee of the Federal University of Minas Gerais (resolution ETIC 133/08) and the Ethics Committee of the Municipal Department of Health of Belo Horizonte (protocol 044/2008), in accordance with ethical provisions established in Resolution 196/96 in relation to research with human beings. Study subjects, including participants of the observed groups, signed a written consent form. To ensure anonymity, informants were identified with the letter 'C' for coordinator, and a number according to the order in which they were contacted.

RESULTS

Content analysis of field observations and interviews led to the identification of the following two categories.

Diversity of message-conveying communication channels

Messages in the studied groups were conveyed through a variety of channels, including films, theatre, posters, pamphlets, booklets and technological devices.

For some coordinators, films encouraged solidarity and group participation in the community, as indicated by the following statement:

> We encourage participants to use the film Pay It Forward for them (...)to help others (C1 - nurse).

Theatre was also used by coordinators to discuss social content, as shown by the following statement:

> Working with social content in theatre is easier, (...) you (...) transfer the person to that scene, but it is still related to his thoughts and context (C3 - nurse).

Coordinators also used posters, pamphlets and booklets that raised issues about the advertising of healthcare campaigns, especially against dengue and sexually transmitted diseases (STDs), most of which are funded by the Ministry of Health. These teaching resources can be found in institutional interaction spaces and act as information channels that clarify and create awareness of healthcare promotion and disease prevention. It was observed that the educational proposals in these teaching resources sometimes clashed with the expectations of health-service users, as expressed by one of the participants:

> The group discusses the spreading of sexually transmitted diseases among the elderly. One of the participants said it was absurd that health units placed posters in the reception area that read: Condom and carnival – a duo that works. (...) An old man with AIDS is a dirty old man (Observation notes - BHU 2).

Another communication channel that deserves attention is the availability of technological devices, such as television, DVDs, sound systems, computers and multimedia. When coordinators use these devices, they do not always perceive that the format of the messages conveyed in the group may not be easily understood by participants that have different realities. For example, CHA conducted an oral multimedia presentation of the epidemiological diagnosis of team 1 of the BHU 1. It was found that these agents were more interested in conveying the content of the presentation than in the possibility that some members might have difficulties in learning and reflecting on this information.

It should also be highlighted that one interviewee was against the use of technological devices because she claimed it hindered good communication:

> When we use this resource [computer], it´s usually when [participants] doze off. When I use posters, I take markers, magazines, they cut things out and convey a message to us (C4 - nurse).

Dynamicity of content discussed in groups

It was found that there was thematic heterogeneity in the groups studied. Topics were related either to disease prevention and control or to health promotion.

When discussing disease, coordinators mainly focused on helping participants to deal with signs and symptoms for crisis prevention and avoidance of long-term hospital stays. When such discussions were based on topics laden with taboos and prejudgement, non-observance by the coordinator of social and cultural aspects was found to generate uneasiness and repulsion among members. This was evident in the statement of a member during a group discussion on the increase of sexually transmitted diseases in the elderly population, as follows:

> (...) I just don´t agree with the manner in which sex is being discussed. (...) When the member speaks, C6 (CHA) stomps or taps his feet, looks at the floor and then at the participant. (...) When he realizes the group is starting to become disorganized CHA intervenes: (...) This topic really needs to be debated. He says that and then changes the subject (Observation notes - BHU 4).

For some collaborators, questioning about variables related to health, sickness, education or communication according to the individual situation and the characteristics of the groups involved represented a challenge. Some of

the collaborators were aware of this, as indicated in one of the interviews:

> [We must] extract the best from every human being and not present ready-made knowledge (C2 - nurse).

In meetings based on repetition of the thematic approach referring to the disease, the group often showed a lack of interest.

> C8 (mid-level nursing) recalls the booklet on diabetes and hypertension that was handed out in one of the previous meetings: We are going to check what they learned from the booklet. During the discourse, some participants gazed around the room, distracted, while others paid attention but showed discouragement (Observation notes - BHU 5).

The manner in which topics were discussed in the groups was also emphasized. When speaking about disease, prevails persuasion about the coordinators risks as a guiding principle grounded on epidemiological information. A lineal and vertical discursive practice was generally maintained, leading to an instrumental conception of language. Because the content of the message was not questioned, the coordinator often hindered dialogue within the group.

> C7 (nurse) starts to talk about the difference between flu and a cold. He reads PowerPoint slides printed on A4 paper. The participants remain silent (Observation notes - BHU 8).

In contrast, some interviewees, faced with the monotony of the group, stated the need to expand discussions into a broader concept of health that observes the human being in all its biopsychosocial dimensions, enabling debates on quality of life, which would comply with the proposal of the National Health Promotion Policy:

> A differentiated healthcare started to emerge, because teaching about hypertension and diabetes was very boring. [We started to]recover a sense of citizenship, and leisure, in the community (C2 - nurse).

Another example that reveals changes in the studied subject area during gatherings occurred in BHU 1. Discussions on the disease focused on a new aspect, namely, the citizen's right to healthcare:

> I perceive the group as (...) an opportunity for us to politically stimulate people to get more involved in fighting for their rights: Oh! You don´t have to pay for the medicine, it is your right. (...) we have to participate in the manifested struggles of the low-income population (C5 - physician).

However, behind this discursive practice, the traditional model may be perpetuated, as indicated by the statement of C5 (physician). Although this coordinator tried to cover subjects that did not merely focus on the disease, and discussed topics that arose from the group itself, he usually guided the subjects that should be debated.

> (...) we try to include topics that interest the participants. For example, they want (...) to discuss family. So we talked about family from a perspective that we believe to be more interesting (C5 - physician).

Coordinators considered that they provide essential guidelines for the practice of health in the community and emphasized the importance of healthy living habits, although they recognized the difficulty in achieving these objectives.

DISCUSSION

This study revealed the existence of a wide range of channels to convey different messages within socioeducational groups. These messages may have been perceived differently by group members because each member has specific cognitive characteristics and particularities in relation to content discussed within the group, which should be considered by the coordinator; doing so requires a certain level of creativity and sensitivity.

Films proved to be a creative communication channel, and can also offer multiple languages for the coordinator's work and introduce the dimension of sensitivity. Some authors[10] have indicated that films offer the use of art to allow interpretations of human behaviour inspired by topics related to multiple dimensions of education (whichever they may be), their meanings and scope, their subjects and practices, and the interaction spaces and educational processes, among other aspects. Films carry ideological markers and material markers of the social horizon of a given period and a social group with a value index (content)[11]. Together, form and content in social interaction produce an ideological significance that axiologically tightens the fabric of the involved fields. When using films, the coordinator must understand that they do not merely transfer the problems and issues of the group to the screen. Use of films is not about making cinema more *school-friendly* or *educational*[10], as art has its own value that is irreducible. Consequently, the coordinator must be clear about what, why, how, for what and for whom the film is being used, because the image holds a communicative value that can convey intentional messages between the producer and the receiver.

In relation to theatre, the sociological character of art is contained in theatrical language[12], originating from life and returning to life, proposing alternatives, and an aesthetic, critical and social perspective, given that *all the products of human creativity are born from and for human society*[12], that is, the artistic language is enunciated in social life.

Bakhtin states that art plays a fundamental role in the people's lives and can help individuals to become responsible for themselves and for others in their social environment. To use or experience art is potentially an ethical act of commitment to improving the conditions of human existence, and to promoting awareness, reflection and language related to otherness. To establish a communicative relationship between coordinators and their groups, the group members must participate in experiences with theatrical language, which enables a dialogue with reality. It is important for coordinators to question,

instigate and collaborate with collective thought to allow members to form significant concepts required for their learning process.

The challenge for coordinators is, therefore, to approach the different artistic languages as a way of empowering, expanding and polishing sensitivities, individual and collective identities, and the dimensions that constitute participants as human beings.

In terms of the teaching material used with groups, the concept of polyphony emphatically permeates these resources[13]. Every statement, enunciation or text refers to multiple voices, most of which are not perceived by the speaker. These voices represent several interests and positions in the social structure, which makes language an arena of social dispute in which relations of power are proposed, negotiated, ratified or rejected[13].

In the current study, the educational proposal contained in the resources used was often based on a communication model with unilateral views conformed by the experiences of the creators of these educational resources, often resulting in resistance on the part of some of the health-service users[3]. This was evident when the functional content of the material (e.g. posters) targeting preventive practices addressed controversial topics, such as sexuality in the elderly.

Understanding a message (e.g. a poster) depends on the complex interaction between several factors[14]. The message, like the disease, reaches people through their experience of and experimentation with social events, which provide meaning and make sense of the world that surrounds them. Each person considers the relationship between individual senses and the broader cultural context in which they are immersed, and this used to build a network of meanings.

In this regard, a previous study[15] showed that there is an interdependence between the text (object of analysis and reflection) and the elaborating and involving context (interrogative or non-conformist, among others) through which the subject thinks and practices the act of cognition and judgement. It is therefore impossible to eliminate or neutralize the second consciousness in the text: that is, the consciousness of the person who becomes aware of the text.

The coordinator must therefore understand that, when using educational material, the text must make sense regardless of its form or support, and cannot be treated as a simple object of analysis without considering dialogism and contextualization.

This is also applicable to technological devices, which are often used by the coordinator as mere message-transmission channels, with previously established meanings, characterizing a communicative practice based on the informational model that disregards human intervention in social life and excludes the complexity of the symbolic dimension that is present in all communicative acts[16]. In these cases, the message or information is not an effective means of communication, as this would require acknowledgement as symbolic content, that is, when it represents something to someone.

In contrast to this model, this study showed an implicit reference of some coordinators to another conception of communication: the dialogic approach[5], which defines the communicative practice not merely as a message-transmission process, but as a constituent of both the subjects and the regular world built and shared intersubjectively.

Some coordinators proposed activities that allowed collective participation by the group, thus including communication in the scope of experience, action and intervention of these people in a language that acquires an expressive and constitutive dimension of their experiences in the world, even if this occurs empirically. It is language that is used by a dialogic subject, who perceives himself in relation to the other person and builds himself within that relationship[16].

The coordinator must therefore enable each member to be an active character in the communication process, who acts and works according to what is offered to them; that is, to detach from what is conventionally called *reception*, acknowledged as complying with interpretational tasks determined by the enunciator in an abstract and idealistic game of stimulus and response[17].

In relation to the discussed content, we found that disease was still the focus of communication in groups, meaning that the subject was viewed as the carrier of an illness that is yet to be known[18]. According to some authors[19], discussion of treatment and cure of a given disease should not focus merely on technical and technological intervention and medicine, as a disease does not only inhabit a biological material body, it is also the body of a being who expresses, in its biological materiality, a sensitive dimension that qualifies them as human.

Furthermore, speaking about disease, health, prevention, body and even medication, which are topics that healthcare professionals must obviously tackle, includes aspects of life that are profoundly rooted in social and cultural values, and can trigger a wide range of reactions (conscious or subconscious) and of varied intensity[20].

In the current study, the difficulty of discussing certain subjects in the groups created a barrier to the establishment of communication, as often there was implicit content in the group that functioned as an obstacle for the attainment of objectives. The coordinator therefore needed to elaborate hypotheses that explain unrevealed facts or processes. These subject areas also addressed the beliefs and values of the coordinator, who sometimes got lost and was unable to conduct the group discussion.

In these situations, the coordinator must be capable of *reading between the lines*, as occurs when reading a text. The topics should be registered for better exploration at

another time. There are three basic questions that the coordinator should have in mind when talking to a group member: *what did he or she say?*; *what does the statement mean?* and *what is not being said?*[21].

This is explained in a previous study[15], in which the authors state that every enunciation, conceived as a unit of verbal communication, is linked to an immediate and concrete social and historical reality, and to other enunciations that should be considered. A response is expected from the interlocutor as soon as a enunciation is constructed, because is intrinsic to interlocutor the capacity to trigger a responsive attitude, and the person making the statement, and the interlocutor who understands the meaning of the enunciation adopts an attitude of agreement or disagreement in relation to the idea presented by the speaker.

This study also showed that communication, tobe reduced to its instrumental dimension, is restricted to the technical evaluation of the messages put into circulation in the group. Thus, the coordinator leaves out what is more strategic thinking: the insertion of education in the complex processes of communication of present-day society.

Moreover, exposure to a given subject in the context of vertical communication is not always brief and simple, and often leads to weariness on the part of the listener, as shown in this study. The information model demands greater attention, as there is always a risk that the receiver can disconnect and stop receiving the message.

However, some coordinators were eager to promote the capacity to interpret and grant new meaning to the subject of disease, which is contrary to the instrumental theory of communication. Such coordinators tried to expand the level of collective awareness in relation to social privations and to the need for political mobilization on the part of group members in a flexible manner that is open to differences.

This suggests that several presuppositions characterize the intention of the coordinator in relation to the group, marked by an assistive and educational approach that adopts information with content focused on reality, based on a communication process that can change reality in such a way that people are granted the right to obtain information in a critical and reflexive manner. Therefore, it is not possible to affirm the total predominance of interventions supported by the idea of risk, although its presence is striking[3].

Another important aspect that should be discussed is the divergence between content and form in the communication practice of some group coordinators. Content and form are always related; the intention of the author is objectified in the discourse according to a given form, which cannot be any other form and which constitutes the mark of the author's individuality in reality[15]. In this human activity, as in all others, the personal moment carries a constitutive importance of all objectivity.

In relation to fostering changes in behaviour of their audience, coordinators run the risk of adopting a prescriptive and behavioural discourse when trying to promote healthy living habits. This discourse is not attuned to the philosophical – conceptual framework of health promotion, and often invades the privacy of individuals or overlooks cultural aspects. Accordingly, coordinators need to deal with the cultural aspects differently, not ignoring the technical knowledge, but also respecting local culture, and conciliating both in their activities.

In order to change the group's habits, the coordinator must promote active comprehension within the group[15], which suggests openness and movement in the act of understanding when aimed at the future, and incorporates the potential to produce the new (e.g. new possibilities). Creative understanding requires an active responsive attitude, defined as the initial preparatory stage for a response that can be updated in any form. Consequently, the triad of body, health and disease is communicated to the group through a number of different channels and at different levels of discourse, which must be understood as an object of social construction that is shared and communicated by individuals[20].

This reinforces the need to redirect subjects presented in the groups according to the local reality. Adaptation of subject areas to the target audience is essential for group planning and development, and allows members to identify with that part of the reality which the coordinator hopes to transform, making them active subjects that build their lives in a social and cultural context permeated by their values, habits, beliefs and expectations.

CONCLUSION

The actions of coordinators do not always enable the establishment of communication that promotes dialogue in a group for the purpose of attaining the stated objectives. However, some coordinators do seek new forms of relating to others based on communicative practices that signal a new work process in which they can acknowledge people as active producers and exchange new interpretations on health.

The coordinator must find support in technical and scientific knowledge to understand the social dynamics in which the group is immersed, as there is a growing demand for this type of intervention in healthcare. Similarly, it is important to promote the social learning space, that is, interaction, educational dialogue and the exchanging of ideas and experiences, all of which are essential elements of the knowledge construction process. One of the greatest challenges of working with groups is the development of attitudes and spaces of meeting that are intersubjective communicational between the coordinator and other members of the group.

Communication established within such groups must comply with demands of the participants, and promote their autonomy during decision-making and the transformation of reality, in order to reconcile the wide range of interests

and meanings created in the relationship between the issuers and the receivers of messages.

This communication needs to find channels that will allow positioning of the population in relation to public policies, programmes, routines and procedures, rather than establishing behaviour that should be learned. Reflection on the problems raised by presuppositions that provide information on the development and use of educational resources must also be incorporated.

It is also important for undergraduate and graduate programmes in the areas of health to incorporate subjects that focus on working with groups and communication in the context of groups. We hope the current study will support the workshop-planning activities of family health teams, while encouraging and providing an instrument for coordinators to seek different forms of communication to enable group interaction that focuses on constructing critical awareness in relation to public and collective interests.

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Acknowledgement

Financial support of CAPES through scholarships.

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