AI Practitioner

Promoting social networks in the healthcare system in Ribeirão Preto/Brazil

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The Brazilian Healthcare System faced many challenges in implementing the new principles of universality of access, comprehensive care, decentralization and social participation. In this article, we present three examples of how group practices influenced by constructionist ideas promote local changes essential to the transformation of the Healthcare System. The first example focuses on interdisciplinary health work. The second is an example of social participation in health politics and the final case illustrates community engagement in the process of producing/delivering healthcare.

In the late eighties, Brazil initiated a Health Reform Process which has subsequently led to a National Healthcare System called Unified Health System (SUS). The SUS is based on constitutional principles of universality, comprehensive care, decentralization, social participation and equal right of access by all citizens to services at all levels of complexity. Since this reform, the concepts of health and illness have been amplified and efforts have been taken to transform the healthcare system into a unified organization at the federal level while simultaneously giving autonomy to different, local levels of care. Special effort has been given to the first level – primary healthcare – which became the central focus of the system since it serves as the entrance to the healthcare system and the first contact with families. This level of care has a community-oriented mode where the goal is to take care of communities. "Taking care" in this context means approaching and connecting all members of the community to the entire healthcare system. In doing so, the aim is to create an environment conducive to collaboration, thereby fostering an atmosphere of cultural and local sensitivity, improving the quality of life and creating a sense of attachment, co-responsibility and participation. In order to develop practices that are relational, integrative and helpful within this new healthcare structure, the need for new interventions designed to challenge the traditional and technique-oriented approaches to healthcare are a priority. Focus is on creating more innovative models and making positive changes.

With the healthcare system as a new governmental priority, more value is given to interdisciplinary work and the social/political/relational aspects of the health/illness process. With this shift in emphasis, the work of psychologists has been gaining a more prominent place within the healthcare process, thereby broadening the meaning of psychological intervention in public health and expanding psychological practices beyond the traditional focus on clinical issues. Emphasizing the local level of healthcare and, consequently, demanding a productive collaboration among the actors involved, challenges healthcare professionals to incorporate multiple voices. This is a context in which social constructionist discourse offers some useful resources. This theoretical perspective emphasizes the relational

and discursive processes through which people construct themselves and the world in which they live. Within a social constructionist perspective, language is understood in its performative character and is considered a social practice that constructs realities.

Associated is the denaturalization of some assumptions usually considered to be essential truths. For constructionist authors, the meanings that inform our understanding of the world are social constructions, an outcome of the conversational exchanges, situated in specific social, historical and cultural contexts. Constructionism focuses, therefore, on the way people co-create, in their discursive practices, certain personal and social realities. This constructionist emphasis on the relational process of world making is especially useful in the production of collective answers to the challenges present in Brazil's healthcare system, because it invites the use of group practices to promote a sense of relational responsibility (McNamee and Gergen, 1999) and a climate of dialogue (Becker et al., 1999).

Group practice in healthcare: a social constructionist approach
Based on social constructionist assumptions, we would like to propose an understanding of "group" as a conversational resource – that is, a group is seen as a specific interactive context in which people engage in the negotiation and construction of meanings. Developing group practices therefore can be described as an attempt to construct a dialogical context based on collaborative discourse, in which the negotiation of meanings can favor the emergence of alternative possibilities and new vocabularies for action. Our focus is on various ways in which these sorts of group practices can be developed.

As Anderson (1997) proposes, in relation to individual and family therapy, the group therapist abandons the position of specialist on the content of the client's narratives and, instead, occupies the position of specialist on the conversational process. In a constructionist view of group practice, the coordinator pays attention to the conversational flow, focusing on the quality of the participants' interactions. Also, the coordinator focuses on how narratives constructed in the group create openings or constraints for alternative ways of describing the world and relating to it.

Thus, the group coordinator can be seen as co-responsible for the narratives constructed in this context. Also, s/he can be seen as a facilitator of the conversational process, aiming for the creation of a dialogical context in which the plurality of voices can be heard and managed in a respectful and reflexive way. Her/his goal is to construct a conversational context that is responsive and non-judgmental. Ideally, the group becomes a context wherein special ways of talk can emerge. Within this perspective, the coordinator is part of the relationship that is constructed in the group and tries to remain attentive to the ways of talking that are developed, to the social discourses which sustain some narratives and to how conversations can favor the generation of new meanings and forms of life.

In this understanding of the group, we have found David Cooperrider´s assumptions about Appreciative Inquiry very useful. We prefer to put the conversational focus on the investigation of resources that are already present in social organizations (communities, groups, teams) and not on the amplification of problem narratives, thereby directing a search for causes and problem solutions. Based on this approach, we attempt to create a group context for the exploration of the stories of success and the creation of new scenarios,

through the envisioning of possible futures based on the acquisitions already made by the group (Hammond, 1996).

In drawing on constructionist authors to think about group practice, it is important to remember that social constructionism is not a method with particular procedures and techniques of intervention. Instead, it is a relational practice, a way of making meaning of the world and engaging in generative forms of dialogue. As McNamee (2004) points out, social constructionism can be considered a discursive option that gives us a new vocabulary for action, which favors the investigation of what kind of social life is made possible when one way of talking is used instead of another.

To illustrate our argument, we will discuss three cases in the remainder of this article. We believe these cases illustrate the ways in which a group can be used as a conversational resource. Informed by an appreciative and dialogical perspective, we believe that imagining the concept (or "entity") of a "group" as a social construction favors the creation of social networks necessary for the improvement of the Brazilian healthcare system. In each of the cases described below, we point to the changes produced through group practice and make explicit how such changes can contribute to the transformation of health institutions in Brazil.

Promoting interdisciplinary work in a Family Healthcare Program
In order to amplify the practices developed in a Family Healthcare Program at Jardinópolis (São Paulo / Brazil), we have started a "Group of Mothers". Our intention was to construct a different model for working in the context of primary healthcare. We were interested in creating a mode of working where different professionals (communitarian agents, medical students and psychologists) could take part in the same context of care. This method varies from traditional work with mothers where "problems" would be assessed and treatment would be designated to only one of the following: a medical student, a psychologist or a communitarian agent.

The objective of the "Group of Mothers" was to promote open conversations about the everyday life and difficulties of mothers. Our aim was to be open to the self-narratives of mothers in order to work with their own resources and potentials.

This group was coordinated by a psychologist (also Professor of Public Health within the Medical Faculty) and co-coordinated by medical students and communitarian agents. All were instructed to participate in the group as they pleased. However, they were given some orienting group "rules" to facilitate the construction of a welcoming and safe conversational space. These rules focused on process issues and were presented to the participants at the beginning of each group. Included were: i) when one talks, the others must listen; ii) people must respect each other's opinions and avoid giving advice; and iii) people can try to help each other by telling personal stories (first person narratives) in which they share a similar experience/difficulty as well as offer descriptions of what they found useful in solving these issues. These rules were proposed by Barreto (2005) for "community therapy."

To evaluate the utility of this practice, we considered the different perspectives of all participants. This included those present as well as those who "populated" the mothers' stories and who were, therefore, significant participants in the storied lives of these women.

For example, it was necessary to consider the communitarian agents' (community volunteers) views. The "group of mothers" offered a new opportunity to connect the mothers' narratives with real or imagined narratives of communitarian agents with whom they might have frequent contact. By exploring the complexity of their frequent interactions, the potential for increased comprehension about the health/illness process was facilitated. Also, the group dialogue favored the mothers' connections with their own stories about "being a mother," constructing the group as a context to deconstruct prejudices and beliefs. Finally, their participation in the construction of the group as a place for sharing experiences, based on a respectful and non-judgmental atmosphere, gave them another model of conversation, less centered on problems and more focused on resources and potentialities.

Considering the medical students' perspectives, the group work was an important space for theoretical and practical learning. The students worked as co-constructors of this dialogical space, learning from within the group about conversational processes which create or constrain possibilities for the emergence of new vocabularies for action. Thus, they practiced some constructionist assumptions about useful ways of being in dialogue, abandoning deficit language and helping people construct alternative self narratives, based on Appreciative Inquiry principles.

We think this kind of interdisciplinary practice improved the quality of medical student training, as well as the professional practices of the health team, inviting all participants to reflect on how their everyday practices promote (or fail to promote) SUS principles. In our experience, the health team was able to create, jointly, a space to perform integrative, collaborative health assistance. Different professionals could work together to create a dialogic context that was relationally responsible (McNamee and Gergen, 1999) and focused on caring for people's health.

Promoting social participation in the healthcare system
Another intervention that aimed to improve the healthcare system was carried out in a non-governmental organization (NGO) whose objective is to advocate for the rights of people living with HIV. One of the principles of the SUS is the democratic participation of citizens in determining how the government defines healthcare practice – in terms of specific lines of action – at all levels of healthcare. However, there are several challenges that impede this goal. For example, after years of political repression, Brazil understandably suffers a wholesale depreciation of citizenship, thereby making democratic and participatory practices alien to many community members. An additional challenge is the healthcare professionals' beliefs that the general population has little (if anything) of use to contribute to the development of policies and practices designed to promote their own health. Finally, the extreme value placed on the technical knowledge of healthcare professionals creates conditions that severely limit the likelihood of active and lively professional–community collaboration. Therefore, the project aimed to promote organized and effective participation of the population in the local healthcare system. To do so, project organizers developed an intervention at an AIDS/NGO, the "Grupo Humanitário de Incentivo à Vida".

This organization had as one of its goals "to give voice" to the HIV carrier. For this reason, it attempted to influence the political stance directed at this population by starting

with a consideration of HIV carriers' interests. However, as you might imagine, these political actions constituted a challenge for proponents of the project, generating many tensions among the organizational members. In the face of these difficulties, an intervention that aimed at facilitating communication among the organization's members was proposed with the hope of creating a collaborative decision making process and, consequently, an integration among organizational members.

The intervention consisted of ten monthly meetings, with the four members of the team responsible for political networking actions and community involvement. These meetings focused on generating new meanings about the actions carried out by the team through a process of "shared inquiry" (Anderson, 1997). The meetings were not structured with a determined set of questions or group exercises to be followed. Rather, the psychologist facilitating the meetings acted from a not-knowing position, searching for the "not yet said," using therapeutic questions (Anderson and Goolishian, 1998), bringing appreciative voices and remaining relationally sensitive to the interests and concerns of the team (McNamee & Gergen, 1999). The psychologist, focusing on the interactive moment, invited the participants to listen carefully to each other and to consider the values of the other members. They were encouraged to talk in a way that was not aimed at persuading the other, but was instead aimed at sharing personal concerns (Becker et al., 1999). These meetings created a culture of dialogue within the team, promoting respect for their differences and strengthening the cohesion and organization of their collective actions.

The outcome of this intervention can be evaluated by the actions accomplished by the team and the organization. In addition to better internal communication, it was possible to carry out a series of political networking actions with different institutions. One year after the intervention, the team counted more than 40 meetings with different organizations for the defense of HIV carriers in the state. The organization also created a permanent forum of AIDS/NGO in the city and a regional meeting of people living with AIDS. All these actions empowered the team and allowed them to have direct interaction with the governmental representatives charged with promoting health assistance for this population, thereby influencing the politics and accomplishing the goal of the organization.

Promoting dialogues of health/illness within communities
The third intervention to be described occurred within a community which is assisted by a primary healthcare center. The goal of the center was to engage people in the whole process of producing and delivering healthcare. According to the Brazilian Primary Healthcare plan, all healthcare practices must include the community, focusing on their needs and emphasizing their participation in the process.

Based on constructionist ideas, the healthcare process is viewed as a social practice in which the meaning of health/illness is dynamically constructed and deconstructed in the interaction between community and health professionals. Taking this perspective into account, community groups were created with the goal of inviting the neighborhood to talk about issues involving health, illness and care. The overriding aim was to create a space where the very idiosyncratic and important local values and culture could be respected – particularly where these values connect with issues of healthcare. The group coordinator

adopted an open stance, being the "architect of dialogue," helping the group explore their health-related subject through dialogue. Respect and appreciation of all opinions, no matter how diverse, was the organizing rule. Thus, within the context of respect and appreciation for various viewpoints and experiences, the conversation that emerged was dialogic in form, considering the group participants experts on their own lives (Anderson & Goolishian, 1988).

Having an open and an appreciative conversation with the community made it possible to consider a multiplicity of meanings about the health/illness process. By integrating both traditional techniques of healthcare with local, community-centered "knowledge" of health and illness, fixed discourses can be denaturalized and the same subject can emerge with different meaning, thereby creating new possibilities for interaction. Additionally, this dialogic process shows us that universal aspects of healthcare, when discussed from within a personal story, transform into unique understandings where each situation generates the possibility for a singular form of care.

This experience allowed us to be sensitive to reflexive practices (i.e., the ways in which we, as professionals, invite others into conversation) and to the importance of context, favoring that both the community members and the health professionals collaborate in the healthcare process. It also indicates that healthcare delivery could be more dialogical, collaborative and inclusive, not just involving the staff and community, but all the social actors involved such as the political administrators designing healthcare policy, the users and the executors/professionals. Furthermore, it assists people in being more active participants within their communities in general and within the healthcare system in particular. This, in turn, creates a social network and enhances a sense of relational responsibility for professionals and users alike.

Concluding remarks

This article points to the significance of social constructionism and Appreciative Inquiry in the construction of dialogical group contexts. These group practices can be used in different settings and have an important impact in the promotion of institutional change. This way of working emphasizes the micro-social context of change, opening the way to broader organizational/institutional transformations. Considering the principles of the healthcare system in Brazil, this micro-context of social participation appears compatible with the national healthcare reform in Brazil and locates communities at the center of change.

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