

# Culture Circles as a Tool for Reflection and Transformation in Healthcare Work

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Círculos de Cultura como Herramienta para la Reflexión y Transformación en el Ámbito Laboral de la Salud

## RESUMO

Neste estudo tem-se por foco investigar as potencialidades e limitações no desenvolvimento do trabalho na Atenção Primária à Saúde (APS) em Fortaleza, Ceará. Nesse diapasão, o **Objetivo** é: identificar como os trabalhadores percebem sua participação na produção do cuidado e analisar os processos de trabalho em saúde. **Método:** tratou-se de uma pesquisa-ação, com abordagem qualitativa, realizada com 17 profissionais de saúde de uma unidade de atenção primária em Fortaleza, Ceará. A coleta das informações aconteceu entre agosto e setembro de 2015, em três encontros conduzidos por meio do uso de círculos de cultura. No campo da saúde, os círculos de cultura são utilizados para discussão de assuntos temáticos advindos das falas dos participantes. **Resultados:** foi possível proporcionar um ambiente de pesquisa favorável a uma discussão problematizadora a respeito do cotidiano, a fim de promover tomada de consciência e fomentar a autonomia e o protagonismo dos participantes. A pesquisa obteve aprovação pelo Comitê de Ética em Pesquisa da Universidade Estadual do Ceará, sob o número 1.115.332. **Conclusão:** as polifonias produzidas revelam que o trabalhador da saúde encontra processos de trabalho fundamentados em ações produtoras de data para parametrização de atividades e tomada de decisões de saúde. Os trabalhadores se mostraram disponíveis para novas produções e encontros mediados por círculos de cultura, entendidos como espaços de dialogicidade e criticidade. **DESCRIPTORES:** Atenção Primária à Saúde; Acolhimento; Trabalho em saúde; Saúde Coletiva.

## ABSTRACT

This study focuses on investigating the potentialities and limitations in the development of Primary Health Care (PHC) in Fortaleza, Ceará. In this context, the **Objective** is: to identify how workers perceive their participation in the provision of care and to analyze health work processes. **Method:** this was an action research study with a qualitative approach, conducted with 17 health professionals from a primary care unit in Fortaleza, Ceará. Data collection took place between August and September 2015, in three meetings conducted using culture circles. In the field of health, culture circles are used to discuss thematic issues arising from participants' statements. **Results:** it was possible to provide a research environment conducive to a problematizing discussion about everyday life, in order to promote awareness and foster the autonomy and protagonism of the participants. The research was approved by the Research Ethics Committee of the State University of Ceará, under number 1,115,332. **Conclusion:** the polyphonies produced reveal that health workers encounter work processes based on actions that produce data for parameterizing activities and making health decisions. Workers showed themselves to be open to new productions and encounters mediated by culture circles, understood as spaces for dialogue and critical thinking.

**DESCRIPTORS:** Primary Health Care; Reception; Health Work; Collective Health.

## RESUMEN

Este estudio se centra en investigar las potencialidades y limitaciones en el desarrollo del trabajo en la Atención Primaria de Salud (APS) en Fortaleza, Ceará. En este sentido, el **Objetivo** es: identificar cómo perciben los trabajadores su participación en la prestación de cuidados y analizar los procesos de trabajo en el ámbito de la salud. **Método:** se trata de una investigación-acción, con enfoque cualitativo, realizada con 17 profesionales de la salud de una unidad de atención primaria en Fortaleza, Ceará. La recopilación de información se llevó a cabo entre agosto y septiembre de 2015, en tres encuentros realizados mediante el uso de círculos de cultura. En el campo de la salud, los círculos culturales se utilizan para debatir temas que surgen de las intervenciones de los participantes. **Resultados:** fue po-

sible proporcionar un ambiente de investigación favorable a una discusión problemática sobre la vida cotidiana, con el fin de promover la toma de conciencia y fomentar la autonomía y el protagonismo de los participantes. La investigación fue aprobada por el Comité de Ética en Investigación de la Universidad Estatal de Ceará, con el número 1.115.332. **Conclusión:** las polifonías producidas revelan que los trabajadores de la salud se enfrentan a procesos de trabajo basados en acciones que generan datos para la parametrización de actividades y la toma de decisiones en materia de salud. Los trabajadores se mostraron dispuestos a nuevas producciones y encuentros mediados por círculos culturales, entendidos como espacios de diálogo y crítica.

**DESCRIPTORES:** Atención primaria de salud; Acogida; Trabajo en salud; Salud colectiva.

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## INTRODUCTION

Research arises from an inquiry, a questioning, about something that provokes the researcher and triggers debates within their imaginary and ideological realm. It arises from its insertion into a real and productive context. It also arises from the identity between the subject and the research objective.

In Minayo<sup>17</sup>, we learned that research is motivated by the relationship between the investigating subject and the investigated subject, implicated in the process of knowledge construction, deconstruction, and reconstruction, in which they are historically connected. For this research,

in which we set out to investigate the work processes and production of care in Primary Health Care (PHC), the use of qualitative research, with a focus on action research, seemed coherent.

Action research, in turn, is a line of research within the qualitative approach that aims to promote interventions and applicability in various forms of collective action and is oriented toward problem-solving or even the transformation of fields of action. Thiollent<sup>20</sup> defends action research, defining it as a methodological proposal capable of responding more efficiently to the researcher's problems and, in particular, formulating guidelines for action that transforms

that reality. It involves organizing the search for solutions to real problems. Thiollent<sup>20</sup> states that, to work in the action research format, researchers and participants must be involved cooperatively and participatively.

According to Barbier<sup>2</sup>, Action research arises from the context of a group in crisis, where the researcher does not provoke it but observes it. Their role is to help the collective define the details pertinent to the problem by raising awareness among the actors involved, through collective action. In this sense, action research is considered eminently pedagogical and political. It serves the education of the individual, of the worker, concerned with their collective spaces. 2

To carry out the action research, we adapted a core element of the Freirean method of adult literacy: the culture circle.

We call culture circles a literacy training strategy for young people and adults that emerged in the 1960s. The creator of the didactic strategy, Paulo Freire, longed for an education for decision-making, social responsibility, political participation and the practice of freedom, this is the title of one of his book<sup>10</sup>. The author imagined structuring a teaching method that could replace the traditional disciplinary and infantilizing school with a mechanism for the circulation and appropriation of knowledge through the conquest of language<sup>21</sup>.

Faced with the need to train educators to facilitate his teaching-learning activity, which would soon cease to be his to gain the world, Freire<sup>9</sup> considered some essential knowledge for the teaching practice of critical educators. For the author, teaching requires methodical rigor, research, and critical thinking so that we can consider ourselves capable of producing knowledge. It also requires ethics and aesthetics, in the sense that decency and beauty go hand in hand, opposing easy deviations and carelessness. It requires the embodiment of words through example. It requires risk, acceptance of the new, and rejection of any form of discrimination; it affirms the importance of recognizing the cultural identity of individuals and groups of people<sup>9</sup>.

The educator (or circle coordinator) did not act as a teacher, but rather as a trigger for dialogue among the literacy students. In the teaching method, one might recognize something of the Socratic maieutics, for, as in Socrates, the acquisition of knowledge occurred through the freest possible exercise of conscience<sup>10</sup>.

We emphasize the relevance of this awareness as the motto of our proposed action research. In a quote

from cultural circle experiences in Santiago, Chile, a woman living in a tenement said: "I like to discuss this because I live this way. While I'm living, however, I don't see it. Now, I observe how I live."<sup>10</sup> Likewise, we propose to allow PHC workers to discuss their work experiences and then see themselves living and doing this work.

Recalling Paulo Freire's ideas and establishing an interface with the health field, we believe that health professionals are also required to possess methodology and critical thinking in their practice to produce health knowledge. Ethics and aesthetics are also required to promote quality and effective health. It requires embodying words through example so that individuals and communities can perceive that health work is eminently relational and that forming bonds with the health team is essential. It also requires recognizing the cultural identity of individuals, families, and communities so that health promotion activities can be created based on perceived and discussed health demands and needs<sup>11</sup>.

Health work is process-based and only possible through encounter. We say that health work is process-based because it requires steps to develop the health product, analogous to the industrial production process. The health worker must possess scientific knowledge and perform tasks to produce health, whether for individuals or for communities. However, it cannot be overlooked that health work is eminently relational. In this context, the idea that "this encounter is permeated by pain, suffering, health knowledge, life experiences, care practices, and subjectivities that affect both the worker and the user" is reinforced<sup>5</sup>.

Paulo Freire's work is linked to the struggles for democracy, citizenship, and popular participation. Therefore, it brings together the themes of health and education. Cultural circles

have been used with great success in education, achieving literacy among thousands of young people and adults, as well as raising political and social awareness. In the health field, the same dialogical and reflective methodology can be applied, given the potential already revealed by dialogues with the promotion of individual and collective health.

Several authors share successful experiences with the use of culture circles in health research<sup>14,7,19,1,16,6</sup>. This dialogical methodology has also been used not only in research, but in the training of workers for the SUS<sup>12,15</sup>.

We also believe that the culture circle is a space-time for seeking to understand limiting situations and the potential of the realities presented and is a young and strong ally in qualitative research methodology, especially in the development of this action research.

## METHODS

This research was carried out in the municipality of Fortaleza, Ceará; more specifically, in a Primary Health Care Unit, in the Bom Sucesso neighborhood, which is part of the geographic coverage area of Regional Secretariat<sup>3</sup>. The city also has five federal health establishments, 18 state, 92 municipal and an estimated 426 private health establishments, according to data from 2013<sup>13</sup>.

For the purposes of knowledge production, in this research we centralized the subject as an actor in the process of apprehending reality, in order to preserve their being as a person, without relegating them to the condition of an object<sup>4</sup>. Considering this methodological approach and guided by the objectives of our work, we conducted three culture circles with groups ranging from 9 to 15 participants in each meeting.

The research subjects, who make up the PHC workforce at this health

unit where the interviews were collected, were included according to the following criteria:

- a) inclusion criteria: mid-level and higher-level workers from the aforementioned UAPS with any form of employment relationship, who were directly involved in health care and care production, who had been working with the team for at least one year and who wished to freely participate in the research;
- b) exclusion criteria were applied to workers who were on vacation or leave during the data collection period.

At each meeting, the group was composed primarily of women, with one meeting having only one male participant. Participants ranged in age from 25 to 62. Their average income ranged from one to eight times the minimum wage. To avoid personal identification, their names were suppressed. Their statements were generically identified by the capital letter T. This letter was intended to refer to the word "worker." To code the worker who made this statement, we organized them by number, which does not refer to any particular classification.

Thus, when organizing the speeches, the participant who attended the first meeting was identified by the letter T and, subsequently, for example, the number 1. The speeches produced in the first culture circle were named C1, the second, C2; and the third, C3. In this way, it was possible to locate the themes developed in each meeting.

We chose to keep a field diary to record the experiences we had while conducting this research, as we realized we were searching for the insights of our research actors-subjects, drawn from our own field experience. The group's statements were collected through voice and video recording using three devices placed in differ-

ent positions in the meeting room to minimize overlapping expressions and lost speech. Three meetings were held between August and September 2015. The physical space, a meeting room, despite the high local temperature, was well-ventilated and private, which hindered outside interference. There was a table approximately two meters long, allowing all group members to sit at the table, along with the researcher.

We transcribed the recordings and images produced by the group, as well as the field diary entries, which make up the research corpus. These were the first steps taken toward processing the data obtained. At this stage, Bardin 3 called pre-analysis.

We performed an initial reading of the transcribed information, allowing ourselves to be influenced by our first impressions and orientations. Seeking to understand the strength of the statements, we went into the exploratory phase, which Bardin 3 defined as one where systematic readings are carried out in order to seek connections and disconnections between the data and understand the relationships obtained.

Bardin 3 guides us that, with each reading, we should determine the text's division points into recording units that can be grouped into categories. These categories should have a sense of thematic and contextual relevance. For the author, this provides researchers with meaningful and reliable results to propose inferences and develop interpretations regarding the intended objectives.

In our research, we were able to learn three analytical categories from the communication text: a) producing care to generate co-accountability; b) "Workhorses, cannon fodder!"; and c) ethical and affective action in healthcare work. Throughout the preparation of this material, we maintained a commitment to respecting the provisions of Resolution No. 466

of December 12, 2012, of the National Health Council.

## RESULTS AND DISCUSSION

The first category was identified by the perception that the initial question, generated in the first culture circle ("What comes to mind when you talk about producing care?"), resonated in the subsequent meetings. Participants felt compelled to first conceptualize the production of care, so that, as the circles developed, they could seek to highlight their own ways of producing care in their work dynamics.

For me, it's about making people feel capable of taking care of themselves, of being responsible for their health [...] we have to encourage this responsibility in them, so they can feel like agents in the health process [...] of being responsible for their own self-care. (T3 C1)

Our job, all of us, is to bring health through what? Guidance and information. But knowing that each person is truly responsible for their own health. (T6 C1)

They (the patient) are responsible for their health; our job is to educate them. (T15 C2)

Franco and Mehry<sup>8</sup> reaffirm that work processes in Family Health are, in themselves, its greatest challenge, since the production of health care occurs fundamentally through relational dynamics and their applicability, as well as through work technologies. The authors highlight the need for professionals who comprise Family Health teams to relearn their work based on relational dynamics that enable the integration of diverse knowledge.

This is why we believe that the implementation of culture circles was advantageous in reactivating desired productions and fostering awareness of the ways in which work at the

health center is developing. As a starting point, we identified that UAPS RC workers perceive themselves as providing care to their patients when they foster self-esteem, self-confidence, self-care, and the certainty that they, the patient, are also responsible for their own health care.

Providing a space and time for listening is essential to getting to know oneself and the other. This is a time for recognizing the patient as both subject and object of care.

[...] It is (however) by listening that you gain the patient's trust. When you give them space to talk, they see your solidarity and realize they can trust you (T3 C2).

It's true! The patient often feels relieved just by saying, I don't need to (...) or even bring a solution (T9 C2).

In category 2, we see the commitment of healthcare professionals to changing the way people manage their health and believe in self-care. Cooperation, solidarity, and a willingness to open up to others to seek out what they don't know or what they lack seem to permeate the discourse of the workers interviewed. However, in the work process that has been implemented recently, there is still a heavy focus on supporting the production of biomedical models, inspired by mechanics, curatives, and procedures.

We believe that these approaches do, in fact, generate visibility, because they are demonstrated through the increase in machinery and labor, such as the number of mammography machines and ICU beds. This reflection does not wish to downplay the importance of these advances in hard and soft technologies for the advancement of healthcare. However, the urgency to resolve mechanical and organizational issues within the health system seems to be an attempt to address the anxieties that society, as a whole, feels about the problem of

public health in Brazil.

Still far from providing society with effective solutions to the health system's limiting issues, the institutions managing the service are seeking to shape care models that promote, at the very least, a quantitative increase in the number of people served at the system's entry point. This directly impacts the way professionals perform their work, their participation in the work process, their passions, and their desire to promote health. It couldn't be otherwise. Solidarity cannot be expected from individuals who cannot see their own precariousness and inadequacy in the suffering and fragility of others.

The professionals, therefore, expressed, for the most part, the importance of orienting their working relationships toward a common ground where it is possible to create therapeutic projects that meet the population's needs. The development of collective projects and shared health planning needs to be viewed with support by the current management of the municipal health system, not only as a possibility, but as a requirement of health workers for the successful execution of their activities<sup>18</sup>.

Regarding ethical and affective behavior in healthcare work, exploring the dynamics of care production with these workers led us to follow the path of affective pathways that, they believe, constitute their main work territory. Freire<sup>9</sup> would highlight the workers' impressions in this regard because, according to him, they would be assuming themselves as historical, thinking, communicative beings, capable of transforming, creating, realizing dreams, of anger and love.

Ethical action among peers is just as important as ethical action toward SUS users. Caring for workplaces and welcoming coworkers, developing the necessary solidarity among them, is an essential ethical action for health-producing activities.

“ For each worker, it is important to realize that it is within the group, through dialogue, that humanistic work that recognizes the value of the service provided is built. ”

We learned from this category that assuming oneself as a healthcare worker means committing to one's own ethics, both particular and general, that advocates rigor in the comprehensiveness of healthcare actions and the promotion of dialogue, so that all those involved in this process feel capable of understanding and acting toward the production of care as a future intervention in the world. Ethical behavior at work has gained intense resonance because it has proven to be a form of resistance among healthcare workers. Respecting patients' freedom and autonomy are ways workers have found to correctly think about their healthcare productions. This movement of thinking correctly to act correctly has proven to be a form of struggle when the same rights are denied to workers. Professionals are constantly challenged by the fatalisms encountered in the course of their work, but through their discourse, they reject determinism. They promote constant exercises of ethics and solidarity.

## CONCLUSION

The polyphonies reverberated with an affectivity of resistance and struggle. This can be interpreted from the perspective we learned that every worker needs to be recognized for their work<sup>18</sup>. They resist having their ways of caring and thinking about health homogenized by the parameterization of work processes. They believe, therefore, that by reclaiming affection in their care practices, they can share the leading role in health actions with the patient, since they find no support for this in health service management. The UAPS RC workers recognize the importance of being affected by the dimension of rights and duties, of collective engagement to identify solutions, of being proactive in order to break cyclical processes of suffering. Not

naively, but ideologically, they believe in the caring affection of their work, because they believe in becoming ESF every day, even though they realize that family and community are no longer at the heart of the new process of care production.

To capture these underlying discourses, gestures, feelings, and expressions within each participant, the use of a culture circle as a methodology was essential. This research fostered a long-simmering discussion among the group of workers at the RC UAPS. These provocations served to raise awareness of their place and size within health promotion and care delivery strategies.

Strong allies of action research, culture circles allowed us to more clearly visualize the true limiting situations in care delivery and the potential that can emerge from this awareness. The participants' vocabulary proved consistent with professionals interested in providing services that meet patients' needs in general. During the problematization process, the workers experienced daily questions and took a stance of interest in improving health services. However, when investigating limiting situations, they tended to feel victimized by the institutionalization of their care-producing actions. They perceive themselves as oppressed, beings denied dialogue and autonomy. However, they found themselves powerful through teamwork.

We believe that culture circles can contribute to the development of relationships based on affection and encounters that redefine joy as a powerful force for recovering desired results. Workers demonstrate openness to knowledge, sensitivity to the beauty of healthcare work, and spurred on by challenges that push them toward bureaucratization, but which they persistently strive to overcome. However, they are aware of their limitations.

With this research format, it was possible to visualize culture circles as spaces where each person brings something of themselves to the group and, at the end of each meeting, takes something from the group. We observed that the workers initiated a process of feedback on the discoveries and gains arising from these meetings because they were developing autonomy to propose generative themes for subsequent meetings and perceived, within the research environment, a safe space for dialogue.

The workers embraced culture circles as a safe strategy for resuming meetings. They asked the researcher to initiate a return to these circles based on culture circle activities and, as a result, train other professionals to facilitate the strategy for shared management of the workspace. The researcher offered to agree with local management on appropriate times for the activities. It is imperative to believe, and more importantly, to use Freire's phrase as a motto for the work experience<sup>9</sup>: "I know things can get worse, but it is also possible to intervene to improve them."

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