

Communication process: a group activities tool in the family health strategy*

PROCESSO COMUNICACIONAL: INSTRUMENTO DAS ATIVIDADES EM GRUPO NA ESTRATÉGIA SAÚDE DA FAMÍLIA

PROCESO COMUNICACIONAL: INSTRUMENTO DE LAS ACTIVIDADES EN GRUPO EN LA ESTRATEGIA SALUD DE LA FAMILIA

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ABSTRACT

The objective of the present study was to analyze the communication process tools triggered in group activities in the Family Health strategy. Data collection was performed using semi-structured interviews recorded with 51 nurses and through non-participating, non-systematic public observation in natural situations of 19 group activities analyzed according to content qualitative approach. Based on the reports of the professionals, two categories emerged: dialogue-action and dialogue-interaction, which evinced that the communication process is an instrumental means of group activities in the Family Health strategy. The former by the predominant use of verbal language as a means for developing operational procedures specific to each professional in relation to monitoring the health of the client, and the latter as an instrument in which, according to the nurses, there is a simultaneous use of verbal and nonverbal communication.

DESCRIPTORS

Comunicação
Comunicação não-verbal
Programa Saúde da Família
Processos grupais
Enfermagem familiar

RESUMO

O estudo teve como objetivo analisar os instrumentos do processo comunicacional desencadeado em atividades grupais na estratégia Saúde da Família. Os dados foram coletados por meio de entrevista semiestruturada gravada com 51 enfermeiros e pela observação não participante em situações naturais, não sistemática e pública de 19 atividades em grupo analisadas segundo abordagem qualitativa de conteúdo. Do discurso dos profissionais emergiram duas categorias: diálogo-ação e diálogo-interação, que evidenciam o processo comunicacional como meio instrumental das atividades grupais na estratégia Saúde da Família. O primeiro pelo uso predominante da linguagem verbal como meio operacional para o desenvolvimento dos procedimentos específicos de cada profissional na relação com o acompanhamento do estado de saúde do cliente, e o segundo como instrumento, no qual coexiste, segundo os enfermeiros, a utilização da comunicação verbal e não verbal.

DESCRITORES

Communication
Nonverbal communication
Family Health Program
Group processes
Family nursing

RESUMEN

El estudio objetivó analizar los instrumentos del proceso comunicacional desencadenado en actividades grupales, en la estrategia Salud de la Familia. Datos recolectados mediante entrevista semiestructurada grabada con 51 enfermeros y por observación no participativa en situaciones naturales, no sistemática y pública de 19 actividades grupales analizadas según abordaje cualitativo de contenido. Del discurso de los profesionales emergieron dos categorías: diálogo-acción y diálogo-interacción, que evidencian el proceso comunicacional como medio instrumental de las actividades grupales en la estrategia Salud de la Familia. El primero por el uso predominante del lenguaje verbal como medio operacional para desarrollar los procedimientos específicos de cada profesional en relación al seguimiento del estado de salud del paciente, y el segundo como instrumento, en el que coexiste, según los enfermeros, la utilización de la comunicación verbal y no verbal.

DESCRIPTORES

Comunicación
Comunicación no verbal
Programa de Salud Familiar
Procesos de grupo
Enfermería de la familia

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INTRODUCTION

This study focused on the production of knowledge concerning the work process established in the scope of Primary Health Care. It specifically addresses the communication process of group activities developed within the Family Health Strategy (ESF)^(a). These can be called group processes in which there is a characteristic work practice intended to understand the interpersonal relationships triggered in the communication among the participants.

Communication, in turn, is a socio-historical phenomenon of daily routine actions of living that produces reciprocal relationships among individuals who share a stereotype, that is, a set of concepts, practices and values validated through the exchange of meanings constructed in the context of human interactions. Such meanings represent the decoding of signs based on the reference of the context of interaction. Therefore, signs are representations that constitute significance and attribute meanings interwoven in a unique existence⁽¹⁾.

Decoding signals constitutes a message that requires the individual to make an interpretation. For that, the content produced should be able to involve or arouse the interest of the individual⁽²⁾. In general, interpretation includes a portion of the communication process from which one grasps the existence of a sender and a receiver as sources that produce messages. These messages are bi-directional, which expresses the continuity of interaction in a format of action-reaction and *vice-versa*⁽³⁾.

The continuity of interaction is under the influence of the degree of the interlocutors' interpretation – sender and receiver – and its components are the individuals' familiarity, competence and knowledge concerning the message content. Such knowledge becomes dynamic because it refers to a temporary interpretation of reality⁽²⁾.

The concreteness of such knowledge is bonded to the decoding of signs expressed in a verbal and non-verbal manner in the interactional context where the dialogue was developed⁽³⁾. Dialogue as an instrument of the communication process allows interlocutors to objectively manifest their feelings and emotions, thus, understanding the content of verbal and non-verbal messages become the only means of understanding between them⁽⁴⁾.

According to the adopted perspective, the communication process developing out of dialogue permits interlocutors to approximate and participate⁽⁴⁾ because it favors interlocutors ability to understand the diverse situ-

ations produced by living in a socio-historical routine in constant transformation⁽¹⁾. This insight becomes apparent when one understands that the dialogical communication process is guided by language produced by the interlocutors, which should be produced in a conscious manner and act as a means of transformation⁽³⁾.

Language in the interactive dynamics of interpersonal relationships that establish life in society permit individuals to grasp the meanings coherently and interpret them in one way and not in another⁽¹⁾. This interpretative understanding relates, in this specific study, the communication process to the work triggered in group activities within the ESF. Hence, communication concretizes the work process within the ESF in the particular group activities designed for the production of health, which expresses the vital coexistence of the communication and work processes.

In general, the communication process becomes instrumental for the development of group activities within the ESF. Consecutively, dialogue as an instrument in the communication process allows the development of actions related to disease prevention and health promotion, including a range from technical procedures to health education⁽⁵⁾.

The dialogue reveals the professionals' practice, who imperatively needs to communicate and make use of verbal and non-verbal language to perform their functions, since communication is essential to life⁽⁴⁾, so that the existence of communication does not depend on the environment into which individuals are inserted.

The dominant existence of communication relies on the fact that even silence may constitute a sign, which when interpreted, receives a status of 'meaningful' and reveals a meaning. We reinforce the idea that the communication process includes verbal expressions, with the representativeness of language in the dialogue, and also non-verbal language that represents the essence of the construction of human relationships. The latter can reiterate, complete the meaning of the first or even present a contrary meaning, and can only be decoded in the interaction that validates the message through the confirmation of the interpretation produced by the receiver⁽³⁾.

The communication process in this study constitutes a means through which group activities are produced within the EFS. Under such a condition, it enables work as a merchandise and represents a means of subsistence for individuals⁽⁶⁾. From this perspective, we investigated how the communication process enables the community's participation in the group activities within the ESF.

...dialogue as an instrument in the communication process allows the development of actions related to disease prevention and health promotion, including a range from technical procedures to health education.

(a) According to the acronym in Portuguese.

METHOD

Study's design: exploratory, descriptive, and analytical study, cross-sectional with the communication process triggered in the group activities between professionals and patients, within the ESF.

Study's setting: The primary health care network within the EFS, Third Regional Coordinator of Health Rio Grande do Sul (3rd CRS-RS) in the extreme south of Brazil. It included 49 Family Health Units in the 12 cities ascribed to the 3rd CRS-RS.

Population: was composed of 65 nurses from the respective EFS teams. Four of which were on vacation and ten did not perform group activities, thus a total of 51 nurses composed the sample.

Data collection procedures: First the number of Family Health teams in the study's region was determined. Then, a formal requirement was sent to the 3rd CRS-RS and to the City Health Departments explaining the study's objectives, ensuring confidentiality of the institutions and participants and presenting approval provided by the Ethics Research Committee in the Health Field at the Federal University of Rio Grande (CEPAS) protocol No. 02/2004. After authorization was obtained from the institutions that provided the names of the nurses from each team and the units' addresses, a meeting was held with each city's team to explain the study's activities to the professionals, informing and ensuring their right to freely withdraw from the study at any time while their personal identity, workplace and cities would be kept confidential. Afterwards, nurses were contacted by phone and the interviews and observations were scheduled according to the team's availability.

The questionnaire used in the interviews and the observation script was tested through a pilot study with a team not included in the selected group. Data were collected between January and July 2006 through semi-

structured interviews recorded with 51 nurses from the Family Health Strategy selected according to the following criteria: working in units managed at a city level or at a Primary Health Care level or in units adhered to the Family Health Strategy; the team should have been composed for more than six months and professionals should have at least six months of experience in the EFS; the team should include all the professionals from a basic team (nurse, physician, nursing auxiliary, and health community agent); and professionals should consent to the study's stages.

Non-participating observation was carried out for 17 teams allocated to nine Family Health units from July 2006 to June 2007 during 19 group activities, which indicated that the communication process produced during the group activities already planned by the team gave priority to dialogues with the consent of the participants⁽⁷⁾. For that, selection criteria were established based on information concerning the interview stage, that is, a larger number of observations were carried out in the city with the larger number of family health units, encompassing urban and rural populations, integration between the professionals and the community, and adherence and persistence in performing the group activities according to the report of the interviewed professionals.

At the end of each interview and recording observations, a number was assigned to the city (C), the team (T), and nurse (N), and observation record (Obs) in order to comply with the standards and guidelines that regulate research with human subjects established by Resolution 196/96, Brazilian National Council of Health.

The content of interviews and observations was qualitatively analyzed⁽⁸⁾ through Nvivo 7.0 from the reading of the material and compilation of the content according to similarity of meaning. Afterwards, ambiguities were clarified and the content was organized into categories and subcategories. Then the material was synthesized into an explicative analysis and finally into a structured analysis (Figure 1).

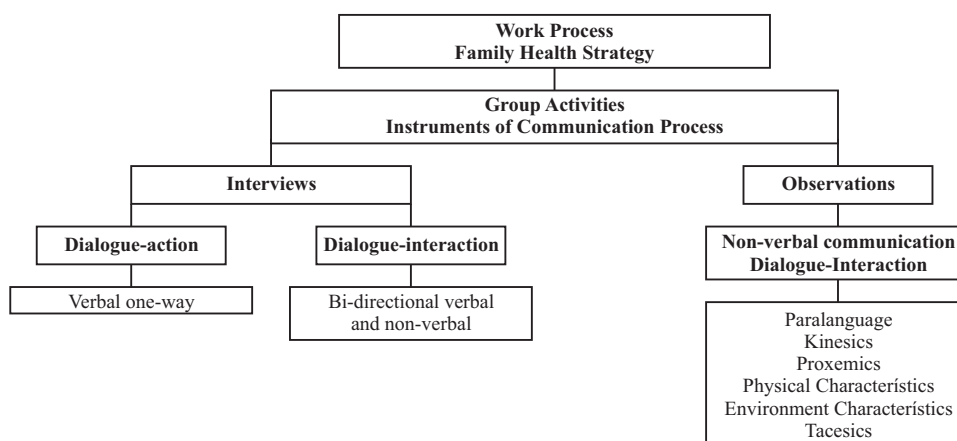


Figure 1 - Analytical structure of categories and subcategories that emerged from the communication process in the group activities within the Family Health Strategy

Non-excluding categories emerged from the analysis of interviews: *dialogue-action* and *dialogue-interaction*. These respectively represent the compilation of meanings of the development of a predominantly one-way verbal communication and a non-verbal and complementary two-way communication. The subcategories that define non-verbal communication were grasped in a non-excluding manner in the process of analyzing the meanings of observations of the communication process triggered in the group activities of the EFS.

Aiming to express the possibilities of the non-verbal communication field, we describe the classification of Silva⁽³⁾: *Paralanguage* – refers to variations of intensity in verbal expression, by the production of sounds not actually coded in the language used, which convey feelings, attitudes, personality, interpersonal relationship and self-conception. *Kinesics* – refers to the interpretation of an interlocutors' body language. *Proxemics* – refers to the interlocutors' use of the interaction space. *Physical interactions* – are linked to the interlocutors and visualized through the image of the objects presented by them. *Environmental Factors* – refer to the disposition of objects in space and by their characteristics such as color, form and size. *Tacesics* – comprises the characteristics of the interlocutors and objects in the space of interaction grasped from a tactile perspective.

RESULTS

Communication Process Instruments

Two categories of meanings that emerged from the nurses' reports and were observed during the group activities of the EFS are presented in this item: *dialogue-action* and *dialogue-interaction*. These represent, respectively, the development of a predominantly one-way communication process and a two-way communication process that contains both verbal and non-verbal forms of communication.

The *dialogue-action* refers to the development of work actions centered on the production of a communication process aimed to solve the patients' organic manifestations and/or disorders. Hence, this interaction will not be explored beyond the clinical practice of nurses, consequently, non-verbalized aspects will not be valued/considered/investigated even if they are present in the work triggered by the contact between nurses and patients.

The *dialogue-interaction* refers to the recognition and use of non-verbal communication concomitantly with verbal communication processes, so that nurses use many possibilities of non-verbal interactions to produce wellbeing, quality of life for patients participating in group activities and investigating, at the same time, organic aspects.

Based on this context, the dialogue is presented as an instrument, which for 35 of the 51 nurses, is intended to

implement technical actions of the work process through the direct use of verbal communication, which includes lectures, guidance, instructions, and verification of vital signs, among others, according to the following excerpt:

[...]we give instructions, chat, talk about food, exercises, verify the blood pressure of everyone [...]give them the medications[...] (C01 T02 N74).

The other 16 nurses report that the dialogue enables the interaction of workers with patients and playful interactions are developed in addition to verbal communication with the use of complementary non-verbal communication such as: theater, painting, dance, games, among others, which is evidenced by the following report:

[...] I use games, group techniques, discussions, theaters, puppets, these kind of things to work with them (C08 T11 N89).

The records of the 19 group activities developed within the ESF support the nurses' testimonies since *dialogue-action* predominates in 13 of them, while observations and the remaining six activities used *dialogue-interaction*. Examples of *dialogue-action* and *dialogue-interaction* are presented:

[...] the worker started the group asking about the patient's wellbeing, informed them of the objectives of the group [...] thanked them for attending and asked the pregnant woman to go to her room for the physical assessment [...] (C05 T93 Obs13).

The nurse asked them to fill the balloon and play without letting it fall [...] She asked everyone to grab a balloon and sit, asked them to burst the balloon and get the paper inside. Then she asked each do what was written on it. They hugged each other, smiled and said good things. After that, they distributed the dishes and soft drinks that everyone brought on the table and began socializing (C08 T100 Obs14).

Another relevant aspect of the group activities reported by the 51 interviewees refers to the object of intervention. Based on it, there are three reports concerning the development of *dialogue-action* in which time available for group activities meet the need for individual clinical demand, as follows:

The nursing technician got a SIASUS form and the patient's file and went to the waiting room where he filled in the form [...] weighed the first patient in the group, verified her blood pressure and said: 14 by 8 (C09 T69 Obs05).

Another 36 nurses reported they work with the collective because the *dialogue-interaction* is produced with workers and patients sharing the same space from the beginning of the group activities until the end.

The nurse went back to the waiting room at 10am and kept measuring and weighing the children from the child-care group for children older than one years old (C05 T92 Obs08).

Some also reported how fluid the group activities within the EFS are. For eight nurses the group activities began with the collective and ended with individual procedures and for another four nurses, the inverse process occurred, they began with individual procedures and ended with the collective.

[...]we talk about generalities, things they want to know, we clarify doubts and then we check blood pressure, glucose, depending on each group. Then there is the distribution of medication [...](C11 T91 N101).

In terms of complementarity, the recording of 19 group activities corroborates the nurses' reports since six observations evidence these are individually developed. In the other nine activities, these are mainly developed with the collective; in two they begin in the collective and then work individually, and in another two they start with individual procedures and then go to the collective.

We highlight that the meaning of *collective* grasped in the nurses' reports and also evidenced in the observations of the group activities is a particularity of this work, capable of conditioning the directionality of the communication process. Hence, the term *collective* represents the grouping of patients with the common interest of having their personal health needs heeded, sharing the same space so as to produce two-way communication.

Dialogue-interaction observed according to Non-Verbal Classification⁽³⁾

This topic refers to inference from the analysis of the non-verbal communication process because the nurses did not report it. Data obtained from observations permitted us to investigate non-verbal communication within the dialogue-interaction according to the adopted classification⁽³⁾.

In general, tacesics predominated in the group activities developed with chronic patients, children and pregnant women, both in the activities developed individually and collectively. Tacesics is concretized through contact between workers and patients in the procedures required for monitoring the health of patients as the following record shows:

He verifies the fetal heart rate, measures fundal height, checks the child's position [...](C05 T93 Obs13).

Kinesics stands out in the groups of chronic patients, prenatal care, better childhood, and the walking group, in which *smiling* is observed in 17 findings. Smiling expressed feelings of gratitude for compliments received, was a form of greeting, continued verbal expression, showed satisfaction with the productivity of actions, and farewell between workers and patients, as seen in the following excerpt:

The smiling patient thanks and says goodbye (C05 T16 Obs03).

There are four observations related to kissing and shaking hands acts, for greeting, appreciation and farewell, expressed in reports such as this:

[...]Then the doctor expresses thanks the presence of all and they parted with a handshake and kisses (C05 T93 Obs02).

In addition to standing up or sitting in the condition of sender-receiver, the use of upper and lower limbs to produce a communicative action complementary to the verbal one is perceived in the following record:

The nurse says to a patient: *You can go there.* And indicates with her left forefinger the bandage room (C05 T92 Obs08).

Proxemics is present in the groups of chronic patients, prenatal care and better early childhood. The use of seats and a table as the main aspects to express the distance between professionals and patients is seen, that is, the use of seats and table can express a closer proximity, which is verified in nine observations, or maintain distinctions, which is observed in five group activities. Two records are presented to clarify this information:

The doctor's desk is up against the wall and the two chairs on which they are sitting (doctor and patient) are beside one another (C05 T93 Obs13).

The professionals are sitting behind the desk and the patients are arranged in lined up chairs on the other end (C05 T93 Obs01).

Environmental factors are mainly included in the groups of chronic patients, prenatal care and the walking group as aspects to entertain and distract patients and to facilitate the team's work. These aspects are evidenced by the presence of music, toys, TV, DVDs, the space itself where activity is developed, which can be within the unit itself or places in the community, among other indications, reflected in records such as this:

A boy plays with a car from the box of toys in the waiting room in the Primary Health Care Unit (C09 T02 Obs05).

The physical characteristics are emphasized in the prenatal, better early childhood and childcare groups. These are especially seen in the professionals' use of uniforms,

[...]the nurse gets to the FHS unit and goes to the nursing/vaccination room in which she puts on a lab coat [...](C08 T02 Obs16).

As well by the use of electronic equipment for their personal use,

1:46pm: the nursing technician leaves the procedures room with headphones connected to an mp3 player and a control form in hand and asks [...](C09 T02 Obs05).

And by the resources used to develop health actions and procedures,

The nursing auxiliary wears gynecological gloves to perform the HGT test(C08 T02 Obs06).

Paralanguage was observed only in the activities with the groups of chronic patients and childcare characterized by the patients' manifestations:

They pass on pictures, everybody laughs remembering the meeting's day and point to each other [...] At the end everyone produces a different sound(C05 T03 Obs01).

And when the professionals alter their tone of voice:

The lady who is part of a group of hypertensive patients goes back to the EFS unit and tries a consultation for today. The nurse [...] says: *If you leave the group, I'll schedule it for you* in a loud tone of voice. (C08 T92 Obs08).

The woman shows the subpoena to testify for negligence in the care of her daughter. The nurse says it is necessary to go to the Guardian Council to say that the woman is who cares for the daughter [...] (C05 T11 Obs07).

The last reports contain meanings related to satisfaction with the large number of care procedures delivered, to the confirmation of actions to be performed to reassure patients concerning legal problems and to inform other professionals where material required to develop activities is, to the low number of participants, to the patients' limited access to the service when it is not the day for group activities, among others.

DISCUSSION

The investigation of the dialogue in this communication process, revealed by the interviewed nurses and evidenced in the observations, highlights the complementarity of the dialogue-action to the dialogue-interaction, that is, the use of playful elements through non-verbal communication in favor of the verbalized language present in both categories.

In this context, the communication process should be a drive toward the implementation of integral health care. For that, care developed within the Family Health Strategy should intervene in decision-making, interactional disturbances, and in facing the patients' issues in order to resolve or mitigate them⁽⁹⁾. Hence, the focus of care should aim to provide routes and local resources to produce growth and mutual support between professionals and patients leading to a greater level of health.

Care delivered to patients and their family members should grasp beyond what is verbalized, requiring a posture from professionals that encourages them to seek between the lines and also be sensitive and, when required during the communication process, assume the function of listeners with the intention to understand what is implicit⁽¹⁰⁾.

To acquire such an understanding it is essential to realize that knowledge is not static, but dynamic in a society

in which messages runs through a prism constituted of interpretations that individuals produce in each moment of their life⁽²⁾. Hence, [...] *communication is not only exchange of information. It is acting, interfering in action and modifying attitudes on different scales*⁽¹⁾.

This set of actions requires a communication process that promotes less conflicts, misunderstandings, and noise in the field of dialogue produced among interlocutors⁽³⁾. From such a perspective, in the analysis of the playful elements mentioned by the interviewees, non-verbal communication, dialogue-interaction as a strategy to complement dialogue-action in which it becomes an instrument of communication processes to meet the interpersonal needs of those participating in the group activities, is envisioned.

The interpersonal needs are presented as a representation of feelings of acceptance and appreciation of each patient as an essential integrant of the group, and also of the responsibility for the concreteness of action and the flammable desire to be unique⁽³⁾.

The nurses also reveal how fluid the group activities are, confirming the existence of verbal and non-verbal communication in a process of complementarity. Hence, the observed communication process includes the interaction of interlocutors in a specific time and space in which needs are shared through meaning-loaded messages. These meanings can influence behavior in a spectrum of action and reaction in which cultural, religious, and socio-environmental factors and previous experiences act on the decoding and interpretation of the message⁽¹¹⁾.

When this set of factors experienced by the interlocutors is shared in group activities ensuring identification in the socio-historical time of events, it produces a stereotype. It permits an immediate (re)cognition of the situation given the speed with which facts are interpreted, gaining a status of truth when perpetuated by a collective represented by a group of individuals with common interests⁽¹⁾.

On the other hand, the contingent that characterizes the work in the group activities as a space of relationships includes interlocutors in permanent social (re)construction due to creative, participative, and interactive⁽¹²⁾ capacity, regardless of the number in the contingent, to the same extent in which the communication process requires only two interlocutors.

Nonetheless, the emphasis reported by nurses and evidenced in the observations for the development of group activities in the presence of the greatest number of patients as possible, which is called *collective*, can be related to factors such as facilitation of access to health services, or the achievement of the strategy's goals by speeding up the work process⁽¹³⁾. In contrast, the communication process, being a work tool in group activities, is directly and indirectly influenced in its quality and efficacy since mes-

sages need to be validated for an insightful interpretation of the content to occur^(1,3).

The environmental factors and subjectivities of the interlocutors require permanent supervision so that noise does not distort the interpretation intended by the sender.

Body language—kinesics—observed in the group activities brings together a set of gestures manifested during interpersonal interactions showing affection constructed between professionals and patients. According to the authors⁽¹¹⁾, this favors message decoding.

It should be noted that the observation of non-verbal communication in the dialogue-interaction permitted us to grasp, through paralinguage, the satisfaction of the professionals during work. However, this class of manifestation may perhaps represent the most significant and evident form of harming an interpersonal relationship, both among professionals and especially between professionals and patients.

Paralinguage permits one to perceive aggressiveness manifested in the actions of professionals, which may be caused by diverse factors such as work overload, excess of responsibilities, health or economic problems, among others⁽¹⁰⁾.

The arrangement of objects in the observed interactional environment—proxemics—reveals an organization of work that gives priority to proximity and collaboration between most of the professionals and patients in the group activities. The attitude of professionals during activities excelled in respect to the ethical performance of actions, intended to meet the principle of equity when they ordered seats beside each other both in collective and individual procedures, and also favored the participation of patients to expose their needs and resources.

Other studies⁽¹⁴⁻¹⁵⁾ show that work that takes into account the diversity of the participants and seeks to construct a point of convergence based on listening to the needs of patients. This is only possible given a mutual commitment of the participants and through the establishment of relationships based on honesty and sincerity in attitudes and dialogue.

For the establishment of these relationships and interactions, we believe that the posture of professionals to consult with the patients, to include them in the unit's events, place them as co-responsible, important and involved in the process of behavioral change⁽¹⁶⁾. The environmental factors revealed that objects contained in the Family Health unit were used to entertain and distract patients and enabled teamwork. The physical characteristics of the team's professionals revealed their work conditions and their concern with safety while developing group activities. Hence, the communication among these professionals becomes a common denominator for the development of teamwork with reciprocal and interac-

tive relationships. These relationships reflect an intrinsic and constantly communicative connection throughout actions, but also a fragmentation of work, which makes communication extrinsic to it⁽¹⁷⁾.

CONCLUSION

The communication process is presented as an instrument that facilitates the work process developed in the group activities within the EFS.

The dialogue-action is represented by the predominant use of verbal language as an instrument of care practice, that is, as an operational means of the development of specific procedures of each professional in relation to the monitoring of the patient's health condition. On the other hand, the dialogue-interaction is characterized as an instrument where, according to nurses, the use of verbal and non-verbal communication co-exists.

The object of work in the group activities is mainly individual, since the meaning of 'collective' is linked to the environment shared for the development of actions.

In this context, the observations of the group activities in the collective and individual scopes permitted us to identify nurses as those responsible for the organization of work within the ESF to achieve the strategy's goals. Hence, they act to ensure the necessary resources to maintain work actions, that is, they give priority to dialogue-action in a communication process that includes the group activities.

In contrast, when they promote the communication process with patients, they produce a dialogue-interaction, which is aimed to produce temporary opportunities of leisure both for the patients and the participating workers.

Additionally, they promote EFS teamwork, since patients enjoy the Family Health Strategy as an option not only for control procedures and monitoring health but also as a place where there is social interaction able to produce entertainment, fun and friendship ties.

The group activities are a privileged space to achieve the integral care of patients. In the context in which the communication process sets itself either as a conscious or unconscious instrument for health workers, care within the EFS is aimed to intervene in the needs verbalized by clients but also to go beyond, seeking new horizons in the range of signs, the content of messages not verbally expressed by patients in the most different socio-cultural environments in which the EFS is inserted.

Based on the addressed aspects, the communication process is present in the work routine of the EFS professionals and in the specificity of the group activities.

The communication process implies an action of complementarity in which non-verbal expression becomes

more insightful in understanding and in-depth in regard to the interpersonal relationships produced in the Family Health work.

Giving visibility to non-verbal communication in the work process within the EFS through continued education facilitates strengthening interpersonal relationships, implying a greater communitarian participation in group activities.

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