

## ***It's like a family: the significance attributed by health professionals to diabetes health education groups***

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**Abstract** *This article analyzes the significance that health professionals attribute to health education groups for people with Type 2 Diabetes Mellitus (T2DM). This ethnographic study was developed with five professionals from an Expanded Family Health team that operated in five diabetes health education groups. Information was gathered using participant observations and semi-structured interviews. Data were analyzed by means of a thematic coding technique. Three different categories emerged: (1) It is a way of educating them: groups as an educational and clinical monitoring forum; (2) they know I will be there for them: the groups as a resource to access the health system; and (3) this serves as a self-help group: after all, what purpose does this group serve? The conclusion reached is that the groups studied were a therapy and support hybrid that, by means of their structure, made it possible for the informants (perhaps, also for the patients) to construct other significance for the standardization of health policies and the dilemma of chronicity. Such hybridization made it possible to create outcomes for the specificities of health work in a “total life” context.*

**Key words** *Health education, Type 2 diabetes mellitus, Medical anthropology, Self-help groups*

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## Introduction

Health education groups, involved in primary healthcare, for those who live with long-term diseases (known as “chronic diseases” in biomedical terms), form social-cultural universes including elements and arrangements that are not as yet fully included under the Cartesian paradigm of health sciences. Situated between a clinical-epidemiological perspective and the experiences of sick people and official medical health care agents, the work that these groups perform involves challenges, conquests and anxieties. For this reason, the focus of this study is based on the significance given by health professionals to the provision of health care within these groups, as well as social-cultural aspects that shape the nature and type of the health care provided within these scenarios.

According to the biomedical sciences, “chronic diseases” can be caused by congenital, genetic or acquired factors. Acquired chronic diseases are characterized by a long latent period frequently influenced by prolonged exposure to related risk factors and, in particular, a certain lifestyle. The adjective “chronic” is indicative of the impossibility of a cure<sup>1</sup>, as well as the need to live one’s life “with and in spite of the illness”<sup>2</sup>. Given the vast panorama of chronic diseases, this article will concentrate on Type 2 Diabetes Mellitus (T2DM). It is a metabolic syndrome caused by the production, secretion or deficient use of insulin, this is characterized by chronic hyperglycemia, frequently accompanied by dyslipidemia, arterial hypertension and endothelial dysfunction<sup>3</sup>. The prevalence of T2DM among the adult population is considered a worldwide public health problem<sup>4-7</sup>.

Treatment for T2DM involves controlling glycemic and metabolic levels, preventing serious or chronic complications, helping sick individuals and their families to adapt to their situation on a psychosocial level, ensuring that medications are taken on a regular basis and, in particular, promoting a change in lifestyle<sup>8</sup>. Among measures used to prevent, evaluate and control T2DM, individual and/or group health education activities should be highlighted. In Brazil, these types of actions have been developed, mainly among groups that are coordinated by health professionals and carried out in basic health care services, where they have become commonly known as “Hiperdia groups.”<sup>9</sup>

Official documents have emphasized the need for health professionals to develop campaigns periodically, as well as educational health groups and

mutual health groups with the aim of promoting healthier life styles<sup>10,11</sup>. In addition, it is widely acknowledged that such health education actions are essential to inform people who are sick, motivating them to deal with their conditions and to prepare them to carry out their treatment schedules to the full<sup>12</sup>. However, health education actions, especially those involving groups, should promote opportunities to socialize knowledge and enable people to share their experiences about living with T2DM, thereby enabling individuals with this disease and their families to have greater autonomy in looking after their own health<sup>13</sup>.

As the link-agent between health policy and a person who lives with T2DM, health care professionals, especially those involved in providing basic health care, occupy a strategic position in official discussions and in the biomedicine literature. Thus, this article seeks to understand the meanings given by health professionals to health education groups for people with T2DM. In this sense, it should be emphasized that there is a need to use an approach that makes it possible to grasp the meanings given to health education groups by the population in question. Thus, it should be emphasized that our theoretical frame of reference was based on socio-anthropological studies related to the management and experience of long-term illnesses<sup>14-17</sup>. As a result, no attempt was made to try to describe the technical and pedagogic aspects of these activities, which would merely reinforce the educative dimension of such groups, whose ultimate goal is to change behavioral patterns so that those suffering from this disease adhere to the proposed treatment.

## Context, subjects, procedures and research instruments

The research study that led to this article was conducted in Campinas, in the interior of São Paulo, between August 2011 and September 2012, in five health education groups for people with “high blood pressure” and T2DM (Hiperdia Groups) by professionals working with Family Health Teams (FHT) from the “São Marcos Region” health center. This region covers several districts and ‘subnormal’ agglomerates and, even though this term does not officially exist, it is used by the population to delimit and describe a territory covered by the FHT and which I visited several times during the course of my field work.

The way that these groups I met were organized began in 2001, the year that the “Reorganization Plan<sup>10</sup> was published. Professionals who regularly took part in these groups were Helena,

Paula and Ricardo, who was a Community Health Agent who participated in these groups for ten, six and eight years respectively. In addition to these professionals, other Silver Team agents occasionally participated in this work or no longer took part due to a series of internal conflicts. One of these conflicts, the one mentioned most often, involved some team members who disagreed with the way the groups were being organized, as will be seen below.

In August 2011, there were 113 registered group members (Table 1) who had taken part in these groups for an average of between five and six years. In general, participants were randomly selected for the different groups (groups were numbered from I to V). All had Hiperdia cards that included their identification details, their group number, and details of their blood pressure, capillary blood glucose levels, weight, body mass index and, on the reverse side, a schedule of their next meetings. Group meetings were held every week, and were distributed so that there was a meeting about once every 45 days. On average, 15 users would take part in these meetings. Group meetings took place inside the health center buildings on Mondays from 1 pm to 3 pm, in a meeting room located to the rear of the building. In general, the excuse given by those who did not attend was the timing (between 1 pm and 3 pm) and the day of the week (Monday), which they claimed was the main reason for not turning up, due to the length of their working day or their domestic chores.

On the day of the meetings, the participants would begin to arrive at around 12.30 pm, when they would go directly to the meeting room. The health professionals would arrive at around 1 pm, greeting all those present. They would then gather together all the cards left on the table and select the individual medical records for all those present. The team would then separate so as to take people's blood pressure (as a nurse, I always

assisted in this activity during my field work), measuring capillary glucose (Paula), recording a person's weight (Ricardo) and recording this information on the medical records and cards (done by all those present).

The educational activity would then take place, which would be conducted by Silver Team members themselves. When I began my field work in 2011, issues such as sexuality, oral health, eating habits, the use of medication, physical exercise, among others, were usually discussed. Once these educational activities were over, Paula began the individual treatment sessions. It was at these times that clinical monitoring practices involving each member of the group effectively took place, both individually and with their closer social relationships (mainly their families). After this session with Paula, the participants could return home or would wait for a neighbor or partner who had not yet been seen by the doctor.

In this context, those who took part as informants for the purpose of this research study, were as follows: 1 family and community doctor, 1 nurse, 2 nursing assistants and 1 Community Health Agent. The participation of these professionals as informants took place during the course of my field work, from the time that we first made contact and established a working relationship. All were given information related to the objectives and methodological procedures of this research and agreed to collaborate with their knowledge and experiences, and each informant agreed to sign an Informed Consent Form. As mentioned previously, the names of all the individuals and institutions used in this article are fictitious and chosen at random. The project was approved by the Research Ethics Committee of the School of Nursing at the University of São Paulo.

My presence in the Hiperdia group and in other activities involving the Silver Team (home visits, medical consultations, reception, team meetings) enabled me to become directly involved in the fieldwork and to establish a network of relationships with professional healthcare workers and others participating in these groups. Thus, collaboration by means of individual semi-structured interviews, using main topics, took place during the last few months I spent in the field. Before that, the informal conversation that I had during social interactions with health professionals represented an important source of information that, gradually, enabled me to become closer to the world of the groups being researched and to understand the significance that these social actors attributed to their work in these contexts.

**Tabela 1.** Distribuição dos usuários por grupos Hiperdia. Campinas, 2011.

Grupo	Usuários Cadastrados
I	27
II	26
III	23
IV	20
V	17
Total	113

Information collected during the participant observations were recorded in a field diary.

As a result, those who took part in this study were Silver Team professionals directly involved in health practices designed for people living with T2DM and who frequented the Hiperdia groups. The interviews took place in the health center itself, were recorded on audio, as authorized by the collaborators, and were transcribed and codified immediately afterwards.

Data analyses took place in four stages. In the first, a brief description was made of each interview (case): including information about the person being interviewed, the context in which the interview took place and central issues were identified. In the second, a more detailed analysis was made of the first case, in order to codify data, which was based on the research theme, the objectives and theoretical assumptions. In the third, an analysis was made of the other two cases and, later, units of significance were identified, by grouping common and uncommon codes. That is to say, the first phase of interpretation was made during this stage, which resulted in the emergence of units of significance. In the fourth and final stage, text excerpts were analyzed in greater detail. Once the whole corpus had been analyzed, a table was produced, which defined the nucleus of meanings. Finally, based on the nucleus of meanings that had been produced, the thematic categories were constructed<sup>18</sup>.

#### **Significance attributed to the Hiperdia groups**

Once the empirical material had been analyzed and interpreted, three thematic categories were obtained: (1) *this is a way of educating them*: the groups as an educational and clinical monitoring space; (2) *they know I will be there for them*: the groups as a resource with which to access the health system; and (3) *this serves as a self-help group*: after all, what is the group for? The core content of each one of the above is shown as follows;

#### ***It is a way of educating them: groups as an educational and clinical monitoring forum***

This category shows how the significance attributed to the groups is strongly linked to the idea of public health practices. Historically speaking, health education (formerly known as sanitary education) was conceived as a process by which knowledge and biomedical science and psychosocial methods developed conceptual systems and values, both in individuals and in society, which

encouraged a healthy lifestyle<sup>19</sup>. This concept continues to feature in graduation courses involving health issues and in official documentation<sup>8,20</sup>. As a result, these professionals reproduce these same concepts in their practical work, which translate into educational activities focused on pathology, which are both vertical and culpatory<sup>21</sup>.

According to research informants, the groups represent privileged spaces where guidance in health care takes place, namely to develop health education actions. *The doctor who started these groups believed this would be a way of providing patients with better health education. The group provides the means of giving them better health education, so that they will stick to their treatment* (Helena). The aim of these actions is directly linked to those promoted by health policies and they are modified according to the issue in focus, that is to say, to the disease or health problems in question. Thus, the groups represent a tool or strategy to satisfy a demand and to ensure that patients adhere to their treatment and therapeutic regimes. From this perspective, the concept of health education operated by informants consists in transmitting clinical information and, in particular, patterns of behavior related to T2DM. On the other hand, other interpretations exist: *I think that the group encourages chronically sick persons to evaluate their problems in greater depth. It gives them greater incentive to exchange their experiences and be constantly learning. The groups serve to enhance the treatment and control of their situation* (Ricardo). However, this coexists with a concept of health education that is more centered on “education” in its normative and pragmatic sense, as well as harboring a “motivating” dimension, in Ricardo’s own words, in that this makes bio-sociability possible<sup>22</sup> marked by the exchange of knowledge and experiences between individuals who share a common health condition. This characterization of relations, using advice based on biomedical knowledge, was also seen in a group created for people who have T2DM, who belong to an association in Sao Paulo, where sociability between the associates made it possible to create links of solidarity that were used to establish exchanges between people who recognized that they shared the same identity<sup>23</sup>.

If these perspectives coexist in these group spaces, it seems that these, ultimately, merge into a common objective: *to reinforce treatment*. These objectives are similar, but not the same, since the notion of *control* introduced by Ricardo in his statement, is located outside the normative field of biomedicine. As a Community Health Agent, who lives in the same neighborhood, works *in*

health, but is not *from* the health area by training, Ricardo characterizes *control* as *seeing if the diabetes is at a high level and knowing something about what to do to lower these levels: take some medicine, drink tea, don't be nervous*. Several studies associate disease management with the notion of “control”<sup>24-27</sup>. However, Brazilian studies have shown that although this is a central issue for healthcare professionals and patients, there are differences and similarities in their significance<sup>28-30</sup>.

The word “control” has two meanings: one is a *biomedical concept*, which means to maintain the level of glucose within benchmark standards established through clinical consensus; the other has a more *popular* meaning, which involves practical concerns that encourage patients to make adjustments to their medical prescriptions in an effort to balance levels, while at the same time dealing with non-medical demands (family, work, religion, friends) that need to be managed in life<sup>29</sup>. With regards to alimentary restrictions of people who have T2DM, for example, Barsaglini and Canesqui<sup>30</sup> show that the notion of “control” is consistent with ideas of flexibility and volition, expressed in terms such as “dose down,” “cut back,” “reduce,” “control,” “correct,” “taste, but do not eat.”

In the context of the health education groups, Fleischer<sup>28</sup> indicates that “control” has a few parameters that need to be exercised and articulated: “punctuality at the group meetings,” maintaining body mass indexes in accordance with clinical protocols, complying fully with prescriptions issued during medical consultations, withdrawing and taking the full amount of medications prescribed.” According to healthcare professionals who worked at the association in São Paulo studied by Lopes<sup>23</sup>, *to be controlled* describes the particular behavior of people who take special care of their state of health, creating new ways to deal with their daily lives.

In the midst of this, the clinical monitoring carried out during each group meeting appears to be related to the idea that it is necessary *to know the patient better, to be closer*, which is the ultimate aim to meet expectations to ensure that the self-help practices prescribed are effective, as well as to create personal links with the person with T2DM. *In the case of patients who belong to the groups who have a companion, we can start to understand our patients better* (Paula). Thus, health care becomes more personalized and, as a result of this, these group participants do not need to go to health units so often, that is to say, they do not *become imbalanced* (present alterations in their capillary glucose levels, for example) or only do so occa-

sionally. *We used to have several patients coming here who were imbalanced. I think there has been a significant reduction in the number of patients who were obviously in a bad way out there in the front (at reception) because of diabetes* (Helena).

In addition, clinical monitoring and the information provided to those suffering from T2DM starts to become a regular “part” of their lives, even when a health worker is “absent.” *We are not going to be there all the time with them and we need to give them the advice they need. Here things are one thing and back at home, in their everyday lives, things can be very different. Patients have to take medicines on a daily basis, for the rest of their lives, and one or another will end up not willing to do this properly* (Ricardo). Thus, by means of the advice given in relation to T2DM, which attempts to “teach” patients, medical knowledge is “removed” from the contextual surroundings of a clinical setting and begins to play a capillary role in the daily life of these individuals<sup>31</sup>.

For Hiperdia groups studied, the daily monitoring of self-care and frequent contact with the medical guidelines was as the most assiduous in meetings to develop certain management ability of the disease itself, ie, produces individuals who “know how to take care.” According to Lopes<sup>23</sup>, these cases feature the “good diabetic,” different from the “angry” or even “do not accept” DM2 and indifferent. For the author, the “good diabetic”, and “whether care”, develops the “trickery” that manifests itself through strategies to “learn to surrender to the seduction of the most desired dishes, making up for the ‘abuse’ with a greater control in the diet the next day, for example”<sup>23</sup>.

However, it was observed that the health education practices associated with clinical monitoring during the group meetings researched, present two “facets”: one is *scientific*, which produces and manipulates a series of technologies that cultivate *self* and ensure that Cartesian biomedical discussions circulate, with the ultimate aim of establishing a regime of control marked by self-discipline, self-knowledge and self-monitoring<sup>24</sup>; and, another, related to *experience*, where the actions and creativity of the individuals involved establishes a network of relationships, which make it possible to redeem from within the educational act performed within the group, the particular elements of the relational structuring characteristics found in grass root classes<sup>32</sup>.

The two “facets” of health practices developed within the Hiperdia groups studied have the potential to recompose the technical act taught through clinical knowledge and epidemiology, though this is a space that has a dialogic

possibility that enables reciprocal learning processes to take place between patients-patients, patients-health care professionals and professionals-professionals.

***They know I will be there for them: the groups as a resource to access the health system***

Coexistence in Hiperdia groups enabled the seizure of creative and original action that is reflected in the uses that members of engender groups to overcome the bureaucracy put in the organization of health services. For Helena, the group means a “resource” for patients, since when they have a need and fail to medical consultation is for the group that they “run”. *When they cannot make an appointment, they use the group to do this. Or perhaps they don't like to come in a group because they think it will take too long, but when they need to, and cannot make an appointment, it's here they come running to!* (Helena).

As discussed above, there are between members of the surveyed groups (professionals and patients) a network of relationships that allows rescue within the group the very elements of their own relative order of the popular classes. This order puts into play several characters: people living with DM2, medical, ACS, a nursing assistant and others. By activating these networks is produced implications, accountabilities, compromises with the other: take it as a person; puts it in the world. So Ricardo is Bahia, lives alone, is peaceful, collaborative and also is ACS; Helena's single, smiling, has a son, was born and raised in the neighborhood and also is nursing assistant; Dona Carla is Cearense, widow moved to Campinas for 24 years, lives with a daughter and a grandson likes to talk in the house driveway and also lives with DM2.

The ethnographic material of this study allowed us to understand the network of relationships and joint forces, through which patients and professionals dialogue, play, make alliances, shape and look for gaps in the structure set by the health system. In this sense, professionals legitimated the uses that patients make of the groups mainly as a way to get “easy” access to medical services. *The group represents a means for them to have access to me, even though I am a person who is easily accessible to them. This system facilitates their access to me, because I am always here at the same time. They do not have to sit waiting for their code number to be called out or go through reception to see me. They know I will be there. There is always someone they are familiar with* (Paula).

That is, the social uses that patients were the groups were based on a network of production

relations and bonds of trust between the actors involved. *They know I'll be there*, says Paula. In addition, the professional attitude to take as a *reference person* for the participants of the groups was revealed as a possibility to carry out in practice the principles of primary health care (accessibility, longitudinality and completeness, mainly) and thus transform the Hiperdia groups in a “door” is always open and welcoming: *we never send away anyone who is not a member of the group! Today he thought he could come and fix something here. So welcome in the group, do as he was participating and in the end he is invited to talk! It is one feature!* (Helena).

However, despite the personalized attention and the creation of links, one cannot overlook the backcloth against which these relationships are played out, namely health policy and its strategies for management of the life of the social group. From this perspective, it is important to emphasize that general elements are also found within these relationships that delimit the asymmetry of knowledge/power between health care professionals and patients.

Sometimes, had been at one point, professionals with their technological knowledge able to meet demands for medicalization of patients, the field of standards and routes to access the health system; and in the other, patients recognized and legitimized the technological knowledge of the professionals as effective in the management of their sufferings and misfortunes, proposing friendly and personal relationships with health care professionals and, in exchange, agreed to participate in the proposed activities within the group.

***Serves as a self-help group: after all, is a group for what?***

According to statements made by the health care professionals, the objective and characteristics of the groups appear to be “divided” between health education and “self-help.” According to Marcia, the group *had to be educational: I think that it had to be more educational. There are patients who come to the group merely to get a prescription for medication and to speak to the doctor. They do not come here because they need to learn anything.* Based on this perspective, the groups represent a public health practice, the aims of which are to adhere to the medical treatment prescribed and reduce the demand of *unbalanced* patients. Therefore, the professionals running these groups should commit themselves to this technique, seeing it as an instrument of their work. The focus on transmitting information and

scientific knowledge, related to diseases and other health conditions, blurred potent aspects that were devised within the groups, such as sharing experiences.

It is important to stress that, during the field work, Marcia no longer took part in the group meetings: *I no longer participate*. Perhaps her condition as an “outsider,” based on her previous experiences, made it impossible for her to understand some of the elements that Paula and Ricardo, for example, were able to describe. These health care professionals attributed other significance to the Hiperdia groups, broadening the “educational” vocation defended by Márcia.

For Ricardo, Paula and Helena, the groups were health care production spaces whose symbolic effectiveness was delimited by these meetings, by the interpersonal relationships, by the connections formed, by the access strategies, by the experience of dealing with long-term illnesses: *they seek to take part in these groups, partly because it is somewhere they can go and visit meet other people regularly. These include elderly people who do not have many leisure activity choices. The group ends up being a place where they can go to meet one another* (Ricardo).

Based on the above discussion of the two “faces” (science and experience) who were demonstrating in the conceptions of education in health of informants, we can say that the “divided” character of the groups is a reflection of these “faces”. In fact, the identity of these groups was constructed and guarantee its continuity over more than 10 years at the time of the survey, just by the co-existence of these “faces” that, at the same time, repulsavam and complemented. The division was called the “eyes” Polarized some professionals who lost sight of the medium, the mixture, the subtlety, the fleeting.

For Paula, the groups also worked as a group of “self-help”: *serves as a self-help group because they see several people with the same problem. You saw the patient talking about? ‘This is like a family!’ So even if the group does not have a purpose of therapy, it ends up being therapeutic, support*. In his speech, Paula pointed out the distinction between therapy and support, although both r to ways to handle subjective aspects in health practice, specifically in Hiperdia groups.

In that context, the term *therapy* meant the way by which professionals could approach *subjective* issues, described by people who have T2DM. Thus, *therapy* operated in a technical, scientific, objective and concrete order. In contrast, the notion of *support* sought to take care of that “product” that was independent of the conduct

of a professional. In other words, the *support* was notable for its relational order, its personal nature, experience, subjectivity and of the abstract. In *support*, the central role of technical knowledge coexisted with other knowledge and experiences, which acted as instigators of other central roles.

In spite of being different, these categories make it possible to grasp the strategies and actions of the social actors, to integrate these “facets” and produce new configurations at every meeting. For this reason, “seen from the outside” the groups could appear to be divided, but when “seen from the inside,” they assumed the contours produced by the groupings in the network of relationships formed by the members. These views “from the inside” and “from the outside” led to conflicts between Silver Team professionals. In general, criticism was made of the way the groups were conducted and these criticisms centered on the figure of the physician. This is what Marcia says: *Previously the group had time duration. Today I do not participate. First, because I was never invited. Second, because I do not like the way the medical leads things. I think the group that it does, unfortunately, medicative! Because patients do not get high*.

For Rose, the nurse who joined the team in July 2012, and his first experience in primary care, the groups were Paula and referred insertion difficulties in the activities: *I am not a reference for hypertension or diabetes, because, in addition to being a newcomer to the team, I was unable to establish a good working relationship with the physician. In the beginning, I did not feel very motivated to take part in this group, precisely because of this authoritarian issue. There are less than 100 patients in her group and only these are monitored. But we have 500 registered patients. So I think that there is still much to be desired in the way these people are treated due to this centralized-physician model. She does not give the nurse any opportunities. My work is not the same as that of a nursing assistant. All right, I can help, check people’s blood pressure, check glucose levels (capillary glucose), but that is not what my job is all about. But otherwise we get on well enough*.

In the informal conversations and interviews with Helena and Ricardo, none of these issues were raised. During the time I took part in the group meetings I noticed that there was a certain integration between these two and Paula. An example of this was mentioned previously when I described the division of tasks within the group. When I started my field work, I experienced no resistance on the part of these three professionals. On the contrary, they were all very receptive,

seeing my research as a way of highlighting issues that could improve the work being done with the groups. This was especially the case during the last meeting I took part in with the group, on September 24 2012, when Paula told the other health professionals that, in her opinion, my presence within the groups had been a good thing, since it had “introduced an outside viewpoint, enhanced our work and this was important due to the criticism that we receive from our colleagues. This has helped us re-think our practices” (Notes taken from the field diary).

It is important to understand more about Paula’s viewpoint as regards these criticisms: *Sometimes the person who is the nurse gets a little uncomfortable: ‘I will not be a mere assistant to the physician!’, ‘That is the work of a (nursing) assistant!’ This is how I am: if nobody else does the job, then I will! If someone else wants to take over, I’ll let them! I even said: ‘hey, if you (nurses) want to come up with a proposal to do a job and I only have to do the part of the prescriptions at the end, I would actually prefer that!’ But, people still get annoyed. And sometimes this is just an excuse! Things have to move along! We need to have credibility with the patients. If we arrived there and said: ‘there is no group today!’ ‘Few people came today; I’m not doing anything!’ [...] things are not going to work out. Why do the groups keep going? Because Ricardo, Helena and I are there every day, always at the same time.*

Despite the fact that these conflicts highlight the different understandings that exist in relation to the Strategic Family Health unit’s work processes, what really interests us here is the way that these conflicts can influence the significance that these health workers give to the groups and their practices. This brings us back to the question of what forms the name of this thematic category: after all, what is this group for? Since 2001, the Brazilian Ministry of Health, in its efforts to reorganize health care for people with T2DM (and arterial hypertension), proposed to have these groups working within basic health care services. However, official documents<sup>10,11</sup> have emphasized the urgent need for these health activities, but without providing health care professionals with the necessary theoretical and methodological means to perform these services. As a last resort, these documents outline the setting-up of these groups as a technical and moral necessity for members of the Family Health Teams, especially for physicians and nurses<sup>8</sup> This situation has begun to undergo changes, as a result of studies

on the subject and the difficulties faced by health care professionals throughout Brazil. In 2014, the Ministry of Health published a document that introduces concrete proposals that can help professional health care workers run these groups<sup>12</sup>.

Finally, the “divided” nature of these groups, as collaborators in this study have pointed out, emphasize the need for a comprehensive perspective in relation to the different “facets” involved. However, according to our informants, the Hiperdia groups embody in their “identity” the signs of dualism that can no longer explain the complexity of social interchange generated in that socio-cultural world. So, the Silver Team’s Hiperdia groups were a hybrid of *therapy* and *support*, which, in the transformation of their arrangements, made it possible for the informants (perhaps for the patients) to construct other significance for the standardization of health policies and for the dilemma of chronicity. This form of hybridization makes it possible to create appropriate solutions for the particularities of health work.

In summary, the plurality of health education concepts, the social uses of groups legitimized by professionals and the hybrid nature of these groups, associated with a relational order established over the years and renewed at each meeting, produced a type of relative *communitas*, to the extent that this constituted a model of human relationships strongly marked by personal ties and a sense of community between individuals, which is non-structured or roughly structured and relatively undifferentiated<sup>33</sup>. I used the adjective “relative” before *communitas* because, as we have seen, a set of knowledge, of practices and of norms based on biomedicine operate there, which establish gradations and relationships of knowledge-power between its members.

Whatever the case, in the significance attributed by those who collaborated in this study, the Hiperdia groups were described *as a family* and, therefore, reproduced within themselves the same moral order of a family institution that exists among grass-root Brazilian societies: the moral of reciprocity based on a core obligation to “continually give, take and reciprocate”<sup>32</sup>. Could it be that this complicity, these arrangements, the legitimizations, the exchanges and trust that forged a link between these individuals, are based on the same language through which, according to Sarti<sup>32</sup>, “the poor translate the social world, orienting and attributing significance to their relationships both inside and outside their homes”?



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