Original Article

The ethical-esthetic-political dimension of SUS Humanization: evaluation study of the institutional supporters training process in Santa Catarina (2012-2014)*

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Marta Verdi
Universidade Federal de Santa Catarina, Departamento de Saúde Pública, Florianópolis-SC, Brasil

Mirelle Finkler
Universidade Federal de Santa Catarina, Departamento de Odontologia, Florianópolis-SC, Brasil

Maria Claudia Souza Matias
Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Saúde Coletiva, Florianópolis-SC, Brasil
Ministério da Saúde, Política Nacional de Humanização, Brasília-DF, Brasil

Abstract

Objective: *to discuss the experiences and insights of institutional supporters trained in Santa Catarina in 2009 regarding the ethical-aesthetic-political dimension (EAPD) of the National Health Service Humanization Policy (NHP).* ***Methods:*** *fourth generation evaluative research was performed between 2012 and 2014, involving documentary analysis, questionnaires, interviews and focus groups.* ***Results:*** *humanization EAPD was related to increased communication between those involved, the inseparability of thinking and doing in healthcare and the production of subjectivity linked to shared management. At the same time, it was possible to observe ethical concepts that sometimes make assertions about the common good based on a moralizing rationale.* ***Conclusion:*** *concomitant with an operating framework based on traditional training paradigms, which enabled the training process, the supporters' unique experimentations opened the way for the inclusion of the ethical-aesthetic-political paradigm.*

Key words: *Humanization of Assistance; Ethics; Health Policy; Unified Health System; Qualitative Research.*

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Correspondence:
Marta Verdi – Rua Laurindo Januário da Silveira, 5125, casa 6, Florianópolis, SC. CEP 88.062-201. *Email*: marta.verdi@ufsc.br

Introduction

One of the challenges that the Brazilian National Humanization Policy (NHP) has faced since its creation in 2003 is the discussion in the area of public health to find a concept for humanization that is supported by principles and values such as individuals' autonomy and leadership, joint accountability, solidarity, defense of health service users' rights and social participation in the management process.[1] Benevides and Passos[2] have drawn attention to the conceptual challenge of humanization, concerning its confirmation as a change strategy for the Brazilian National Health System (SUS). In this sense, the idea of humanization in NHP is not that of the idealization of human beings – harmonic, benevolent, capable of predicting the consequences of their acts. Rather, it is based on the diversity and concreteness of their experiences as people who, although they are contradictory and unfinished, also have the potential to create practices and self, in the quest for new life projects.[3]

To understand the consequences of this proposal in changing management and healthcare practices, it is essential to consider the paradigm that sustains it. The ethical-aesthetic-political paradigm on which NHP is based was formulated by Guattari[4] to counter the scientific paradigm. NHP's paradigm associates these three dimensions, intending to make human experiences singular, not general, as part of a social and political commitment to reality which operates by listening to the differences between individuals. Thus, the ethical dimension is characterized by listening and the transformation that this provokes in us, enabling other ways of being, related to the affirmation of life as being multiplicity and openness.[5]

The aesthetic dimension is geared to the invention of trajectories, ways of doing things, producing new forms of subjectification and realities, as part of a commitment to continuous movement and creative flows. Life is seen as a "work of art",[6] open to the reinvention of being and feeling, based on the most effective ways of producing health.

According to Rolnik,[7] the political dimension is focused on fighting the forces within us which obstruct future possibilities. It provides for the constitution of a "field of intervention", which individuals should turn to in order to problematize and criticize reality. For NHP, this dimension is envisaged in relations of power and institutional democratization, because it believes in the protagonism of individuals, all of whom are different from each other.[8,9]

The scientific paradigm has been hegemonic with regard to knowledge production and health training.[7] This results in peculiarities in the challenges faced by NHP, ranging from understanding what it proposes, to its being absorbed throughout the territory. Investment in efforts to train institutional supporters is among the strategies adopted by NHP to overcome this challenge. These processes focus on methodology and objectives that are innovative, since neither training-intervention nor institutional support were common in the Brazilian National Health System (SUS) before 2006, when the first NHP training course was conducted with this aim.

> *The training courses for NHP institutional supporters seek to associate training and concrete intervention.*

Institutional support aims at developing jointly managed projects, intended to promote and follow up on processes of change within organizations, based on concepts and technologies of institutional analysis and management. Thus, supporters work with groups, helping them in the process of problematizing reality, and unleashing movements that increase the ability to analyze and make interventions.[10]

Training-intervention perceives training as a practice that interferes with our worldview and how we relate to others. As such, it seeks to enable experimentation based both on problematizing reality and building forms of subjectification that provoke movements and destabilize existing ways of being in the world. It emphasizes experimentation, sharing and problematization of experiences as ways of transforming individuals and realities.[11-14]

In this sense, the training courses for NHP institutional supporters seek to associate training and concrete intervention. By analyzing rising demands from the territories, supporters who are being trained, together with local groups, formulate an Intervention Plan,[1] in which participants experience the construction and implementation of a process of interfering in healthcare practice during training.

Both institutional support and training-intervention are proposals that are coherent in relation to the

ethical-aesthetic-political paradigm. Having a clear notion of how these anti-hegemonic dimensions have become part of the trained supporters' routine and how they analyze and comprehend their realities are key to NHP sustainability.

This article has been produced based on discussions and results achieved though a multicenter evaluation study aimed at verifying the effects of the training received by institutional supporters and developed by NHP. In order to evaluate these effects, three training processes were chosen which had already been concluded when the research project was being built. It was expected that this would enable the most consolidated effects of the training process on health production in the territories to be evaluated. Courses conducted in Rio Grande do Sul, Santa Catarina and São Paulo States were selected. Standing out among the effects were the insights and experimentations of the ethical-aesthetic-political dimension (EAPD) experienced by the supporters during and after the training process, in their health practices and services.

The purpose of this article is to discuss the experiences and insights of institutional supporters trained in Santa Catarina State in 2009 regarding the ethical--aesthetic-political dimension (EAPD) of the National Health Service Humanization Policy (NHP).

Methods

This qualitative study was conducted between 2012 and 2014 and was based on fourth generation evaluative methodology, which is collaborative and formative. This methodology is characterized as research-training--intervention.

Fourth generation evaluative research covers the world of lived experience. It faces the challenge of following, researching and assessing the encounters between the different subjects involved, contributing to their demands, values, feelings, wishes and conflicts. This perspective tries to ensure an increase in the "level of ownership" the different subjects have of these aspects. Under this approach, evaluation requires the construction of a network of discussion and analysis, whereby it is understood that if evaluating means emitting a value judgment, it is necessary to take into consideration that the values and judgments express the history and worldview of both those who evaluate and those who are evaluated.[15-18]

The discussions on the supporters' insights and experiences were conducted based on frameworks supported by the ethical-aesthetic-political paradigm,[4,6] establishing a dialogue with the everyday bioethics,[19] a field in ethics dedicated to the discussion of the production of common good in healthcare and topics such as the defense of people's rights, their autonomy and empowerment.

To build this theoretical and methodological framework, strategies were chosen that aimed to achieve at the same time shared research management, researcher training and intervention in health production: the formation of Expanded Research Committees, the holding of eight workshops on research and two seminars with the supporters and other interest groups.[20] The Expanded Research Committees were inspired on the idea of the NHP Expanded Research Community (ERC), which is a mechanism created to be a space of jointly managed work, knowledge production and exchange of experiences and participation.

The sample used by this study were the 57 institutional supporters who took the course from May to December 2009 in Santa Catarina State. They were SUS workers and managers from 24 different municipalities in that State. The course was offered in partnership with the Santa Catarina State Health Department, through its Public Health School, and the Federal University of Santa Catarina (Table 1). It involved classroom activities and distance learning using the *EAD TelEduc* platform. The participants were divided into eight Health Production Units (PUs), comprised of the course students and organized into macro-region healthcare groups coordinated by a trainer/tutor.

The following strategies were used to include all the trained supporters in all stages of data collection: contact via telephone or e-mail, invitation to attend to an event in their state about institutional support in the Health System (SUS) where the study was officially launched, and invitation to all the supporters attending the event.

The data collection procedures included three stages: documental research; questionnaire administration; and focus groups and interviews.

The first stage took place from January to September 2012 and comprised documental analysis of the 57 intervention plans (IP) of the 57 supporters who had done the training course. Each IP was comprised of a report delivered at the end of the course by the supporter about the process of building their service

intervention. All the IPs were analyzed using Atlas.ti® qualitative data analysis software.

The second stage was planned considering a prior analysis of the results generated by the documental research. The electronic questionnaires were comprised of open and closed questions covering: the supporters' identification data; length of time and type of work at SUS; reasons for changing the place or type of work at SUS; evaluation of colleagues' and managers' knowledge about NHP before and after the course; intervention plan guidelines; plan implementation and effects; what was easy and what was difficult with the intervention; plan effects during and after the course; adequacy of pedagogical strategies and course management; and the changes in the relationship between the supporter and SUS after the course. The electronic questionnaires, which could be answered from October to December 2012, were available online at the FormSUS platform.

In the third stage, the guidelines for the focus groups and the semi-structured interviews were planned and organized based on prior analysis of the data from the previous stages. These were conducted in the second semester of 2013. The guidelines comprised EAPD aspects experienced by the supporters, insights about the supporter function, the network experimentation as a result of the course and experimentation of devices throughout the intervention process. In this stage the participants could analyze and "question" the initial analyses, by confirming them or providing new information and analysis perspectives to the research process. Three focus groups were held, as well as five interviews which took place when it was not possible to hold focus groups. Data was recorded in this last stage in the form of narratives. Ten supporters from four of the state's health macro-regions took part .

The body of data available for analysis at the end of the data collection process was comprised of 57 IPs, 35 answered questionnaires and eight narratives (three focus groups and five interviews). The documental analysis enabled an initial list of preliminary categories to be prepared which comprised the main topics mentioned. These preliminary categories originated the study's analysis categories, which were qualified, changed or confirmed with data obtained during later stages, via data triangulation. This resulted in eight main categories or analytical axes. Standing out among these is the EAPD category which is the focus in this study.

The process of analyzing the "EADP in SUS humanization" category involved the following sub-categories: increase in communication between the individuals, inclusion of individuals and analyzers, respect for differences, the place of power in relationships, and the production of subjectivity related to joint accountability and shared management. The acronyms "FG" for focus groups and "IP" for intervention plan were adopted to indentify the origin of representative speech found in the analysis.

The research project was submitted to the Research Ethics Committee of the Santa Catarina State Health Department and approved by Report No. 0241.3108-11, dated November 18 2011. Only after this approval and the consent of the Public Health School were the supporters invited to participate in the study. Their acceptance was voluntary and they had the right to leave the research at any of the stages, to remain anonymous, to access the research results and to participate in the Free and Informed Consent Process, as well as all the other ethical aspects mentioned in National Health Council Resolution No. 466/2012.

Results

35 of the 57 supporters who were contacted and invited answered the questionnaire. Many reasons were given for not participating, such as having left the state, having changed jobs or area, not being involved with the health area anymore, lack of availability, and problems accessing the FormSUS platform. With regard to the supporters who answered to the questionnaire, most of them had been working for more than 10 years in municipal SUS services and were graduated mostly in Nursing and Social Services. 27 Had post-graduation diplomas in the health area.

Analysis of the IPs showed that the supporters' discourse and experiences at the end of the course revealed different insights about EADP. The importance of expanding the communication level appeared at times, pointing to the need for negotiation among individuals, groups, policies and services. Such expansion – or mainstreaming – was associated with the possibility of increasing the analyses and interventions in different contexts. Expanding communication indicated one of the effects of the course, as was the perception of networking between individuals, groups, services, territories, and policies, as found in the IP of one of the supporters:

the possibility of building a bridge between two SUS

> policies became very clear to me: the Mental Health Policy and the National Humanization Policy, starting with the analysis of the workers' daily routine (...) it would be essential to dialogue with the workers groups (...) the inclusion of others in discussions is not an easy task, and SUS proposes a policy that must be built in groups, so our main challenge was thinking how we would sustain ourselves as groups (IP).

The topic of inclusion appeared referring to both individuals and also to the inclusion of conflicts, although the latter did not always appear as something that should necessarily be included in the discussion and problematized collectively.

The opinion was also observed that changes in service reality need to happen collectively, in order to include new subjects and increase the perspective of analysis and knowledge sharing. Nevertheless, difficulties with inclusion were reported by 31 of the 35 supporters whose replies to the questionnaires showed the existence of joint management during the course, but with difficulties in including some actors.

Concerning the inclusion of new actors, another insight revealed by IP data, focus groups and interviews was that there should necessarily be no dissociation between those who plan and those who execute actions.

Micro politics as a real possibility of interfering in practices and individuals was another convergence with the ethical-aesthetic-political experience observed in the narratives produced by the supporters in the focus group, as exemplified by the following testimonial "Now, they understand that they have incorporated making shared decisions: 'I've assimilated it, I'm not going to decide on my own' (FG)".

The theme of commitment and accountability appeared in the supporters discourse after analyzing their territory and work process. Commitment was perceived by the supporters from a more individual perspective, whereby a supporter convokes him or herself and other supporters to accomplish the task of changing reality, achieving commitment in which everybody's presence is indispensable, progressing to a perspective of joint accountability. During the course, this analysis gave rise to certain criticism related to situations in which responsibility is not shared.

It is important to highlight that when answering the questionnaire almost all the supporters stated that they felt "highly engaged" or "engaged" in the course. This was confirmed in the focus groups.

> Signs are sent out "convoking" the supporters... (*sic*) This evokes a collective analysis about the involvement of the participants at the time of the course (...) there were some participants (...) [who were there] at their managers' request, and did not identify with the NHP proposals and they stopped participating in the middle of the course (FG).

Notwithstanding, in the IPs this commitment was seen to be associated with working as groups in the PUs. The data taken from the questionnaire about these issues presented similar results, indicating that the supporters considered the group experience to be "strong". It is possible that the supporters' level of commitment may have influenced the intensity of the group work that happened in the PUs and vice-versa, given that we tend to defend (or fight for) things that motivate us, move us, and make sense.

In this sense, the defense of a "SUS that works" – as focused by NHP– is the expression of a certain re-enchantment with that which is concrete and belief in transformation of reality based on health system principles, including the principle of integrality. Some of the discourses show concern about how care is conducted, and the integrality of actions is pointed out as being a basic principle for healthcare.

Some IP reports showed progress concerning the defense of the right to health; however, sometimes, this defense goes no further than meeting the requirements of the law, prescribing behaviors or programming actions:

> they privileged some patients, "jumping the queue", "finding a way round things", distributing medicine without a prescription, doing requests for private exams on the SUS, without the doctor even seeing the patient. What was correct and allowed before is now incorrect and forbidden, and not practiced anymore. The "new method of working" in accordance with the law caused resistance by some users (...) however those who did not have these privileges are certainly enjoying and supporting the new form of management and appreciating the health professionals, building together a resolute and humanized service (IP).

The defense of that which is public, the defense of producing something which is common amidst differences, was associated with the idea of collective interest, which needs to be seen as a work object because of the value of its use.

> We therefore want to produce together that which is common through differences. That which is common

> reflects the consensus that allows us to operate at a given moment, but not necessarily for ever (IP).
>
> Recognizing each other as being different is very simple (...) but respecting differences is not enough, it is necessary to want differences, to want other perspectives. Looking from other perspectives enables one to change and this is enriching! Through the conversation network it is possible to make our own view more flexible. It is an individual collective construction (FG).

When the supporters literally mention the topic of ethics, there are discourses that express humanization as a consequence of ethics being incorporated in the health area, and that connect humanization to respect for autonomy and the promotion of protagonism: "As we have already mentioned, receptivity is not a space or place, but an ethical attitude and does not require the right moment or the right professional to do it (IP)".

The theme of difference – otherness, the way we deal with others – was associated with the ethical dimension by the supporters. However the theme of empathy as a condition for experiencing respect for differences and morality – the set of rules considered correct – was also cited, bringing the discussion to the field of the consequences of acting. For example: "NHP issues are directly connected to the institution's mission, that is, courage, generosity, opening the way, allowing oneself to be touched by difference in order to be different, all of this with the aim of improving SUS, which is an ethical-political priority that unites this group (IP)".

The ethical dimension also appeared in the perspective of the conflicts faced by the supporter when experiencing this function. The analysis (of implication) of the position of power held by the supporter in mesh of institutional forces appears when reflecting about ethics , as can be seen in this testimonial: "Some notions formed as a result of the NHP course provided the opportunity of analyzing institutional and political power relations reverberating in supporters' ethical--political posture and view. These effects gave rise to some personal conflicts (GF)".

With regard to the way the supporters experienced EAPD, the term "ethics" was found to appear frequently in their intervention plans. In general it referred to situations that were morally reprehensible. This could be an indication of the understanding of humanization based on symptom-concept – for example, in the case of supporters who "take" humanization to others. This is a deontological and moralizing conception of ethics, which prescribes rules of conduct and behavior, in opposition to the conception of ethics as a reflection about morality. For example: "The other team members reported that many health workers did not have ethical attitudes appropriate for working in a Health Center and their roles when receiving service users and the attitude required (...) [of a] health professional needed to be reexamined (IP)".

At times, a possible break away by the supporters from the concept of humanization based on from the ideal of being human can be seen. This appears to be an important factor of analysis of the training process, given that on the other hand in some of their discourses the supporters see themselves in a relatively central position within SUS and responsible for system changes. This may indicate a process of capture, whereby the support function is connected to a certain notion of militancy. NHP is "the" way. And how can one "escape" from this subjectivity? By being a "Messiah-trainer", who has control over all their actions, including that of educating "good" supporters? In this sense, in the same way that the term humanization is a paradox, the ethical dimension should also be analyzed from the point of view of a paradox, and not as a contradiction or a Manichean way of evaluating practices.

> "We don't know how to experiment new things.. there needs to be a driving force", says the supporter, referring to the function of an omnipotent and omnipresent individual, capable of "motivating" a group or people. The focus, apparently, is on the figure of an actor and not a group, as a supporter capable of solving problems and pointing ways out (FG).

The supporters experienced two forms of experimentation during the course: one of them was the discussion about sharing power and management methods in the course itself; whilst simultaneously facing a reality contrary to sharing decision making in municipal management spaces. Here they were raising the issue of power concentration and challenges to institutional democratization, together with criticism of traditional management models.

Some discourses take the production of subjectivity as a topic that deserves to be problematized, attaching it to the possibility of shared management, joint accountability and production of protagonism, as in this example: "It is easy to keep the status quo. The hard part is our awareness that change must begin with us! (IP)".

Table 1 – Summary of the institutional supporters' training process in Santa Catarina, 2009

Characteristics	Institutional supporters' training course in Santa Catarina
Type of course	Professional development
Targets	To train 60 institutional supporters
Partnerships	Ministry of Health/National Humanization Policy (MS/PNH) Santa Catarina State Health Department (SES/SC)/School of Public Health Federal University of Santa Catarina (UFSC)
Funding	MS/PNH (80%) SES/SC (20%)
Course period	May to December 2009
No. of hours	230h
Health Production Units (PUs)	Eight PUs distributed in the state macro-regions
Final results	• 57 supporters trained • 28 Santa Catarina municipalities and 1 from Paraná State • 57 interventions in management practices and healthcare • Two health regional administrations of SES/SC • 24 municipal health departments • 12 hospitals • 38 PUs meetings, with the participation of the National Health System (SUS) workers and managers • Consolidation of inter-institutional partnership between MS, SES/SC and UFSC

Source: Adapted from Paulon *et al.*, 2014.[20]

With regard to the topic of joint accountability, although this may derive from an ethical position that prioritizes sharing, collective actions and inclusion, it is important to highlight that joint accountability was not necessarily connected to this dimension in the supporters' discourse.

Discussion

Generally speaking, the supporters' discourse on humanization associates EAPD with a set of attitudes, principles and values that guide reflection and daily actions in health services and SUS more broadly. At the same time, it associates EAPD with the destabilization of existing powers through democratization of power relations. Both conceptions contain ethical and political elements.

Berlinguer[15] affirms that the condition that makes it possible for individuals to move from passiveness to protagonism is the exercise of participation and sharing in the development of abilities that enable a population's wealth to be converted into actions that promote health. The attention paid by the supporters to topics like the power sharing points in this direction, as does their concern about the ethical intentionality that drives their thoughts and daily tasks. This is related to one of the biggest challenges facing SUS: building an agenda that emphasizes care and shared accountability.

In NHP inclusion takes on an ethical-aesthetic--political sense, because based on differences and unpheaval they produce, efforts are made to build a common plan that does not despise individuals and their concrete experiences of life and is not centralized around any particular polarity, but rather agreements are made that allow work aimed at a common cause and the common good.[21]

Continuing from the perspective of the course perspective as something that triggers action but does not end the continuous process of the supporters' training, some ethical conceptions that sometimes make assertions about the common good can be observed, divided into rights and duties. A logic that is moralizing and delimits truth and judgments appears in these concepts, related to moral aspects – those that produce conduct restraints –, and not what has been referred to as ethics here: an individual practice, through which self transformation is pursued.[22]

As such, one of the reasons for evaluating these processes is to build a narrative that provides hints on triggering experimentation of care of the self, the ethical-aesthetic-political exercise intended to produce new positions regarding SUS and one's understanding of life. There were some signs of this repositioning in the questionnaires, and all 35 supporters' answers pointed to them having changed in their relationship with SUS because of the course.

The conception of the ethical dimension as being that which is subjective and relational – the links between health professionals and service users – is frequent in academic productions and can be observed in the discourse of some of the supporters. As Heckert *et al*.[23] point out, from this point of view ethics can be perceived as a dimension with no political content, reduced to the intersubjective/interpersonal and private-intimate level.

In turn, Machado and Lavrador[24] affirm that when we move away from intolerance and indifference to that which is different, we become closer to ethics, which necessarily implies self-analysis and a critical view concerning moral prescriptions, considering the power games involved in each situation. This way, the ethical perspective would involve "care of the self" that happens when individuals are open to tenderness and sensitivity. The expression "care of the self" was first used by Michel Foucault to refer to a complex notion adopted by the Greeks that meant a set of related attitudes, practices and actions that had in common the act of turning to oneself –converting to oneself –, a search for establishing a relationship of probity between actions and thoughts. In care of the self, the right action, according to true principles, is what leads the individual to measure their progress in building an ethically correct self, to be sought within themselves:

> thinking about ethics, intervening ethically, is to think/intervene, above all, about ourselves, about life, about living. It is the political potential of the expansion of social networks through the ethical exercise of "care of the self" in its aesthetic ability to invent other possibilities in life, expanding norms, changing the status quo. In other words, it is continuous resistance to all naturalized ways of survival.[20]

With regard to the notions of joint accountability and their inclusion as important elements in the ethical dimension, Oliveira[25] says that it is the relation of support that prepares the supporter, in the ethical sense of releasing active forces and "taking care so that reactive forces are not used for fear and war, but are operated with prudence in relationships". The production of new subjectiveness, based on solidarity and equity, foresees the inclusion of individuals, groups and social analyzers expressed during crises and upheavals, allowing the individuals to face what is out of place about them, and which are capable of leading them to subjective repositioning and finding new forms of being.[26]

Individuals are produced in the encounter of forces and in processes. For this reason, information and the acquisition of technical-scientific knowledge *per si* do not result in changes in practices, so that training actions are needed which problematize healthcare practices and work processes.

The values that guide NHP, such as autonomy and individual protagonism, including joint accountability, solidarity in the bonds that are formed, defense of users' rights and collective participation in the management process, among others, are coherent with EADP and aim to make this paradigm a reality in the context of health production and SUS, as observed in the supporters' insights.

Inseparability between these dimensions has been analyzed by authors such as Campos[27] and Ayres.[28] While Campos considers the NHP humanization proposal to be primarily political, because it increases the health agenda in Brazil, Ayres sees in this proposal a way of ensuring ethics in the construction of SUS. The focus of political challenges must be on cultivating ethics which emancipate individuals, through the acknowledgment of the centrality of this word and the dignity of dialogue, as means of shared construction among individuals who have all the right to universal, equitable and complete healthcare.[28]

It is important to mention that the time difference in the data production was considered when discussing the results, by identifying the different sources and the way they dialogue with the contents of the IPs – relativizing , denying, or confirming them. The option was made to analyze insights and experiences of supporters' only from Santa Catarina State because, although the pedagogical-political analysis in all the three states was initially the same, the courses took on singular characteristics as they developed.[20]

Together with operational aspects of the traditional paradigms found in training courses and which are necessary as a strategy for courses being feasible, nevertheless there were some ways of escaping from this that enabled the inclusion of the ethical-aesthetic-political paradigm owing to the singular experimentation that these supporters performed on the pedagogical strategies. The value of using this form of training moves towards increased ability to analyze and intervene in both oneself and reality. These changes, key to triggering social change, are possible when they intend to create a plan for experimenting the production of driving

forces that generate and include new ways of doing things and new individuals. As such training acquires an ethical-political sense, because it does not intend to include in order to manipulate or soften individuals and relations. On the contrary, by using the differences and the upheavals they produce [, it intends] to build a common plan (...) as a provisory synthesis, as an agreement that allows us to act for a common cause, for the common good.[30]

A conception of training that promotes alternatives to concrete problems, based on critical reflection on how others are included in relations and that has institutional democracy as an objective, is particularly relevant to lever changes in the SUS healthcare model.

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Authors' Contributions

Verdi M participated in the study conception and design, data analysis and critical review of the intellectual content.

Verdi M and Finkler M participated in the study conception and design, collection and data analysis, and the article drafting.

All the authors have approved the final version of the manuscript and are responsible for all the work aspects, ensuring its accuracy and integrity.

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