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# Nutritional education groups in two contexts in Latin America: São Paulo and Bogotá

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This study compared nutritional education groups regarding their theoretical and practical dimensions, within primary health care, between São Paulo and Bogotá. A descriptive study was conducted in stages: identification of the professionals; characterization of educational groups; identification of social representations about nutritional education; and comparison of the linkage between theory and practice in the groups, per city. Through interviews with 54 nutritionists 17 central ideas were identified, which were classified into thematic axes that related to the groups. In both contexts, the importance of participant empowerment was highlighted, with similarities in the profile of actions, but with differentiation of the mediators' autonomy. It was found that the theory/practice of the groups was in transition from the traditional to a more humanistic approach. However, this was at a slow speed, compared with healthcare policies and needs.

Keywords: Primary Health Care. Health Education. Food and nutritional education. Educational groups.

## Introduction

Health promotion (HP) is a strategy which is being propagated throughout the world to face the many health problems which affect populations[1]. It is recommended that this should be regarded as a process of the empowerment of the community, in the quest for the improvement of their quality of life and health, and that it should mainly be undertaken under the aegis of Primary Health Care (PHC). Thus, countries of South America such as Brazil and Colombia, characterized by social inequality and iniquity, are presently to be found at a moment of the strengthening of PHC[2].

In Brazil, the United Health System (UHS) (*Sistema Único de Saúde - SUS*) possesses a privileged PHC scenario for PH named the Family Health Strategy (FHS) (*Estratégia Saúde da*

*Família - ESF*), which foresees the placing of a multiprofessional team in the Basic Health Units (BHU) (*Unidades Básicas de Saúde - UBS*). In 2008, for the purpose of reinforcing the FHS, Nucleuses of Support for Family Health (NSFH) (*Núcleos de Apoio à Saúde da Família - NASF*) were created and these count on professional personnel from the different areas of knowledge to support and expand FHS actions[3,4]. On the other hand, in Colombia, the health system, denominated the General System of Social Security in Health (S*istema General de Seguridad Social en Salud)*, consists of both private and public services, while the PHC, known as the Collective Intervention Plan (CIP) (*Plan de Intervenciones Colectivas - PIC*) is free of charge for the population[5].

With a view to meeting the demands of the PHC, a recognized practice of HP are the educational groups which provide the opportunity for discussion between individuals as to the way in which they can overcome their difficulties and live more harmoniously with their health conditions. Their growing use has been observed and they are ever more frequently described in academic studies and stimulated by public health policies[6,7].

The metropolises of São Paulo (Brazil) e Bogotá (Colombia), both economic centers, are of similar demographic profile because they have both registered increases in the rates of non-transmissible chronic diseases, which calls for actions for the prevention and treatment of diseases and for HP[8].

São Paulo is at the present time the city which possesses the greatest number of FHS and NSFH teams in the country, and it was ascertained that in 2010 the nutritionists of these teams possessed the most active educational groups[9]. In Bogotá, on the other hand, due to the lack of a national PHC policy, the District Health Secretariat (DHS) (*Secretaria Distrital de Salud - SDS*) developed Promotional Strategy of Quality of Life and Health (*La Estrategia Promocional de Calidad de Vida y Salud)*, in 2005, whose actions are undertaken by multiprofessional teams, each of which includes a nutritionist. Recently the national government took over the PHC as its central strategy in the reorganization of the system in which the CIP act. Since then, as has happened in Brazil, this level of health care has been considered in the light of the logic of territorialization, in the attempt to bring the professional staff closer to the population, as well as having a HP focus[10,11].

This present study brought together the same practice, i.e. the educational groups, in the two different countries with similar public health problems, but of different magnitudes as regards contexts, histories and the development of health systems. This study provided elements for discussion on the contents of HP, PHC and Health Education which are now in a stage of the strengthening of the localities, both in the practical as in the theoretical dimension. Studies which contrast these dimensions make it possible the reflection on the knowledge and perception of the theoretical reference of health professionals and its impact on the practical daily work. Thus this article has as its objective a comparison of the educational groups which work on feeding and

nutrition in both their theoretical and practical dimensions, within the PHC, as between São Paulo (Brazil) and Bogotá (Colombia).

## Methodology

This is a descriptive research project which used the comparative method to classify the characteristics of the educational groups in the cities, São Paulo and Bogotá, to explain the similarities and the differences which the processes of articulation between theory and practice of distinct social contexts present[12].

The data collection took place in three distinct moments: (1) the mapping of the professional personnel; (2) the application of a questionnaire for the characterization of the professional personnel and of the educational groups, and (3) an interview on Nutrition Education (NE). The process took place during the period from July to December 2012, first in Bogotá and later in São Paulo. The pilot test of the instruments and their transcultural translation had been undertaken previously[13].

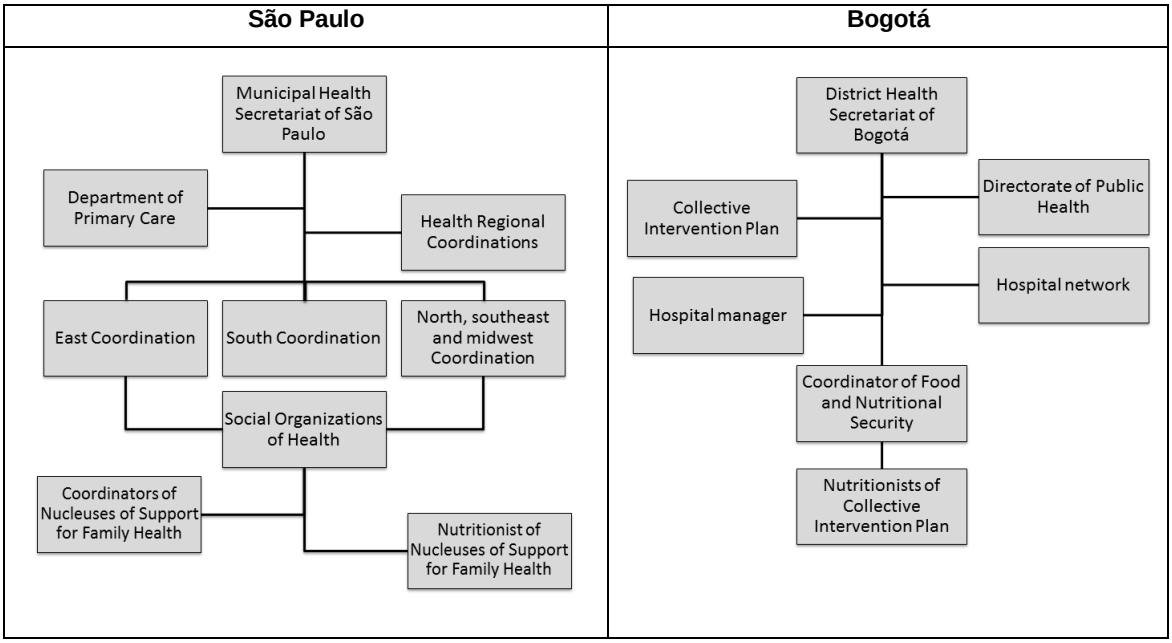
The data collected on the characteristics of the educational groups were considered to represent the practical dimension while the perceptions of the participants in NE in parallel with the theoretical references of the public policies which cover the field in the two countries, such as the Reference of Eating and Nutritional Education for Public Policies[14] (*Referência de Educação Alimentar e Nutricional para as Políticas Públicas*) and the Eating Guides[15] (*Guías Alimentarias)* were taken as theoretical.

The study population was composed of nutritionists, educational group mediators of both São Paulo and Bogotá, who acted in PHC. The nutritionist was chosen in view of the recognition of the importance of the Nutrition Education field within the HP. The mapping was elaborated on the basis of the information given by key informants in: São Paulo, by the Social Health Organizations [(e)] and, in Bogotá, by the DHS. In view of the voluntary participation, the professionals were selected according to the organizational structure of the voluntary participation programs of the cities presented in Figure 1. A total of 27 nutritionists were identified in each of the two cities.

For the practical dimension, the online questionnaire "Identification of the Nutritional Education Groups", by Google docs, was applied. The questionnaire called for information on sex, age, training, time in present position and work activities. Of the 54 participants in the research project, 42 replied to the questionnaire, 18 from São Paulo and 24 from Bogotá. For the

[(e)] The management of the health units of the state of São Paulo is characterized by acting in partnership with Social Organizations of Health which are non-profit making private sector institutions which collaborate in a complementary way with a view to the consolidation of UHS.

**Figure 1.** Flowchart traveled for mapping the location of nutritionists who work in Primary Health Care in São Paulo and Bogotá, 2012.




characterization of the groups, name, type of group (open or closed), population, number of participants, place, frequency of the action, professional personnel involved, themes addressed, and material and/or equipment used were identified. For the analysis of the groups by convention, the first group described by each professional, which contained all the information requested, was selected. The arithmetical averages of age, length of training and time in present position were calculated.

As for the theoretical dimension, an interview was held by a previously trained researcher, who used the question: What does Nutritional Education mean to you? The interviews were held at the workplace and were recorded and transcribed by the researchers. The Collective Subject Discourse (*Discurso do Sujeito Coletivo - DSC*), a technique based on the theory of social representations which consists of selecting, out of each individual testimony, the key expressions which are the most meaningful passages of a reply, was used to analyze the responses. These key expressions represent the Central Ideas (CI) which summarize the discursive content and are then used to construct synthetic discourses, in the first person singular, which constitute the DSC which seeks to express the thought of a group. Thus were undertaken the stages: analysis and extraction of the CI of each testimony; the linking of the Central Ideas, and the formulation of the discourses properly so called. Then the data were categorized by means of the units of the texts which were repeated, which were grouped and classified in themes and named using part of the discourses[16].

For the comparison, the segmentation of the data was obtained by city, and the findings compared and contextualized within the respective perspectives of Health Education, Nutrition

Education, educational group and the context of Primary Health Care in the two cities. For the presentation of the findings, an attempt was made to construct a parallel to the theoretical dimension, comparing the perceptions found in the interviews with the practice and the characteristics of the groups described in the questionnaire.

For convenience, the letters "S" and "B" were adopted to designate São Paulo and Bogotá, respectively, in the identification of the discourses. This research paper is part of the study "Nutritional Education in Primary Health Care", accepted by the District Health Secretariat of Bogotá and approved by the respective Ethics Committees of the Municipal Health Secretariat of São Pauloand of the School of Public Health of the University of São Paulo.

## Results and discussion

Similar characteristics were found among the professional personnel as regards sex, age, length of training and tenure of position. A noteworthy difference relates to professional qualifications for, while all those interviewed in São Paulo possessed at least one post-graduate course, in Bogotá, on the other hand, only 25.0% had this level of preparation. It may be suggested that this difference is a consequence of the pattern of the work market, seeing that in São Paulo there are 19 graduate courses in nutrition for a population of 10.434,252 inhabitants[17,18], whereas in Bogotá there are two courses for a population of 7.363,782[19,20]. Thus, as a result of the greater number of professional personnel trained in São Paulo, these often find it necessary to specialize to obtain leading positions in the work market.

Of the 18 participants in São Paulo, only four had chosen to specialize in their present field of activity while the majority had sought courses in the field of clinical nutrition such as "Functional Nutrition", "Nutritional Therapy, Obesity and Slimming", differently from their Colombian colleagues.

A similarity was found in the description of work activities, as the most often quoted was the leadership of educational groups, indicating that this function is chosen because of the advantages obtained as compared with those offered by individual care: it favors communication between the actors and promotes the meeting with like professionals in the formation of social networks and the encouragement of autonomy[6,7].

### Theoretical dimension and the practice of the educational groups in Nutrition

As a result of the interviews, theoretical dimension, 17 distinct Central Ideas were found, classified in six themes (Chart 1). These themes were related to the practical characteristics of the educational groups described, presented below.

**Chart 1.** Classification of Central Ideas by theme, according to the perception of those interviewed about nutrition education, in São Paulo and Bogotá, 2012.

| Themes | São Paulo | Bogotá |
|---|---|---|
| They exist to transmit knowledge | IC-S1 – It consists of the transmission of knowledge to the population (n=7) | IC-B1 – It provides the population with knowledge (n=10) |
| *It provides patterns of healthy eating* | IC-S2 – It seeks to bring about changes in people's eating habits (n= 8)<br>IC-S8 – It attempts to make people aware of healthy eating (n=3) | IC-B2 – It is a process that promotes dietary change (n=11) |
| *It is a space for the negotiation of the eating habit* | IC-S3 – It attempts to educate in accordance with the person's real life situation (n=8) | IC-B6 – It provides changes in view of the multiple causes of food (n=2) |
| *It is a process of exchange* | IC-S7 – It is an exchange of knowledge between the educator and the learner (n=4) | IC-B3 – It attempts to construct collective knowledge (n=2) |
| *It gives autonomy of choice* | IC-S4 – It is a long term, continuous process (n=6)<br>IC-S6 – It gives autonomy to the individual (n=3)<br>IC-S10 – It generates multipliers on healthy eating (n=1) | - |
| *How? When?* | IC-S5 – It is a tool for preventing diseases (n= 8)<br>IC-S9 – It seeks to educate using game resources (n=2) | IC-B4 - Techniques used to work with the population (n=2)<br>IC-B5 – It provides felt motivation (n=1)<br>IC-B7 – It works with the community in a practical way(n=1) |

**They exist to transmit knowledge**

Those interviewed in the two cities indicated the importance of knowledge, especially scientific knowledge, as appears here: "They exist to transmit knowledge about the consumption of foodstuffs, the way in which they should be consumed, the way in which they should be cleaned [...]" (DSC-B1). This approach is based on the idea that there is someone who knows and someone who does not know. The logic is that of the transmission of knowledge on the presumption that the other will change his behavior by reason of what he has been taught[1]. Studies question this approach because they show that human behavior is influenced by a variety of factors – physiological, psychological, social and environmental. Further, experiments have concluded that it is efficient in increasing knowledge but, with rare exceptions, is insufficient to change practice[21, 22].

However, it has been ascertained that Colombian public policies mention that the increase in an individual's knowledge does, in fact, favor changes in his choice of foodstuffs, thus corroborating this latter finding. Differently from Brazil which puts the emphasis on the importance of giving value to the participants' prior knowledge, however, this same approach was encouraged

by the health services[14,15]. Thus a historical component was discerned in the conception of the Brazilian participants.

Apart from the value given to scientific knowledge, there exists, in practice, a demand that the professional needs to meet because his availability in terms of time may interfere with the shape and size of the group. The groups described were similar in this aspect. In São Paulo, groups with from 7 to 55 participants were mentioned and, in Bogotá, groups of from 5 to 55. This characteristic may affect the educational process, because it suggests that the larger groups tend to transmit knowledge, because the emotional exchanges between the members are more superficial.

**They are standards of healthy feeding**

Those interviewed in both cities recognize that NE is a practice whose essence resides in producing a change of behavior: "To my mind, the first paradigm that I had to eradicate from my community groups was that we do not teach nutrition, because nutrition is a science which doctors, nurses and nutritionists have to learn; what we teach are practices of healthy eating [...]" (DSC-B2). It is understood that this perception goes against the behaviorist approach of Health Promotion, which understands that the human being is a product of the environment in which he experiences constantly, in all the stages of his life, three events: stimulus, response and reinforcement[23]. Thus it is observed that educating, in accordance with this perception, consists of the professional's disseminating standards of healthy eating, possibly regardless of the local situation and individual peculiarities.

Further, within this thematic axis, São Paulo presented the perception of NE as a process of awareness: "What is it then that you have to create an awareness of? [...] the importance of your having healthy eating, the benefits you can enjoy and then you quote the benefits and the negative effects, so then you can create an awareness in many folk [...]**"** (DSC-S8). The behaviorism of PH and awareness are linked to the history of Health Education which was based on the recommendation of right and wrong behavior, once again dominated by the idea of scientific power[24].

Within this theme, one holds the individual as responsible for his own health, seeing that the professional expounds the correct behavior, offering the individual the option of obeying or not. Here, according to Gazzinelli et al.[24], 'there is always an external agent which causes disease and which must be combated like an 'enemy', whether it be sugar, diabetes, salt, fats, no relation being made with other factors involved in the health-disease process, such as society, social and health inequalities, which are stated as being of the essence of NE by the public policies of the two countries'[14,15].

As has been observed in this present study, educational practices in health employed on historical occasions never disappear completely. This does not mean that they should not be taken into consideration but rather that one is here dealing with the need to: "[...] ask whether these representations are sufficiently inclusive to absorb the challenge presented to education in

contemporary societies or if they can contribute to increasing the vulnerability lived by people who do not include themselves in their descriptions"[22] (p. 1340).

One of the present challenges to the practice in both cities is the increase in the prevalence of non-transmissible chronic diseases. The groups described in São Paulo are related to such diseases, especially obesity, indicated by the names – "lose to gain", "healthy slimming", "weights and measures", "tightening your belt", "the right measure", among others. On the other hand, in Bogotá, less restricted names are given, such as *"tú vales"* and *"muévete comunidad",* which are names of the District Health Secretariat programs. They are thus different from the names given to the groups in São Paulo which are given by the health professionals and/or participants, as well as reflecting the focus of Health Promotion[11].

The characteristics of the groups, including their names and respective populations, can exercise an influence on the kind of approach used for the education concerned. It is further suggested that the theme here discussed should be taken up more frequently in groups of homogeneous population, as is found in those of São Paulo. Seeing that "the diagnosis of a disease is always based on a universalizing principle, generalizable to everybody, that is to say, it presupposes regularity and results in equality"[25], alluding to the tendency to ignore individual characteristics. As regards the population which the groups seek to serve, they were found to be alike, seeing that in both cities the elderly were the most frequently referred to.

**A space for the negotiation of the eating habit**

This theme emphasizes the importance of taking into consideration the experiences and knowledge of those participating in the action, emphasized in the public policies of both places[14,15]. In this sense there was similarity in the DSC: "NE [...] is a space for negotiating the eating habits of an individual, a population, but in accordance with their context, its cultural aspect, its economic aspect, well, this whole series of situations which in some way establish the people's eating patterns and how you can modify or reorganize their eating in accordance with what they have lived" (DSC-B6). This discourse tends to the humanistic approach to Health Promotion which has the concept that the human being is his own architect. Knowledge rests on individual subjective experience and becomes concrete on the basis of his personal interpretation and of his relationships with self-fulfilling, flexible and creatively adaptable people[23].

The importance of having an ear qualified to recognize and involve experiences and knowledge in the educational process is brought out. This process can be expanded in the presence of more than one professional in the action, seeing that different professionals have different views of care. In this regard a similarity in the findings was perceived, because both the cities possessed either the exclusive mediation of the person interviewed or shared it with other mediators. In São Paulo, the most quoted were: PE instructor, psychologist, physiotherapist, and assistant nurse. In Bogotá, on the other hand, they were: social welfare worker, psychologist, physiotherapist and educational agent.

Another important item of a humanistic educational practice of HP is the place used, because it suggests that the education can be favored when it takes place somewhere where the people concerned live and relate to each other, due to the proximity to their life situation. In this study a difference was found between the cities. Whereas São Paulo emphasized the Basic Health Units, Bogotá highlighted social institutions such as the *salão comunal* (community space), churches and schools. It is suggested that this may be a consequence of the difference in work modalities, because the NSFH guidelines oblige them to be close to family health teams which, in their turn, are located in the Basic Health Units[4]. In Bogotá, the professional staff of the Collective Intervention Plan is favored because their activity takes place in the spaces of the people's daily life, classified as family, community, work and institutional[10].

**Process of exchange**

A similarity was discovered in the perception of the Brazilians and the Colombians interviewed, as one discovered that NE was given value as a more inclusive education: "I understand it as a process of exchange, of the theoretical knowledge of the nutrition professional for the knowledge of life of the user, of the patient who's in the group. I think that Nutrition Education only takes place when both sides are open to it [...]" (DSC-S7). This approach, also seen in the theoretical references in the two contexts[14, 15] is similar, according to Barker & Swift[21], to the social cognition model which is based on the collective construction of a new learning founded on the knowledge, attitudes and beliefs of the participants and these, in their turn, are influenced "[...] by the collective experience, by the fragments of the scientific theories and of school knowledge, modified to serve daily life"[24] (p. 202).

The collective construction is, in practice, directly related to the themes addressed in the meetings, seeing that they may or not be constructed between professionals and participants. In this aspect, the São Paulo groups presented themes such as: the food pyramid, helpings of food, the fractioning of the diet, reading of labels, fashionable diets, culinary workshop and space for themes suggested by the participants. In Bogotá: healthy eating, basic concepts of feeding and nutrition, hygiene and the handling of food, fruit and vegetables, eating by age group and adjusted for the family, food labels, the food train, eating and nutritional safety and the right to eat.

It is suggested that the difference of the themes adopted as between the two countries may be due to the difference in work proposals, because the professionals of the NSFH are instructed to undertake actions which promote healthy eating, the opportunity being given, either for the professionals or the participants, to choose the themes and confirm the final choice[4]. It is presupposed that the characteristics of the São Paulo groups, including the themes, are influenced by the experience and the training of the professionals concerned. However, recalling that the majority are specialists in the field of clinical nutrition, it is suggested that care be taken to ensure that scientific knowledge should not predominate in the development of the action because,

according to Campos as quoted by Ribeiro, Pires & Blank[26], excessive specialization creates, legitimizes and fragments care.

On the other hand, in Bogotá, it was observed that the themes quoted belong to the program guides, mainly to those of *"tú vales"* and *"muévete comunidad"*. Both these programs use the methodology of actions based on the community, making use of information, communication, education and social action as an approach, presented by the District Health Secretariat as a new proposal for health care for Latin America[27]. The former has as its intention the encouragement of the consumption of fruit and vegetables, the practice of physical activity and the reduction of the smoking habit, while the latter takes physical activity as its focus[11]. Thus the members of the Bogotá groups have less autonomy in their choice of themes than do those of São Paulo.

**To have autonomy of choice**

As regards the posture of the groups' participants, São Paulo stood out as presenting the perception of NE as a stimulus to autonomy: "For me Nutrition Education is your having the opportunity to capacitate or pass this education on to the other so that they have the tools, are autonomous, so as to have autonomy of choice [...] "(DSC-S6).

The definition of autonomy is close to that of empowerment as it relates to the ability of the individual and the group to decide about the questions that affect them in their many spheres of life including health, politics, economics, social and cultural life, mobilizing them so they perceive themselves to be an integral part of the collectivity. This approach approximates to that of Popular Health Education (PHE) (*Educação Popular em Saúde - EPS*), conceived both as a philosophy and a methodology of education[28] which "seeks to work on the human being and the groups involved pedagogically [...] in such a way as to promote the growth of the ability to exercise critical analysis as to reality and the perfecting of strategies of struggle and confrontation"[29].

In accordance with Vasconcelos[29], basing his references on Brazilian public health policies, PHE seeks the rupture of authoritarian and normalizing education, a still deeply-rooted concept - as is seen in this study, because "instead of seeking to disseminate concepts and behavior considered correct, it seeks to raise problems, in open discussion, which are bothering and oppressing the actors", and suggest solutions. The author states that the PHE is an innovating and pioneering element in health, being considered a Latin American way of doing Health Promotion.

However, despite its theoretical recognition, there are difficulties in incorporating it in practice - due to institutional complexity - such as the heavy burden of disease, of social life, such as the incentives to consumption and to individualism, apart from the difficulty involved in the dialog between the professional and the population due to the existence of cultural barriers and the distance from the authorities caused by power inequality[30].

The Bogotá DHS recommends that the professional personnel should encourage the autonomy of the community, with the articulation of scientific and popular knowledge, for the

construction of a better quality of life. This recommendation is present in the programs[31], although it was not to be found in the discourse analyzed. This finding corroborates that of a study undertaken with 34 nutritionists, in Medellín, the purpose of which was to explore their perception of the role of the popular knowledge of eating and it was discovered that the professionals recognize its importance although with the sense of exploiting it and removing it from the population as it is not scientific knowledge[32].

It is suggested that the difference of the findings as between the two cities arises from the leading role that Brazil plays in PHE, as it has enjoyed a position of leadership in the methodological systematization of the work of the author Paulo Freire. Due to its importance in the country, the National Policy of Popular Health Education (*Política Nacional de Educação Popular em Saúde*) has recently been approved for the purpose of strengthening popular advocacy of the care offered by UHS and its administration[4,33].

PHE gives the opportunity to construct/develop personal and social abilities, one of them being the development of the figure of multiplier in the community[34]. From this point of view, São Paulo again stood out with the discourse: "It is in a certain way their also being multipliers, then they will act not only in the group but also at home and at events" (DSC-S10). Though this perception was not brought out in the discourse of those interviewed in Bogotá, the programs *"tú vales"* and *"muévete comunidad"* include in their methodology the provision of educational materials such as primers, financed by the District Health Secretariat, for the participants so they will become multipliers in the community[11].

A revision undertaken by Wiggins[28] indicated that PHE seeks improvements in PH, a change of behavior, knowledge of health and transformations in health and eating safety. However, it is a long-term method as it implies a long process of reflection-transformation. From this point of view, one found in São Paulo: "I think that Nutrition Education is something that penetrates the mind gradually and that has the effect of changing eating habits throughout life, so it is a somewhat lengthy period [...]" (DSC-S3).

Because it is a long, continuous method, a basic consideration regarding the practice of groups is the duration and frequency of their meetings, as to whether they provide the time sufficient to produce this long-term effect. In São Paulo, the groups analyzed hold fortnightly and monthly meetings lasting from half an hour to two hours on from six to an undetermined number of occasions, the majority of them being described as open groups. On the other hand, the Bogotá groups hold their meetings with from weekly to monthly frequency, lasting from one to four hours with from one to ten encounters per group, all of which are classified as closed.

This difference is once again a consequence of the programs adopted. In Bogotá, the DHS gives guidance as to the organization of the groups at four moments; preparation of the program with the population, identification of needs, undertaking of the action with a pre-established number of encounters and assessment[11]. On the other hand, in São Paulo, there is no fixed guidance for the practice, it being the responsibility of the professional concerned to decide on

such characteristics. Both findings are questionable in the light of the proposal of this present approach, seeing that in Bogotá the number of meetings is small for such an educational process and in São Paulo the open groups may hinder the integration of the members and, consequently, the construction of the educational process.

**How? When?**

Those interviewed both in São Paulo and Bogotá raised the importance of how NE should be undertaken, differentiating it from the themes already quoted which indicated the theoretical approach to education. Thus, in Bogotá, NE was differentiated as it was recognized as a pedagogical strategy: "For me they are the pedagogical strategies used to teach the community eating and healthy nutrition" (DSC-B4). It also arose as a tool to trigger changes in eating habits: "[...] This is the part of education in eating that has a component which awakens interest and also a felt motivation" (DSC-B5). Further, in the same city, the practice was emphasized as being of the essence of the educational process: "It is to educate the community in what? How? When? About eating, not in a theoretical way but a very practical one" (DSC-B7).

São Paulo stood out in its perception of NE as a strategy for the prevention of disease: "[...] it is a great tool we have in our hands for the prevention of diseases" (DSC-S5). Here one returns to one of the principles of PHC – the promotion of health. However, as has been affirmed by Chiesa et al.[35], there is a difficulty in the operationalization of actions which promote health services, one of the motives being the lack of understanding on the part of the professional personnel with regard to the concept as they often reduce it to the prevention of diseases, as has been found in this research project.

In the field, various practical strategies can be used to favor the participation of all the actors in a group. Thus São Paulo presented a concern about the educational materials: "[...] and there are the difficulties which we end up by facing - isn't it true? - which do not depend much on us, but I think we really manage to make the difference, even though you may not have that material of your dreams, that alimentary pyramid which you wanted" (DSC-S9).

Although the discourses were different as regards content, it was observed that the perceptions focus on the practice, which might be related to the use of material resources and/or equipment. In the groups described it was ascertained that in São Paulo the most cited were the video tapes, the food pyramid, photos or figures of foodstuffs, leaflets, food wrappings and slides. In Bogotá, on the other hand, they were the posters, food train, videos, slides, raw foodstuffs, photos and figures of foodstuffs and educational primers of the programs. The similarity in the use of pictorial representations of recommendations of food consumption, the food pyramid and the food train is noteworthy as is also the differential of Bogotá on account of the provision of educational material by the DHS, demonstrating the institutional support in the form of resources for the development of the groups. The use of such strategies might well favor the action, as has been verified in experiences with the use of videos[36] and leaflets[37].

**Final considerations**

It was possible to verify similarities and differences between São Paulo and Bogotá as regards the relation theory/practice of the groups of Nutrition Education. It is considered that the themes presented are permeable, though it is believed that there is a preponderance of one approach over the other in educational action.

The difference in the degree of autonomy of those interviewed is noteworthy, this being a possible consequence of the respective public health policies. In São Paulo, these permit greater flexibility in the choice of the characteristics of the groups and the approaches adopted, thus, the experience and knowledge of the professional responsible are indicated as influential factors, and they may be close to the Health Promotion view, such as that of the Popular Health Education found - or otherwise, as in the case of other historical perspectives also identified. In Bogotá, on the other hand, despite the public policies indicating a more inclusive care, the programs restrict professional autonomy, making the articulation of the needs felt and manifested during the educational process of the group impossible.

The study contrasted the theoretical dimension and its impact on the practice of work and it is suggested that São Paulo stands out in relation to Bogotá in the theoretical dimension due to the recognition of the stimulus of autonomy and of the multiplier, indicating an advance in facing up to the complexity of primary care. However, due to the findings of the practical dimension, one questions whether the recognition of these subjectivities guarantees new ways of producing health.

One understands that there exist multiple obstacles which professionals face in their day-to-day work which they need to overcome in order to break away from present-day health care logic. However, it is evident that the two cities, within their respective health policy contexts, possess potential within the actions which promote collective health, associated with popular wisdom, which need to be given their full value and institutionally strengthened. Because it is believed that by means of political, economic and administrative support, the ideology of total care may be disseminated in other spaces and thus attain its true value.

As for the groups, a wide variety of the necessary characteristics was observed in both places. It is understood that some of those characteristics - meetings in the territories, number of participants, shared mediation, closed groups and use of educational material - may favor group education. Beyond those characteristics, it is recommended that the objective of the group and the role of the actors involved be explored because the formulation and planning of these items may determine the type of approach to be adopted. The role of the professional here suggested is that of mediating the learning of the participants and that these latter, in their turn, be producers of new subjectivities.

It is concluded that the practices and perceptions of the professionals are at a moment of transition from traditional approach (focused on scientific knowledge) to another more humanistic of Health Promotion. However, the qualification of the human resources of both the cities

investigated with a view to meeting the present demands in terms of their health needs and policies is urgent. Given that both these countries recognize that the approach is moving in the direction of Popular Health Education, their incorporation as an instrument of professional training is suggested, because the professionals concerned, as well as the participants in the groups, also possess their singularities of health and life which should be assimilated and confronted.

**Collaborators**

The authors have worked together on all the stages of the production of this manuscript.

**Referências**

1. Cervera DPP, Parreira BDM, Goulart BF. Educação em saúde: percepção dos enfermeiros da atenção básica em Uberaba (MG). Cienc Saude Colet. 2011; 17 Supl. 1:1547-54.

2. Organização Pan-Americana de Saúde. La Atención Primaria en Salud Renovada en el contexto mundial y regional: un enfoque renovado para transformar la práctica en salud [Internet]; 2007 [acesso 2012 Dez 9]. Disponível em: http://www.gestarsalud.com/cms/files/aps.pdf

3. Ministério da Saúde. Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde. 3a ed. Brasília (DF): MS; 2010.

4. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Diretrizes do NASF: Núcleo de Apoio a Saúde da Família. Brasília (DF): MS; 2009.

5. Lei nº 100, de 23 de diciembre de 1993. Por la cual se crea el sistema de seguridad social integral y se dictan otras disposiciones. Bogotá (DC): Republica de Colômbia; 1993.

6. Neto JLF, Kind L. Promoção da Saúde: práticas grupais na estratégia saúde da família. São Paulo: Hucitec; 2011.

7. Furlan PG, Campos GWS. Os grupos na Atenção Básica à Saúde. In: Ministério da Saúde. Secretaria de Atenção à Saúde. Cadernos HumanizaSUS. Brasília (DF): MS; 2010. p. 105-16.

8. Di Cesare M. El perfil epidemiológico de América Latina y el Caribe: desafíos, limites y acciones [Internet]. Chile: Colección Documentos de proyectos; 2011 [acesso 2013 Dez 16]. Disponível em: http://www.eclac.org/publicaciones/xml/9/44309/lcw395.pdf

9. Cervato-Mancuso AM, Tonacio LV, Silva ER, Vieira VL. A atuação do nutricionista na Atenção Básica à Saúde em um grande centro urbano. Cienc Saude Colet. 2012; 17(2):3289-300.

10. Secretaria Distrital de Salud de Bogotá. Direccion de Saúde Pública. Plan de Intervenciones Colectivas. Bogotá (DC): SDS; 2012.

11. Secretaria Distrital de Salud de Bogotá. Âmbito Comunitário. Guia Operativa: fortalecimiento de organizaciones desde la integralidad de los programas Tú Vales, Muévete Comunidad. Bogotá (DC): SDS; 2011.

12. Schneider S, Schimitt CJ. O uso do método comparativo nas Ciências Sociais. Cadernos de Sociologia [Internet]; 1998 [acesso 2014 Jan 11]. Disponível em: http://www.ufrgs.br/pgdr/arquivos/373.pdf

13. Sánchez R, Echeverry J. Validación de escalas de medición en salud. Rev Salud Publica. 2004; 6(3): 302-18.

14. Ministério do Desenvolvimento Social e Combate à Fome. Secretaria Nacional de Segurança Alimentar e Nutricional. Marco de referência de educação alimentar e nutricional para as políticas públicas. Brasília (DF): MDS; 2012.

15. Ministerio de Salud. Instituto Colombiano de Bienestar Familiar. Guías Alimentarias: para la población colombiana mayor de dos años. Bogotá (DC): SDS; 1999.

16. Lefèvre F, Lefèvre AMC, Texeira J. O discurso do sujeito coletivo: uma abordagem em pesquisa qualitativa. Caxias do Sul: Educs; 2003.

17. Ministério da Educação. Instituição de ensino superior e cursos cadastrados: nutrição [Internet]. Brasília (DF): MEC; 2013 [acesso 2013 Abr 6]. Disponível em: http://emec.mec.gov.br/

18. Instituto Brasileiro de Geografia e Estatística. Censo demográfico [Internet]; 2010 [acesso 2013 Dez 19]. Disponível em: http://www.ibge.gov.br/home/estatistica/populacao/censo2010/default.shtm

19. Departamento Administrativo Nacional de Estadística. ***Indicadores demográficos y tablas abreviadas 2005 – 2020 [Internet]. 2010 [acesso 2012 Dez 19].*** Disponível em: http://www.dane.gov.co/index.php?option=com_content&view=article&id=238&Itemid=121

20. Asociación Colombiana de Facultades de Nutrición y Dietética. Formación de recurso humano en nutrición y dietética: bases para la formulación de políticas. Medelín: Catédra litográfica; 2004.

21. Barker M, Swift JA. The application of psychological theory to nutrition behaviour change. Proc Nutr Soc. 2009; 68(2):205-9.

22. Meyer DEE, Mello DF, Valadão MM, Ayres JRCM. "Você aprende. A gente ensina?": interrogando relações entre educação e saúde desde a perspectiva da vulnerabilidade. Cad Saude Publica. 2006; 22(6):1335-42.

23. Macena RHM. Tendências pedagógicas e Educação em Saúde. Anima. 2002; 1(5):29-36.

24. Gazzinelli MF, Gazzinelli A, Reis DC, Penna CMM. Educação em saúde: conhecimentos, representações sociais e experiências da doença. Cad Saude Publica. 2005; 21(1):200-6.

25. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Clínica ampliada, equipe de referência e Projeto Terapêutico Singular. 2a ed. Brasília (DF): MS; 2007.

26. Ribeiro EM, Pires D, Blank VLG. A teorização sobre processo de trabalho em saúde como instrumental para análise do trabalho no Programa Saúde da Família. Cad Saude Publica. 2004; 20(2):438-46.

27. Lucumí DI, Sarmiento OL, Forero R, Gomez LF, Espinosa G. Community intervention to promote consumption of fruits and vegetables, smoke-free homes, and physical activity among home caregivers in Bogotá, Colombia. Prev Chronic Dis. 2006; 3(4):1-13.

28. Wiggins N. Popular education for health promotion and community empowerment. Health Promot Int. 2012; 27(3):356-71.

29. Vasconcelos EM. Educação popular: instrumento de gestão participativa dos serviços de saúde. In: Ministério da Saúde. Secretaria de Gestão Estratégica e Participativa. Departamento de Apoio à Gestão Participativa. Caderno de educação popular e saúde. Brasília (DF): MS; 2007. p. 19-29.

30. Vasconcelos EM. O significado e Educação Popular na realidade e na utopia da Atenção Primária à Saúde brasileira. In: Mano MAM, Prado EV, organizadores. Vivências de Educação Popular na Atenção Primária à Saúde: a realidade e a utopia. São Carlos: EDUFSCar; 2010. p. 13-8.

31. Secretaria Distrital de Salud de Bogotá. Direccion de Saúde Pública. Análisis de situación de Salud y gestión del conocimiento: Plan de Intervenciones Colectivas – PIC. Bogotá (DC): SDS; 2012.

32. Montoya LMA. Significado del saber popular en alimentación en un grupo de nutricionistas dietistas. Perspect Nutr Hum. 2007; 9(1):49-60.

33. Ministério da Saúde. Conselho Nacional de Saúde. Relatório final da 14ª Conferência Nacional de Saúde: todos usam o SUS, SUS na seguridade social, política pública, patrimônio do povo brasileiro. Brasília (DF): MS; 2012.

34. Lopes R, Tocantins FR. Promoção da saúde e a educação crítica. Interface (Botucatu). 2012; 16(40):235-48.

35. Chiesa AM, Fracolli LA, Zoboli ELPC, Maeda ST, Castro DFA, Barros DG, et al. Possibilidades do WHOQOL-bref para a promoção da saúde na estratégia saúde da família. Rev Esc Enferm USP. 2011; 45(spe2):1743-7.

36. Mcclinchy J, Dickinson A, Barron D, Thomas H. Practitioner and lay perspectives of the service provision of nutrition information leaflets in primary care. J Hum Nutr Diet. 2011; 24(6):552-9.

37. Ramsay SA, Holyoke L, Branen LJ, Fletcher J. Six characteristics of nutrition education videos that support learning and motivation to learn. J Nutr Educ Behav. 2012; 44(6):614-7.

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