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Research Article

Women's support group: the development of facilitation skills and the generation of a health-promoting group dynamic

Grupo de mulheres: o desenvolvimento de habilidades de facilitação e a geração de uma dinâmica de grupo promotora de saúde

Grupo de mujeres: el desarrollo de habilidades de facilitación y la generación de una dinámica grupal promotora de salud

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Abstract

Introduction: Running support groups is one of the actions of Primary Health Care teams. This type of intervention enables the development of actions that go beyond individual consultations as the only space of care, providing health education, integration, exchange of experiences, and an enlargement in the support network. Although these groups do not necessarily have the purpose of being therapeutic in terms of mental health, they are presented as spaces for building health promotion and disease prevention. The alternative of groups as care practice generates improvement for all involved individuals — users and professionals — as it makes it possible to highlight the community's knowledge, opening the possibility that health interventions are created collectively. **Objective:** To analyze the process of ability development in regards to the facilitation of support groups and the impacts of the acquired skills on its dynamics, as well as on its effectiveness as a health production tool, considering the skills and competencies in Family and Community Medicine. **Methods:** Qualitative study developed at UBS Santa Cecilia. The meetings took place for one hour weekly over a six months period and the tool used to monitor the development of the facilitation skill was the instrument "Structured Observation," based on five basic skills for facilitating groups. The dynamics consisted of the determination of a professional facilitator and an observer, who recorded the interventions that were carried out, with these roles being reversed at each meeting. The data were analyzed bi-weekly, with reflections and suggestions for improving interventions. **Results:** Each competence described in the tool resulted in the development of essential skills for the functioning of the group. One of the major indicators of the achievement of the desired skills occurred by observing interventions that were less and less necessary, with participants taking on the roles of protagonists and becoming responsible for the development of the group, questioning, producing, and acquiring health. **Conclusions:** The use of an instrument for observing and reflecting on the skills of the agent acting as a group facilitator allows the dynamics to be fluidly established, with a quick understanding of the participants about their roles in the general context of the group. It was also observed that the relationship established between them resulted in the formation of a support network, improvement of self-care and knowledge, health information and social support for those involved.

Keywords: Primary health care; Group practice; Women; Community action; Health education.

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Resumo

Introdução: A realização de grupos é uma das possibilidades de atuação das equipes da Atenção Primária à Saúde. Esse tipo de intervenção possibilita o desenvolvimento de ações de cuidado que extrapolam as consultas individuais, propiciando educação em saúde, integração, troca de experiências e ampliação da rede de apoio. Ainda que não tenham necessariamente o propósito de serem terapêuticos em termos de saúde mental, apresentam-se como espaços de promoção de saúde e prevenção de agravos. O trabalho com grupos é capaz de gerar aprimoramento para todas as pessoas envolvidas — usuários e profissionais — na medida em que possibilita colocar em evidência os saberes da comunidade, abrindo a possibilidade de que as intervenções em saúde sejam criadas em coletivo. **Objetivo:** Analisar o processo de desenvolvimento da habilidade de facilitação de grupos e os impactos das habilidades adquiridas na sua dinâmica, bem como na sua efetividade como ferramenta de produção de saúde, considerando as habilidades e competências da Medicina de Família e Comunidade. **Métodos:** Trata-se de pesquisa qualitativa desenvolvida na UBS Santa Cecília. Os encontros aconteceram semanalmente pelo período de uma hora durante seis meses. A ferramenta utilizada para acompanhamento do desenvolvimento da habilidade de facilitação se deu pela observação estruturada, baseada em cinco competências básicas para facilitação de grupos. A dinâmica estabelecida consistiu na determinação de uma profissional facilitadora e outra observadora, que registrou as intervenções realizadas, sendo esses papéis invertidos a cada encontro. Quinzenalmente os dados eram analisados, gerando reflexões e sugestões para melhoria das intervenções. **Resultados:** Cada competência descrita na ferramenta utilizada teve como resultado o desenvolvimento de habilidades primordiais para o funcionamento do grupo. Um dos maiores indicadores do êxito em alcançar as habilidades desejadas ocorreu pela observação de intervenções cada vez menos necessárias, tomando as participantes os papéis de protagonistas e responsáveis pelo desenvolvimento do grupo, questionando, produzindo e obtendo saúde. **Conclusões:** A utilização de um instrumento de observação e reflexão das competências do agente atuante como facilitador de um grupo permitiu que a dinâmica se estabelecesse de forma fluida com rápido entendimento das participantes sobre seus papéis no contexto geral do grupo. Observou-se também que a relação estabelecida entre elas resultou na formação de rede de apoio, melhoria do autocuidado e conhecimento, informação em saúde e apoio social às envolvidas.

Palavras-chave: Atenção primária em saúde; Prática de grupo; Mulheres; Ação comunitária; Educação em saúde.

Resumen

Introducción: La realización de grupos es una de las acciones de los equipos de la Atención Primaria a la Salud. Este tipo de intervención hace posible el desarrollo de acciones que extrapolan las consultas individuales como único espacio de cuidado, ofreciendo educación en salud, integración, intercambio de experiencias y ampliación de la red de apoyo. Aunque estos grupos no tengan necesariamente el propósito de ser terapéutico en términos de salud mental, se presentan como sitios de construcción de promoción de salud y prevención de agravios. La alternativa de los grupos como una práctica asistencial crea una mejora para todas las personas involucradas — usuarios y profesionales — ya que habilita colocar en evidencia los saberes de la comunidad, abriendo la posibilidad de que las intervenciones en salud sean creadas en colectivo. **Objetivo:** Analizar el proceso de desarrollo de la habilidad de facilitación de grupos y los impactos de las habilidades adquiridas en la dinámica de este, así como en la efectividad como herramienta de producción de salud, considerando las habilidades y competencias de la Medicina de Familia y Comunidad. **Métodos:** Se trata de estudio cualitativo llevado a cabo en la UBS Santa Cecília. Los encuentros ocurrieron semanalmente durante una hora por seis meses y la herramienta utilizada para seguimiento del desarrollo de la habilidad de facilitación fue el instrumento Observación Estructurada, basado en cinco competencias básicas para facilitación de grupos. La dinámica establecida consistió en la determinación de una profesional facilitadora y otra observadora, que registró las intervenciones realizadas, siendo esos papeles cambiados a cada encuentro. A cada quince días los datos eran analizados, haciendo reflexiones y sugestiones para mejorar las intervenciones. **Resultados:** Cada competencia descrita en la herramienta utilizada tuvo como resultado el desarrollo de habilidades primordiales para el funcionamiento del grupo. Uno de los grandes indicadores del éxito en alcanzar las habilidades deseadas ocurrió por la observación de intervenciones cada vez menos necesarias, tomando las participantes los papeles de protagonistas y responsables por el desarrollo del grupo, cuestionando, produciendo y obteniendo salud. **Conclusiones:** La utilización de un instrumento de observación y reflexión de las competencias del agente actuante como facilitador de un grupo permiten que la dinámica se establezca de forma fluida con rápido entendimiento de las participantes sobre sus papeles en el contexto general del grupo. Se pudo observar también que la relación establecida entre ellas resultó en la formación de red de apoyo, mejora del autocuidado y conocimiento, información en salud y apoyo social a las involucradas.

Palabras clave: Atención primaria de salud; Práctica de grupo; Mujeres; Acción comunitária; Educación en salud.

INTRODUCTION

The organization of groups is one of the actions undertaken by Primary Health Care (PHC) teams and is an integral part of the training curriculum for family practice physicians. It is considered an essential skill in the foundations of community-oriented practice.[1] This type of intervention allows for the development of activities that extend beyond individual consultations as the sole form of care. It offers opportunities for health education, integration, the exchange of experiences, and the expansion of support networks.[2]

While these groups are not necessarily intended to be therapeutic in terms of mental health, they serve as spaces for promoting health and preventing disease. According to Dias et al.,[3] the use of groups as a care practice benefits everyone involved — both users and professionals — by highlighting community knowledge and enabling the collective creation of health interventions.

The current literature contains articles documenting experiences with groups in PHC.[2,4,5] The experiences described in these studies, which are qualitative in nature,[6] highlight the therapeutic potential of this type of intervention in the PHC context.

As described in the work "*O Pequeno Grupo como um Sistema Complexo*",[7] most health workers do not feel adequately prepared to facilitate groups. This is often due to insecurity about handling unexpected situations or concerns about "empty meetings," where participants do not spontaneously bring up issues. Recognizing this gap and confident in the potential of groups to produce health benefits, Seminotti[7] and Seminotti & Pinto[8] developed and proposed the use of a tool called structured observation[8] (Appendix 1). This tool is intended as a strategy for training group facilitators in Primary Care.

Given the growing demand for mental health services, the context of gender disparities in today's society and their impact, and the prevalence of care for women in PHC, this study aimed to contribute to the theoretical foundation for developing group facilitation skills. It focuses on the competencies required of family and community doctors and seeks to demonstrate the potential of group work in enhancing the quality of care, including individualized care, for women participants.

METHODS

This is a qualitative exploratory study conducted at HCPA/UBS Santa Cecília, located at the headquarters of *Associação de Colaboradores do Hospital de Clínicas* (ASHCLIN). The tool used to monitor the development of group facilitation skills was called structured observation,[8] originating from the PluriVox Program.[8] This document is based on five basic skills for group facilitation (Appendix 1). The designated dynamic involved assigning one professional as the facilitator and another as the observer, who was responsible for recording data according to the five skills outlined in the instrument. The observer noted the group's progress, the exercise of each competence, and the impact of each intervention. The roles of observation and facilitation alternated between the professionals at each meeting. Inclusion criteria for joining the group were as follows: women who were users of UBS Santa Cecília, experiencing psychological distress, and with limited social support networks. These women were selected by researchers based on individual consultations within the unit's routine. During these consultations, situations were identified where women frequently requested health services and increasing "care" resources (such as exams and referrals). The complaints were varied, often broad, and frequently changed with each consultation. Symptoms included pain in different parts of the body, general tiredness, mental exhaustion, sadness, and a feeling of being overwhelmed. In addition to clinical assessment and investigation of the main complaint, emotional support and the degree of suffering were evaluated. When a weak support network was detected, the group was offered to the patient. Exclusion criteria included patients who were not motivated for a collective and prolonged approach, those who declined the invitation to participate, patients in acute distress who primarily required individual care, and patients in professional situations where confidentiality might be compromised. Recruitment targeted women who met these criteria, regardless of age. In the group planning, a maximum limit of eight participants was set (in practice, new participants were

only accepted when a previous member left or withdrew), as the group size should not hinder clear communication and the dynamics of interactions, which are based on trust and bond formation.[9] The group was classified as semi-open, according to Zimerman,[9] with the inclusion of a new participant only if a previous member left.

The group meetings were held weekly, lasting one hour at a set time, over a period of six months. The facilitators were residents in Family Practice, who are also the primary researchers. They received bi-weekly supervision from the responsible advisor (the Residency Program preceptor) and the external consultant (a psychologist specializing in group facilitation and the creator of the Plurivox Program[8]). The notes were recorded on a single form according to the structured observation framework and stored on the institutional Google Drive. The topics discussed in the group were those introduced by the participants, with facilitators intervening as needed (such as to redirect the conversation, encourage other participants to share their perspectives, or ensure that the insights gained were being understood). Every two weeks, the collected data were analyzed and discussed with the external consultant. The facilitators' interventions and their effects on the group were evaluated, leading to reflections and suggestions for improving the interventions.

After six months of meetings, the data collected through the forms were reviewed again to analyze the development of the facilitators' skills and their roles within the health-promoting group dynamic.

At the beginning of the meetings, each participant was asked to fill out an informed consent. This research project adheres to the standards set by the National Research Ethics Commission (*Comissão Nacional de Ética em Pesquisa* – Conep), in accordance with Resolution No. 466 of December 12, 2012, from the National Health Council, and was approved by the institution's Research Ethics Committee (Certificate of Presentation for Ethical Assessment No. 65253522.1.0000.5327).

RESULTS

The results presented here are based on six months of weekly meetings. After each meeting, the facilitators convened for an additional hour to discuss the group's development and progress. This process included bi-weekly supervision from the external consultant and the preceptor.

To describe the results obtained and analyzed, the five competencies recommended by the Plurivox Program[8] will be detailed and discussed regarding the impact of their implementation on making the group a means of promoting health.[7,8] Some situations that occurred during the meetings will be used as practical examples to illustrate the group's potential for fostering collective health.

The structured observation tool[8] was essential for analyzing the results obtained and for establishing a temporal link with the development of the group as the meetings progressed.

The first competence — which, as described by Seminotti & Pinto,[8] involves "providing essential information, introducing oneself and inviting participants to do the same, proposing and managing the definition of rules and coexistence agreements, and defining the group's objectives" — was exercised at the beginning of all meetings. Initial presentations were made during the first meetings, as soon as the group was formed and whenever new members joined. This facilitated initial interactions among people who did not yet know each other and provided important insights into how participants perceived each other individually. Rules and coexistence agreements were revisited at each meeting, with participants being asked if any adjustments were needed. Additionally, every decision regarding the group — such as rescheduling meetings or including new members — was made collectively with the participants.

This approach helped establish a relationship of trust between the members and facilitators, fostering a sense of belonging and encouraging active participation and shared responsibility. As the group evolved, participants began to understand and apply these principles more actively. For example, they decided to create a virtual group on WhatsApp, named UBS Girls, where they agreed to communicate absences and confirm meetings. This communication tool was used solely for confirming meetings and justifying absences.

The second competence[8] involves stimulating and enabling conversation among all group members. In the initial meetings, participants frequently directed topics toward the facilitators, seeking individual attention from them. To facilitate group-wide conversation, the facilitators initially needed to intervene more actively and redirect questions to the entire group. As the meetings progressed, this trend diminished. The topics discussed were diverse, including psychiatric, psychological, clinical, and interpersonal issues. Participants often posed questions such as "How should I handle this situation?" with their attention focused on the facilitators. Following PluriVox's competencies,[8] the facilitators redirected these key questions back to the group. This approach helped establish a procedural flow where participants began addressing questions to the group itself. Instead of asking, "What does this mean, doctor?" or "What should I do about this, doctor?" participants started to inquire, "I'd like to know what the girls (participants) have to say about what I shared today" or "Would you help me brainstorm a solution for this?". Additionally, when new members joined the group, they were encouraged by existing members to share their experiences and insights. This practice facilitated the establishment of bonds with newcomers, helping them feel more comfortable and integrated into the group.

The third competency[8] involves ensuring that everyone shares an understanding of the discussion and that all viewpoints are expressed. Developing this skill in facilitation creates a respectful and tolerant group environment, allowing participants to express their opinions freely without fear of retaliation. This fosters psychological safety, enabling participants to share their struggles and difficulties in a supportive environment, with interventions coming from group members rather than judgments. Issues such as domestic violence, substance abuse, sexual abuse, and induced abortion were discussed openly. In these situations, other group members took on roles as counselors and confidants. As relationships developed, clear expressions of support and the formation of support networks (often lacking for many participants) emerged. For example, when one member was scheduled for ophthalmological surgery, two other participants volunteered to accompany her during her hospital stay. In another case, an older participant with mobility issues began receiving rides home from a fellow group member, who also occasionally assisted with weekly grocery shopping.

The fourth competency[8] focuses on whether the group's work generates health benefits, specifically by assessing if understandings produce learning and/or insight. This skill, which was frequently utilized by the facilitators, was crucial for helping participants recognize the health benefits achieved in each meeting. The outcomes of discussions and shared information emerged throughout the meetings, often through feedback on advice and strategies participants had implemented at home. For example, an aged participant repeatedly expressed difficulty in relating to her family and distress over her dependence on and cohabitation with them. She frequently sought advice from the group on how to address this situation and requested tips. After several weeks of planning and discussion, in the fifth month of the group, this participant reported that she had successfully moved to a nursing home of her choice. Despite family opposition, she was very happy with her decision. She concluded by expressing gratitude to the group for their support during this significant transition.

The fifth strategy,[8] which involves closing each group meeting and evaluating what has been achieved and what still needs to be addressed, was the most challenging for the facilitators to develop. Due to the limited duration of the meetings, one hour, and the number of participants, closing each session often proved difficult, usually ending with one person speaking. Throughout the meetings, managing time became increasingly important. When feasible, participants were invited to reflect on their feelings at the beginning and end of each session. This practice helped them recognize the impact of the brief interventions and the influence of the meetings on their mood, thereby reinforcing their commitment to attending each weekly session.

The strategy of discussing the interventions every two weeks with the supervisor and the external consultant facilitated reflection on the development of facilitation skills and their impact on the group's dynamism and independence. Additionally, this process highlighted the benefits of decentralizing the facilitator role within the group. It supported the notion that the group can function and promote health independently of the facilitator, provided that the necessary skills are present among the members.

Finally, several important observations about the participants' health outcomes can be described. Over the six-month period, a robust support network developed, and noticeable individual changes and progress were evident. For instance, one participant, who was experiencing the onset of a depressive episode, took on the role of organizing the group's gatherings. She was attentive to absent members, actively revised agreements, encouraged discussions, and provided insights at the end of each meeting. According to her, this involvement helped her reestablish her routine and maintain her mental health care. Another participant, who struggled with refractory depression and interpersonal relationships, was able to share experiences she had never disclosed before, especially in a group setting with a significant number of people. All participants who were part of the group during the reported period expressed deep gratitude for the opportunity and showed commitment to sustaining the group, even after the initial facilitators left. As the facilitators' residency period was nearing its end, a transition plan for new facilitators was developed. This transition occurred gradually, with the outgoing facilitators remaining involved to help maintain the established trust and psychological safety. The transition also included the presence of the supervisor to ensure continuity and provide a stable reference figure. Following the six-month period, the meetings continued, preserving the group's initial dynamics, with the ongoing support of the participants.

DISCUSSION

The development of group facilitation skills was crucial for establishing effective group dynamics. Both the systematization of supervision activities using a structured instrument and the reflections on the results were as vital as the facilitation process itself. The sense of belonging to the group and the participants' role as health contributors were closely linked to the facilitators' ability to position themselves as key players and share responsibility in addressing common issues. This shift was evident throughout the meetings as facilitators' interventions became less frequent, with group members occasionally assuming facilitating roles. Additionally, the situations discussed during the meetings highlighted and clarified the group's contribution to health. This was supported by reports of improved self-care, self-preservation, development of interpersonal relationships, and the creation of a support network.

In this study, the characteristic of group work as a flexible technology, adaptable to the realities and needs of a population, and specifically its participants, can be considered an advantage. Considering the principles of the Family Health Strategy[10] (the primary organizational model of PHC in Brazil), group formation is replicable across various settings. It can take different forms and serve as a promising strategy for addressing multiple demands that would traditionally be handled through individual consultations. However, the effectiveness of a group is not guaranteed solely by its existence. It requires a well-structured facilitation process, careful criteria for group composition, and attentive management of the group's development. Additionally, there is no assurance against potential failures in its goal to promote health. Thus, while the formation of groups can be replicated, their outcomes are neither unique nor predictable.

The structured observation tool[8] used here aids in systematizing facilitation skills, which are essential for ensuring that the group operates methodically and becomes a source of health production. It serves as both a didactic and practical approach for monitoring intervention moments. Additionally, systematization enhances understanding of the health benefits generated by the group. However, despite its simplicity, the tool requires guidance from a teacher and an external consultant specialized in group dynamics. Without subsequent reflection, using the tool might disconnect its application from the context and fail to contribute effectively to the facilitator's training.

Zimerman[9] highlights the crucial role of the coordinator (referred to here as the facilitator) in the evolution of any group. The author identifies several basic attributes essential for effective group leadership, including "liking and believing in groups," "coherence," "sense of ethics," "respect," "continence," "thinking function," "communication," and "synthesis and integration." It is therefore observed that, in addition to the need or therapeutic potential that a group can offer, professionals who assume the role of facilitators must be attentive in their interventions, exercising their skills at each meeting and constantly reflecting on the group's development process once it is formed. Zimerman[9] also notes the value of supervision by a more experienced professional to observe interventions and support the learning process of group facilitation. The structured observation tool[8] complements this by monitoring the facilitator's skill evolution according to these attributes. It also suggests the need for a third professional (a supervisor) to enhance the facilitation learning process.

This study underscores the importance of understanding the role of facilitation in the formation and maintenance of therapeutic groups. The structured observation tool[8] described can assist professionals who lack specific training in group work or have not received relevant coursework during their academic studies, and who may therefore feel uncertain about leading groups in various settings. Moreover, the ability to effectively facilitate groups guides participants toward health production. This process can foster self-knowledge, self-help, social and emotional support, and the development of a support network.

CONCLUSION

This qualitative study enabled the monitoring and evaluation of the impact of training and facilitating a group of women. It provides insights into the various effects of the group within the contexts of health production, service dynamics, health care resolution, and professional training in PHC.[11]

On an individual level, the therapeutic potential was evident among the participants, who took on active roles and shared responsibility for the health promotion achieved beyond the scope of individual consultations.

Regarding the training of PHC professionals, group facilitation expanded their therapeutic toolkit, directly impacting the skills acquired during their training. The structured observation tool from the PluriVox[8] program could be integrated into PHC, aligning group formation with the ongoing education of professionals.

There is a recommendation for integrating group work into PHC routines. However, Family Practice residency programs, and medical training in general, often do not offer basic knowledge for facilitating groups. The PluriVox Program[8] addresses this gap by providing a simple and effective facilitation procedure through five fundamental skills or steps. These skills enable participants to share their issues and actively engage in finding solutions. The structured observation method supports these five skills by having facilitators and observers alternate roles. The observer records the exercise of these skills, noting the moments in the group when they are applied and their impact on participants. This record is then shared in a file for discussion with those responsible for training. A practical challenge of implementing this method is managing residents' time, which often has limited flexibility and minimal space for collective activities.

For the health service, groups can represent a way to address multiple health demands, coordinating and expanding access, strengthening the community's connection with the service, and freeing up individual consultation spaces for other needs. From this perspective, the experience of the women's group described here, using structured observation, can be applied in various health services, particularly in PHC, unifying health outcomes with the development of relevant competencies for Family Practice.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

MT: Project administration, Formal analysis, Conceptualization, Data curation, Writing – original draft, Writing – review & editing, Investigation, Methodology, Funding acquisition, Resources, Validation, Visualization. ES: Project administration, Conceptualization, Data curation, Writing – review & editing, Investigation, Methodology, Funding acquisition, Resources, Validation, Visualization. CG: Project administration, Formal analysis, Writing – review & editing, Methodology, Supervision, Validation, Visualization. MG: Formal analysis, Supervision, Visualization. NS: Project administration, Formal analysis, Writing – review & editing, Methodology, Software, Validation, Visualization.

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APPENDICES AND/OR ATTACHMENTS

Appendix 1:

PluriVox Program

Group Facilitation

The PluriVox Program consists of a small group concept, conceived as a complex system Seminotti (2016), and a strategy to face the complexity and uncertainties of group life/processes. The strategy consists of five skills to be exercised by those who facilitate the group; a minimum structure, consisting of five steps, which indicates a path to follow in facilitation; support 'tips' for executing the skills; and a structured observation protocol, aimed at developing the exercise of skills (SEMINOTTI & PINTO, 2022).

Competencies of facilitation, 'tips' for exercising the competencies, objectives of the competencies, and observation protocol

Competency 1: Provide essential information, introduce oneself and invite participants to do the same, propose and manage the establishment of rules and agreements for interaction, and define the objectives of the group;

'Tips' for exercising the competency

Introduce oneself and clarify the group's objectives and the benefits participants will gain from it. Ask participants to introduce themselves and share what they expect from the group. Based on this, define the group's objectives and rules for interaction. Regarding the rules, consider aspects that require confidentiality and the need to redefine them as the group progresses. For groups that involve multiple sessions or projects with many sessions, encourage participants to refer to what was discussed in the previous session, any significant events that occurred between sessions, and the solutions and issues to be shared in the current session.

Objective of exercising the competency

To create a climate of psychological safety within the group, providing participants with assurances that their thoughts and feelings about themselves and/or others will be received without criticism.

Competency 2: Encourage and facilitate conversation among all participants;

'Tips' for exercising the competency

The facilitator should avoid answering questions directed specifically to them (except those within their responsibility) and encourage others in the group to respond; invite the group to discuss common issues and suggest potential solutions; ask participants to share their understanding of what has been communicated; offer alternative forms of expression beyond verbal communication (group dynamics, cut and paste activities, body movements, games, music, dance, etc.); conduct integration exercises to foster trust and build bonds within the group; provide individual attention when requested, and encourage the sharing of personal conversations with the group.

Objective of exercising the competency

To encourage and develop circular conversation within the group, involving all participants, rather than just radial conversation, where everyone speaks only to the facilitator.

Competency 3: Ensure that the communications are understood and comprehended by everyone, and that viewpoints on what is shared are expressed;

'Tips' for exercising the competency

In the role of facilitation, one should avoid the tendency to respond to participants' questions directly and instead encourage others to provide answers, fostering a diversity of perspectives; enable clarification of meanings and understandings of what has been communicated, as well as those interpreted by listeners; refrain from offering universal explanations or interpretations of group phenomena and accept the unique and local perspectives of participants (this recommendation does not prevent communicating the generic understanding that the facilitation has about what was discussed and does not imply the omission of responsibility of who facilitates, but it is necessary to clarify that this is just an understanding). The PluriVox design incorporates the notion that participants possess knowledge and abilities that make them capable of addressing the topics under discussion.

Objective of exercising the competency

To develop conversations that encourage the free expression of the knowledge and abilities of all participants, not just those of facilitators. It is essential to welcome, recognize, and legitimize the diverse responses to shared questions.

Competency 4: Assess whether the understandings lead to learning and/or insights;

'Tips' for exercising the competency

At certain points during the group and in the group project, encourage participants to share if they have started to understand the issues discussed in a different way. You might ask, "Are you learning something new?". Observe whether the learning developed by group participants leads to healthier lifestyle habits, and if so, encourage them to share any changes they have made in their habits.

Objective of exercising the competency

Assess and encourage the expression of any individual and/or collective learning or insights that emerged during the current session, those that developed between group sessions, and those that have accumulated throughout the group's history/project. Focus on how these insights offer solutions or approaches to the problems shared within the group.

Competency 5: Evaluate, at the end of the group, what has been achieved, what is still missing, and what each participant needs to contribute to achieve in the next group session;

'Tips' for exercising the competency

Conduct brief assessment exercises at the end of each group session. This can involve asking participants to express what 'remains' from the session in a single word or phrase; periodically create a routine to evaluate the group's progress and work; list activities for the next session, incorporating those that are of interest to the participants.

Objective of exercising the competency

To encourage reflection and expression about what occurred during the session and throughout the group's history, identify relevant connections between sessions (recurring themes and/or referrals from previous discussions) and introduce potential topics for future sessions.

Structured observation model

Facilitators working in pairs should divide their roles into observer and facilitator before starting the group. They need to communicate these roles to the group and can alternate them during each session. The facilitator should strive to use the skills recommended by PluriVox, while the observer focuses on recording the exercise of these skills in the observation protocol. This record is used for discussion after the session to enhance facilitation skills. Although the primary role of the observer is to note and discuss the facilitation, they may also contribute to the facilitation process by offering suggestions via WhatsApp or directly during the group. In online settings, the observer can even provide feedback through a chat function directly to the facilitator.

In the structured observation model (below), those who perform the observation role must focus their attention on those who facilitate the group, aiming for discussion after the group with the objective of developing facilitation skills. Therefore, the record must include the items indicated in the model

Competency exercised (in this field, the intervention should be classified by the observer according to the description of the competency)	-Context in which the competency was exercised (briefly describe what was happening in the group at that moment. For example: a participant asked the facilitator for a solution to problem X that she had reported); -What the facilitator said to exercise the competency. For example: the facilitator asked if anyone had anything to say to the participant who requested a solution. -What was the impact on the group resulting from the exercise of the competency (briefly describe the group's response to the exercise of the competency; for example: other participants reported experiencing the same problem but were unsure how to resolve it.