COMMUNITY HEALTH NURSING PRACTICES IN CONTEXTS OF POVERTY, UNCERTAINTY AND UNPREDICTABILITY: A SYSTEMATIZATION OF PERSONAL EXPERIENCES

Hélène Laperrière[1]

Laperrière H. Community health nursing practices in contexts of poverty, uncertainty and unpredictability: a systematization of personal experiences. Rev Latino-am Enfermagem 2007 setembro-outubro; 15(número especial):721-8.

Several years of professional nursing practices, while living in the poorest neighbourhoods in the outlying areas of Brazil's Amazon region, have led the author to develop a better understanding of marginalized populations. Providing care to people with leprosy and sex workers in riverside communities has taken place in conditions of uncertainty, insecurity, unpredictability and institutional violence. The question raised is how we can develop community health nursing practices in this context. A systematization of personal experiences based on popular education is used and analyzed as a way of learning by obtaining scientific knowledge through critical analysis of field practices. Ties of solidarity and belonging developed in informal, mutual-help action groups are promising avenues for research and the development of knowledge in health promotion, prevention and community care and a necessary contribution to national public health programmers.

DESCRIPTORS: community health nursing; professional practice; problem-based learning; community networks; poverty

PRÁCTICAS DE ENFERMERÍA EN SALUD COMUNITARIA EN CONTEXTOS DE POBREZA, INCERTIDUMBRE Y IMPREVISIBILIDAD? SISTEMATIZACIÓN DE EXPERIENCIAS PERSONALES

Varios años de prácticas profesionales de enfermería, viviendo en los distritos más pobres de las áreas periféricas de la región amazónica de Brasil, llevaron o autor a desarrollar una mejor comprensión de poblaciones marginalizadas. La provisión de cuidados a personas con lepra y trabajadores del sexo en comunidades ribereñas ha sido llevado a cabo en condiciones de incertidumbre, inseguridad, imprevisibilidad y violencia institucional. Se pregunta como podemos desarrollar prácticas de enfermería en salud comunitaria en este contexto. Una sistematización de experiencias personales basada en educación popular es usada y analizada como un método de saber, obteniendo conocimiento científico mediante un análisis crítico de prácticas en el campo. Lazos de solidaridad y pertenencia desarrollados en grupos de acción informales, de ayuda mutua son caminos prometedores para la investigación y el desarrollo de conocimiento en la promoción de la salud, prevención y atención comunitaria y una contribución necesaria a programas nacionales de salud pública.

DESCRIPTORES: enfermería en salud comunitaria; práctica profesional; aprendizaje basado en problemas; redes; comunitaria; pobreza

PRÁTICAS DE ENFERMAGEM EM SAÚDE COLETIVA NOS CONTEXTOS DE POBREZA, INCERTEZA E IMPREVISIBILIDADE: UMA SISTEMATIZAÇÃO DE EXPERIÊNCIAS PESSOAIS NA AMAZÔNIA

Muitos anos de prática profissional em enfermagem, vivendo nas vizinhanças mais pobres de áreas distantes da região Amazônica brasileira levaram a autora a desenvolver uma melhor compreensão das populações marginalizadas. O cuidado às pessoas com lepra e trabalhadores do sexo de comunidades ribeirinhas tem sido realizado em condições de incerteza, insegurança, imprevisibilidade e violência institucional. A questão levantada é como podemos desenvolver práticas de enfermagem na saúde da comunidade neste contexto. A sistematização de experiências pessoais baseadas na educação popular é usada e analisada como uma maneira de conhecer e obter conhecimento científico através da análise crítica das práticas da área. Laços de solidariedade e pertencimento desenvolvidos em ações de grupos informais de ajuda mútua são caminhos promissores para pesquisa e desenvolvimento do conhecimento em promoção a saúde, prevenção e cuidado à comunidade e uma contribuição necessária para os programas de saúde pública nacional.

DESCRITORES: enfermagem de saúde comunitária; prática profissional; aprendizagem baseada em problemas; redes comunitárias; pobreza

[1] RN, Doctoral Student in Public Health at the University of Montreal, Professor at the Federal University of Ottawa, College of Nursing, Canada, e-mail: hlaperri@uottawa.ca

THE PROBLEMATIZATION

The promotion of healthcare's inequalities among populations in special situations, such as black, rural and rainforest people are of interest for the Brazilian National Policies of Health. Several years of community health nursing, including six in lower class neighborhoods in the outlying areas of Brazil's Amazon region have led the author to become acquainted with groups and collectivities which are marginalized with respect to health services. Be it providing care for people with leprosy by traveling around riverside community on wooden boats or doing prevention work with sex workers in prostitution urban areas, the care work experiences have taken place in conditions of uncertainty, insecurity and institutional violence. Being close to the community in her interventions gives rise to commitment and solidarity in socio-political actions in civil society organizations (community groups, association of women, coalition for the fight against Aids or poverty).

In these conditions, defending the care provided to these populations often becomes a political act. Here, Demo's "knowing how to care"[1] involves broadening the technical role of clinical assistance, prevention and heath promotion—which is an important part of care work—to include a critical examination of the socio-political and socioeconomic reality of community health practices. These experiences have drawn out the relevance of developing a better understanding of the social and political role played by nurses. Community health nursing involves a practice in many areas of the community including at the population health level, but also uses diverse approaches to care and health improvement for individual, families, groups, communities or populations.

Using the principles of liberation theology in medical practice, Farmer explains how primary care and preventive services might be made in local community with a « pragmatic solidarity » in caring with biological suffering of HIV/AIDS patients in Latin America[2]. Prevention requires dynamic evaluations and a grounding in local cultures that respects the dynamics of local preventive practices, especially in settings in which the relevant variables cannot be predetermined. Where crucial variables of concrete political power, obscure relationships of illicit activities and catastrophic natural disasters define a world far away from the expectancies of researchers[3]. There are several challenges that can increase external validity awareness. There is also the political defy of learning from our experiences[4]. How can we take into account uncomfortably contextual details from nursing practices with these populations, many of which are stories that remains untold because of their potential dangerousness and the difficulties of making them public in an "evidence-based practice" that can be published?

OBJECTIVE

The rational of this article is to provide strategies to better know how to build up community health practices based on experiential learning with marginalized populations (per example, persons living with Aids, sex workers, rural and isolated riverside populations, street gangs, popular living zones with limited economic resources) by using the history of cumulative experiences as pertinent information to construct knowledge which confronts uncontrollable contextual variables (inertias, routines, physical dangers, political structures of oppression, election campaign).

The systematization of personal experiences is here use as a method of critical review. What do we know from experience to be share to others? This is a tentative to find what Demo called "equilibrium in-between form and content"[5] to surpass silence to formalized an answer. Based on Latin-American popular education, this method is a form of savoir by obtaining scientific knowledge through critical analysis of field practices. It raises here the question of how can we develop community health nursing practices, including health promotion, prevention and care in contexts of poverty, uncertainty and unpredictability. Also based on Schön "reflexive practitioner concept"[6], this paper aims at explaining the process of reflexive construction and intersubjectivity of the author to discover a way to communicate experiences learning with colleagues and students.

LATIN-AMERICAN SYSTEMATIZATION OF EXPERIENCES AS A METHODOLOGY OF CRITICAL REVIEW

The systematization of experiences works with a simple heuristic structure. It is a collective effort

to agree in the description of a problem situation and the goal of the action toward change; the progress of the change process are understood in terms of situational factors that help or hinder the goal attainment, and the group's rating of their own actions as successes or failures in advancing their action[7]. For Morgan & Monreal, this method integrates theory and practice, with the goal of producing knowledge from experience in order to offer orientation for similar experiences[8]. Systematization is a form of investigation to obtain scientific knowledge from reality, through theoretical reflection and critical analysis from practices. It permits a retrospective regard of the past and, from the learning derived, to orient the future. These authors explained the distinction between systematization from other forms of knowledge production. It helps to understand "scientifically" a practice, an experience in which one has participated, and from those, elaborate knew savoir that permits not only its comprehension, but also it contribution as a tool of social transformation[8]. To systematize means to have some questions in one's head that guide the analysis of an experience so as to identify some perspectives and actions that might modify the problem in a movement for a better society[9]. Some route questions help for the critical revision: How can I describe what I do, explain how to I do it, justify my actions, and so to be able to defend what I do and how I do it, and this in order to vindicate what will be necessary to be able to do in order to attain the agreed aims?

A *recollection of information* was firstly done from my history of experiences from diverse practices of popular education and community health practices with riverside populations of Brazilian Amazonian region. The main ideas of this paper were previously debated with colleagues in the 2006 CASN National Research Conference in Victoria BC (Canada). In addition to collaboration with formal public health programs as a community health nursing volunteer, there was the living experience as a community animator and resident among rural communities for more than six years in the field (1994-2000; 2004). A *reconstruction* of the most significant elements of the professional activities was previously realized as a recuperation of the personal professional history.

The first integration work was community animation in neighborhood committees of the Women's association (from 1994 to 1997). Several educational documents and manuals were produced or adapted to the Amazonian culture in cooperation with the Women' Association. Those popular education activities dealt with topics directly pertinent to the everyday life of women such as conjugal violence, the use of the "See - Judge - Act" method, political education, care for women, the use of medicinal plants, the organization of neighborhood committees and training for active participation in democratic elections. Further, there was the training of community health agents in both institutional and non-institutional areas [Pastoral da saúde] (from 1996 to1999). This activity implied conducting community actions to identify needs and to organize the training of community members in community health practices; to underline and develop popular knowledge of traditional health practices present in the local population, and to supervise persons enrolled in practicum activities for Canada, Latin America and the Brazilian capital.

After three years, the social engagement was transformed in a public health nursing as a joint coordination of municipal Leprosy programs of rural extension for a reference center for the Amazonian region. It was created with the aim of offering treatment for skin and sexually transmitted diseases as well as to develop technological and scientific activities in the field of research, education, training and extension. Part of the collaboration with the rural extension of their institutional regional Leprosy program was to carry out the training of community health agents, health-workers of the hospital and the municipal secretary office and undertaking a number of prolonged trips into the riverside communities, in order to organize a campaign on leprosy, which was both educational and clinical.

Later one, there was a gradual integration to the joint coordination of DST/AIDS peer-education activities with sex workers (from 1999 to 2000). The project sought to improve citizenship rights and to encourage safer sexual practices as well as to provide specialized medical and nursing care for free diagnosis and treatment of STDs. Based on a peer-education method, community peer-educators were selected, employed and trained to carry out educational activities about systematic condom use. These activities were conducted in different meeting places (floating port, bars, hotels, public parks, streets, schools, etc.). The return in this region after three years was to do an evaluation in this context of unpredictability with peer-education projects for sex workers, men who have sex with men, and youth

from popular barrios or "invasão" [invasion] areas (from January to June 2004). The evaluation situation was immersed in socio-political danger, which affected socio-political relations among all actors — sanitary, police, legal, governmental, cultural (educators and the clergy), and criminal. Given its proximity to the border, the region had problems related to smuggling and drug trafficking, the flux of clandestine people, and land invasion issues, with their violent consequences.

The philosophy of data quality control explained by Narroll pointed out the conditions of observation which can be linked to those field experiences as a community animator, nurse, researcher-ethnographer and inhabitant of the region[10]. To live and practice in another culture oblige the development of an ethnographer nurse role to empathize with the community to serve. Among the main control factors that increase the quality of this systematization of experiences' data are: (a) the "use by the ethnographer of direct observation and personal participation in an ongoing culture as a major source of field data"; (b) the length of stay of the researcher in the field among the people studied; (c) the familiarity with the language of the people; (d) the role of the ethnographer among the people studied (social scientist, missionary, government official) and the explicitness and generality of the reports on the trait in question[10].

A LECTURE OF PERSONAL EXPERIENCE INTERLINKED WITH LITERATURE

From this recuperation of the history of author's personal experiences, categories were define according to general recognized functions in nursing such as mediation, education, practice/research and ethic. Those categories were analysed with literature in order to realize a critic interpretation of personal and professional experiences and extract learning to be shared and used in public and community health nursing practices facing poverty.

Being a mediator between community, health network and academia

The national and international cultures of a foreign managerial sector are not always able to decode the local contingent factors of variability and view them as obstacles rather than as healthy requests for adjustment. To better take into account local actors directly involved in change, the starting point consists in a mediating function based on practices, which are introduced in the community. This mediating function involves coaching as a strategy for mobilizing nurses in the community network. As community and public health nurses, we are in a position to experience uncomfortable defining traits of the local context —such as violence, traffic drugs traffic, prostitution and socio-political restraints, which higher-level agencies prefer to ignore[11].

Working in close proximity to the community brings out the existence of inequalities that can invalidate many empowerment and health policy participatory approaches as conceived by the upper levels of the network. While one can draw attention to theoretical inequalities, on the local level, the others on the field have to deal with concrete inequalities, which determine the health of vulnerable populations. This fact engenders the necessity of basing nursing on discussions with other sectors, community groups and disciplines about the kinds of desired societies, economies, and political systems and the reasons for wanting them.

Nurses become mediators between the community and academia, with a view to the strengthening of the collective construction of knowledge going from the base (local community actors and professionals in community networks) up, such so that research activities take this knowledge into consideration and give it visibility in a "knowledgeable vocabulary." In another publication, I talked about "intermediaries", but here I would like to follow Latour in his distinction between intermediaries and "mediators"[12]. For him, intermediaries "is what transports meaning without transformation"; while mediators "transform, translate, distort, and modify the meaning or the elements they are supposed to carry". "Their input is never a good predictor of their output; their specificity has to be taken into account every time"[12]. According to this distinction, nurses are not mere intermediaries (passive transmitters) of knowledge connecting academia and public health networks to community, but possess the autonomy to adapt the communication according to context and situations. Dubet also talks about "mediators"[13]. For him, mediators have a cultural proximity with the populations they work with. They are essential for

their "being", for "what they are" and their "personal characteristics", capable of engaging with other through their natural skills. This connects to the result of an ethnographic study in Brazilian shantytown: community health agents confront personal and professional identities in situations influenced by power and personal prestige, fidelity and moral engagement with their community within a formal work commitment[14].

One important competency to develop is the way to make care accessible to a local group living in a socio-economically (precariousness) and socio-politically (inequalities with regard to being heard and considered) vulnerable context. While remaining critical with regard to the political implications of partnerships, nurses can catalyze collaborative projects between the local community, front-line intervention organizations, the administrative level of health care for the population, and the teaching and research communities. The engagement in the settings of organized collectives of people living in vulnerable contexts can also be viewed as a professional practice (e.g., with community groups in the fight against AIDS, collective kitchens, refugee rights groups, youth shelters, etc). In this connection, their professional functions involve health promotion, prevention and social action related to individuals, groups, organized collectives or local communities.

Educating people to see and act together in conditions of precariousness and insecurity

It is important to pay attention to the evolutionary process within projects, programs and healthcare services. To be immersed in the local activities help to get a better grasp of the realism that "deviations" or "gaps" might actually be adjustments and safeguards developed by the local health professional, despite apparent "deviations from the ends" of the pre-established public health program objectives. During the nursing research activities performed in 2004, the perception of the dynamism of the process would not have been possible if it had been based only at a moment in time. It was an ethnographic approach and previous practices in the community over time (1994-2000) that made it possible to observe these changes.

There is a "nursing potential" in drawing out and giving visibility to knowledge generated by fieldwork. However, there is a lack of recognition of nurses' contribution to developing the community approach in public policies. Nurses take a local approach based on closeness to the community, enabling the construction of knowledge based on the experiences of local actors. This approach acts as a catalyzer for exchanging knowledge among nurses, the organized collective, and the local, regional, national and international academic community. For example, the collective production of an evaluation guide involving a coalition of community AIDS organizations led to the development of promising practical evaluation tools for improving the visibility of local knowledge generated by local interveners, including nurses specializing in AIDS[9].

There is an important literature in health promotion that favors the empowerment of people living in contexts of vulnerability. It implicitly means that these marginalized sectors should acquire capacities to take themselves in hand and to advance their cause. On the other hand, Freire sees the emancipation of community not as the result of adapting to a reality, but, rather, as the capacity of its members to break with crystallized ideas about accommodation and to opt for transforming and intervening in the world[15]. He believes in the possibility people have for becoming active and fully participating people able to take chances and become carriers of social change. This radical way of seeing people stands apart from the conception of health education aimed at knowledge transfer to the community.

What is involved here is a sharing dimension in our understanding of knowledge conceptualization and diffusion, which goes beyond the simple notion of unilateral knowledge transfer from experts to a lay public. It calls for an exchange of knowledge in which experts also place themselves in the role of a lay public, realizing that both interactive sectors have something to learn from the other. The systematization of health popular education experiences brought a Peruvian interdisciplinary team to analyze the spontaneous practice from community to resolve their health and other problems[16]. The empowerment and participation' s philosophy must be realistic with regard to raising the consciousness of people who have long been immersed in collective and individual powerlessness. These people do not need to be "enlightened" or have their "consciousness raised." Rather, they need to acquire concrete strategies for increasing their resources and social capital.

Developing a theoretical-practical mediation of research in action

The maximization of group participation and autonomy has a direct effect on the choice of a theoretical framework for developing community health knowledge. In graduate studies programs, professional nurses try to incorporate practice and research in a single career space. This merging of the conception of research and practice can potentially shift knowledge development in the direction of community practice settings. It opens the door not only to interdisciplinary approaches, but also to diversity in the production of community health knowledge. "Research in action" is a potential tool for developing this theoretical-practical mediating role in groups and collectivities.

Action-research stresses the resolution of real, concrete problems determined by participants who feel they are important in their daily lives. Drevdahl proposes an action-research model that takes this requirement into account and advocates the search for actions to help the community aim at changing its conditions of social precariousness rather than merely adapting to them[17]. She argues that participatory research is both intervention and knowledge production, inasmuch as the latter is used to better understand and change situations of social oppression within the community.

In addition, "research in action" is also viewed here as a form of learning in which participants and researchers co-generate knowledge via a dialectical process that also draws on the diversity of experiences. Physicians, nurses and community workers have to come to terms with a task that requires constant availability to provide the emergency services characteristic of the social services, health and community network. As such, research activities are added onto professional responsibilities with users, who remain their priority. Meetings with the community and various cultural events (festivals, celebrations, and training sessions) are important opportunities for research, leading to the identification of issues for discussion, to giving meaning to collectively generated information and to thinking about the progress made by community health nursing actions. Walking five minutes from home to join a weekly meeting in an "invasão" [land invasion] during a year was for the author a very rich opportunity to better understand the living conditions and real needs of a group of people living in a marginalized situation with precarious means for subsistence.

Participation also presupposes intercultural negotiation in every sense of the term: ethnic cultures, nations, regions and unequal power relationships. The open expression of the participants' thinking is the foundation of this agreement. It is a dialogue that begins with an explanation of research in action, that is, in situations that require direct action. Abstract, theoretical explanations of participatory perspectives are incomprehensible to participants. They grasp their practices on the basis of a palpable reality and the emerging problems encountered in day-to-day life and survival. During the group discussions with participants of the peer-education evaluation' experience with sex workers, information was produced through analogies with environment, nature, with comparisons with similar situations, and by individual or collective experiences of the Amazonian portrait.

By becoming involved in local activities with community groups, there are potential opportunities to create spaces for groups and collectives living in contexts of vulnerability to express themselves. These explorations of concrete pathways for producing changes in their lives eventually become the real "arguments" for their empowerment. The premise of participatory action-research is the importance of establishing a dialogue with participants to ensure an understanding of their situation and their possibilities for making suggestions likely to be incorporated into a research protocol and the participation of the researcher as volunteers among the participant DST/AIDS community groups. As an international volunteer and inhabitant, this situation meant to deal with multiple languages to communicate such as Portuguese and Spanish with local colleagues, English with the funding institution and French with family which encourage "multi-language comprehension"[18] and minus ethnocentricity. Participation presupposes the inclusion of the variety of individuals or organized collectives upon whom the success or failure of implementing community care partly depends.

As a starting point for incorporating research into community health practices, many actors can be identified in terms of their influence on community care: a) direct actors in the local structure of community health activities (users, local community workers and partners); b) indirect actors in the social services and health network, and legal, political and cultural apparatuses; and c) regional and national

actors such as health and social services agencies, politicians and the research community[19]. There is, however, an increased potential for collective action aimed at a common goal or project when rigid formal rules are set aside and through the creation or emergence of informal spaces not subject to any form of control; this opaque space allows flowing discussion[20]. A pre-established agenda and technical vocabularies imposed to participant by municipal health comities increase the inequalities of participation between health professional and population[21]. People who are invited to talk freely about their project might hold back if they think that controversial information might be publicly disclosed.

Articulating professional ethics within a nursing militancy

Despite the growing importance of participation and critical consciousness in peer education with HIV/AIDS programs, no study underlines or even mentions the dangers involved in conducting peer-education, evaluation and research when living in the community. Community action and developing social policies are legitimate concerns for the nursing discipline and profession. However, most nursing theories are articulated around either holistic or unique conceptions of people as individuals. These conceptions inhibit the analysis of larger social structures and the identification of community approaches that can lead to political gains[22]. Understanding the individual outside his context has led to an understanding of nursing care outside its political context.

Viewing health as an individual matter relegates the social and political causes to the realm of the implicit and ultimately negligible variables, which can lead to a loss of health to the background. By viewing health as a social obligation, there is a need to develop community nursing care that contributes to creating, maintaining and promoting healthy environmental, social and political contexts. Every year, the local riverside population of Amazonas (Brazil) suffers “enchente” [floods] during July, by opposition to the “seca” [dryness] of October period. Those natural disasters must be recognized and taken into account as important constraints for public health program extension in those isolated areas, given the additional difficulty for the passage between rural communities and municipalities. Fluvial transport, like “recreo”, is the unique way to reach those distant communities and should be measured in the evaluation of local community health nursing practices, while the national ethic and policy assumed equality in healthcare distribution. Enacting ethical practice involved working in the spaces ‘in-between’ various players, encountering tensions and conflicts in values, making choices and choosing their responses[23]. In this context of vulnerability, questions that introduce a political agenda in community health nursing practice are inevitable. Nurses already draw upon several kinds of knowledge, including art, empiricism, personal and ethics as well as socio-political knowledge[24]. This knowledge might bring an understanding of the nurses’ and patients’ socio-political context as well as the way in which society views the role of nurses and how they understand society and its policies. Acquiring those skills, that entail taking positions, will pose explicitly the challenges in terms of political options and cleavages in-between public health institutions, nurses, patients and their so-called vulnerable communities.

FINAL CONSIDERATIONS: LEARNING FROM EXPERIENCES

Frequenting groups and collectives and sharing their everyday life gives a better understanding of the social conditions that have an impact on their autonomy with regard to health. In remaining close to the local actors directly involved in a health prevention and promotion project, nurses develop a privileged position enabling them to think while in action. Physical movement in reaction to the concrete reality of a health problem (field presence of practices) leads to the creation of intuitive thinking in light of complicated and unprecedented situations, to the ability to come up with original solutions or to find ways to meet the real needs of a given group or community.

The ties of solidarity and belonging developed in informal, mutual-help action groups represent interesting avenues for research on the development of knowledge related to health prevention and promotion. A realistic and inclusive view is necessary in the settings in which nurses often work. In these settings, one has to know how to act in emergency situations and how to make decisions in the absence of certainty, with limited means and intrusive problems, which make it impossible to isolate “health” as an

independent field of professional action. The autonomy of public and community health nurses can be developed through their becoming conscious of their personal choices, their values and their commitments, an awareness of the reasons, explicit or implicit, behind their acts, which derive from their knowledge of how to act in society. A given society has life situations that differ widely from those imagined in an abstract and universalistic notion of health. If we want to be agents of change and not oppressors to groups living in contexts of vulnerability, we also have to go through this process of emancipation and development of personal and collective autonomies that is part and parcel of our convictions. Zúñiga argues that the systematization of experiences possesses a power of convocation for a collective expression of professional knowledge[7]. Originally created in the seventies and eighties, it provides a method to redefine the interpretations and models of social practices from the peculiar Latin American reality[25]. It might be a useful tool for health professionals to face the challenge of describing their "indescribable" field practices.

REFERENCES

1. Demo P. Saber pensar. Guia da escola cidadã No 6. Instituto Paulo Freire. São Paulo (SP): Cortez; 2001.

2. Farmer P. Health, healing, and social justice. Insight from liberation theology. In: Pathologies of power. Berkley: University of California Press; 2003. p. 139-59.

3. Zúñiga R, Laperrière H. Avaliação comunitária: conflitos verticais e ambigüidades metodológicas. In: Bosi MLM, Mercado FJ, editors. Avaliação qualitativa de programas de saúde. Enfoques emergentes. Petrópolis: Vozes; 2006. p.118-44.

4. Jara O. El Desafío Político de aprender de nuestras prácticas. Proceedings of the Encuentro Internacional sobre Educación Popular y Educación para el Desarrollo; 2002 November; País Vasco, Murguía. Available from: http://www.alforja.or.cr/sistem/biblio.html.

5. Demo P. Pesquisa qualitativa. Busca de equilíbrio entre forma e conteúdo. Rev Latino-am. Enfermagem. 1998 abril; 6(2):89-104.

6. Schön DA. The reflective practitioner. New York: Basic Books Inc; 1983.

7. Zúñiga R. Sobre el sistematizar. Revista de trabajo social; 1992; 61: 19-29.

8. Morgan ML, Monreal ML. Una propuesta de lineamientos orientadores para la sistematización de experiencias en trabajo social. In: Morgan ML, Monreal ML, Escobar M, Escalante NG, editors. Sistematización, propuesta metodologica y dos experiencias: Peru y Columbia. Lima: CELATS; 1991. p.11-36.

9. Zúñiga R, Luly MH. Savoir-faire et savoir-dire. Un guide d'évaluation communautaire. Montréal: COCQ-sida; 2005.

10. Narroll R. Data quality control. A new research technique. New York: Free Press of Glencoe; 1962. p.14-15.

11. Laperrière H, Zúñiga R. Sociopolitical determinants of an AIDS prevention program: multiple actors and vertical relationships of control and influence. Policy, Politics & Nurs Prac; 2006; 7(2):1-11.

12. Latour B. Reassembling the social. Oxford: Oxford University; 2005.

13. Dubet F. Hors de l'institution: les médiateurs. In: Le déclin de l'institution. Paris: du Seuil; 2002. p.269-302.

14. Zanchetta MS, Leite LC, Perreault M, Lefebre H. Education and professional strengthening of the community health agent - an ethnography study. Online Braz J Nurs [Online] 2005; 4(3). Available at: http://www.uff.br/objnursing/viewarticle.php?id=74&layout=html.

15. Freire P. Pedagogia da indignação. São Paulo (SP): Editora UNESP; 1996.

16. Escobar M. Sistematización de una experiencia de educación popular en salud. In: Morgan ML, Monreal ML, Escobar M, Escalante NG, editors. Sistematización, propuesta metodologica y dos experiencias: Peru y Columbia, Lima: CELATS; 1991. p.37-114.

17. Drevdahl D. Coming to voice: the power of emancipatory community interventions. ANS Adv Nurs Sci; 1995; 18(2):13-24.

18. González, EMG, Lincoln YS. Decolonizing Qualitative Research: Non-traditional Reporting Forms in the Academy. Forum Qualitative Social Research [On-line Journal] 2006 September [cited 2007 February 11]; 7(4). Available from: http://www.qualitative-research.net/fqs-texte/4-06/06-4-1-e.htm.

19. Laperrière H. Evaluative Research in Socio-political and Socio-cultural Context: Methodological Challenges and the Urgency of Social Interventions and Health Prevention in Remote Regions. Forum: Qualitative Social Research [On-line Journal] 2007 February [cited 2007 February 11]; 7(4). Available at: http://www.qualitative-research.net/fqs-texte/4-06/06-4-6-e.htm.

20. Friedberg E. Going beyond the Either/Or. J Manage Gov; 2000; 4:35-52.

21. Wendhausen A. O duplo sentido do controle social. (des) caminhos da participação em saúde. Itajaí: UNIVALI; 2002.

22. Drevdahl D. Sailing beyond: nursing theory and the person. ANS Adv Nurs Sci 1999; 21(4):1-13.

23. Varcoe C, Doane G, Rodney P, Storch JL, Mahoney K, McPherson G, et al. Ethical practice in nursing: working the in-betweens. JAN J Adv Nurs 2004; 45(93): 316-25.

24. White J. Patterns of knowing: Review, critique, and update. ANS Adv Nurs Sci 1995; 17(4):73-86.

25. Jara O. Systematizacíon de experiencias y corrientes innovadoras del pensamiento latinoamericano. Uma aproximacíon histórica. La Piragua 2006; 23: 7-16. Available at: http://www.ceaal.org/main/contenido.php? elemid= 127813.

Recebido em: 21.2.2007
Aprovado em: 20.8.2007