DISCOVERING POPULAR EDUCATION IN PROFESSIONAL COMMUNITY HEALTH CARE PRACTICES

DESCOBRINDO A EDUCAÇÃO POPULAR NAS PRÁTICAS PROFISSIONAIS DE SAÚDE COMUNITÁRIA

DESCUBRIENDO LA EDUCACIÓN POPULAR CON LAS PRÁCTICAS PROFESIONALES DE SALUD COMUNITARIA

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ABSTRACT: Exploring the relationship between popular education and health care as regards to public and community health nursing, a case is made that popular education is more than a pedagogical approach to teaching. Following an inductive strategy, experiential vignettes of the author's practices and commitments in impoverished Brazilian populations are systematized to identify contributions of popular education in health care. Experiential learning leads to a preferential option for the poor, a reduction of power inequalities between program agents and the people, the use of Observe-Judge-Act methodology and a theory that is realistic in terms of possible changes of consciousness. Popular education fosters both the emergence of tacit nursing care actions and includes those of voiceless populations living in poverty.

PALAVRAS-CHAVE: Enfermagem em saúde comunitária. Educação em saúde. Pobreza.

RESUMO: Explorando a relação entre a educação popular e os serviços de saúde, quanto à enfermagem pública e comunitária, é permitido mostrar que a educação popular é mais que uma abordagem pedagógica de ensino. Seguindo uma estratégia indutiva, vinhetas que ilustram as práticas e compromissos da autora em populações brasileiras empobrecidas são sistematizadas com a finalidade de identificar as contribuições da educação popular no cuidado à saúde pública. A aprendizagem experiencial leva a uma opção preferencial pelos pobres, uma diminuição das desigualdades de poder entre os agentes dos programas e a população, ao uso da metodologia Observar-Julgar-Atuar e de teoria que é realística em termos de possíveis mudanças de consciência. A educação popular fomenta ao mesmo tempo a emergência de tácitos cuidados de enfermagem e inclui os das populações sem-voz, vivendo na pobreza.

PALABRAS CLAVE: Enfermería em salud comunitaria. Educación en salud. Pobreza.

RESUMEM: La exploración de la relación de la educación popular y los servicios de salud en materia de enfermería en salud pública y comunitaria permite mostrar cómo la educación popular es algo más que un enfoque pedagógico en la enseñanza. Siguiendo una estrategia inductiva, viñetas que reflejan las prácticas e implicaciones de la autora en poblaciones brasileñas marginales son sistematizadas con el fin de identificar las contribuciones de la educación popular a la salud pública. El aprendizaje vivencial realizado orienta a una opción preferencial por los pobres, una reducción de las desigualdades de poder entre los agentes de los programa y la población, el uso de la metodología de Ver, Juzgar, Actuar, y, de una teoría realista respecto a los posibles cambios de conciencia de los que viven en la miseria.

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INTRODUCTION: AN INITIAL PREMISE

This paper is an analysis of questions regarding popular education and health care that may contribute to the area of public and community health nursing. My argument is that popular education in health care is more than a pedagogical approach to teaching. It is more a way of viewing social relations as being centred on a desire to bring about change. Public health programs define the relations among sectors as the responsibility to contribute to the dissemination of knowledge acknowledged as scientifically reliable to populations that can benefit from this societal investment in improving their living conditions. In attempting to reach out to marginalized populations in peripheral neighbourhoods and remote regions, public and community health nurses work in demanding contexts. They nevertheless succeed in transmitting implicit contents that facilitate and even enable the continuity of programs and health services. As mediators in defending care rights for marginalized peoples, they share in part the discrimination and oppression experienced by these groups. The popular education perspective fosters here not only the emergence of these invisible nursing care acts in a formal discourse of care knowledge, but also includes those of voiceless populations for health policy programming affected by a project in which they did not participate.

In relation to experiential knowledge acquired as a community facilitator, nurse and researcher, the present article seeks to give the power of acts back to local actors in public health programs. Within the framework of popular education, health care becomes a possibility for re-appropriating prevention acts and community health care by those working at the grassroots level (nurses, social workers, psychologists, family physicians, dentists, community health workers and other caregivers), the participants (program users) and groups typically forgotten (marginalized socio-political actors). A review of these field experiences as a nurse gave rise to questioning about the "invisibilization" of peripheral popular knowledge (practical efficacy), that is, knowledge that has been developed to deal with the unforeseeable aspects of day-to-day life in situations in which the participants have little power to "predict and control".

The public health programs with which I was involved in Amazonian region (Brazil) were mostly evaluated quantitatively, but the testimonies such that the stories told to explain why objectives were not met within the prescribed timeline or the difficulties of intervening in catastrophic circumstances could not be expressed. They were eliminated from reports because of their "anecdotal nature". For example, the management of a related leprosy detection program only wanted information about infection rates, spread and number of individual interventions in the report of our 20-day trip through rural villages during the flood season, which was so violent that it changed all idyllic visions of "mother nature". Since they are not consistent with scientifically-accepted measurable indicators, several intervention activities are passed over in silence. They are gagged by the requirement to use only available and acceptable indicators. This is the case for conviviality actions, original ways of establishing a bond of trust and overcoming obstacles encountered in contexts rife with danger.

Concrete insertion into local projects as a nurse taught me both that we have very few professional responses to complex health issues in remote and impoverished regions and about ways of being, living and caring for people in the community. Indeed, some rural communities have developed ways of living, of amusing themselves and of dancing as ways to improve the quality of life in a context of extreme adversity. This is also the case for the sex workers in a prevention project, among whom I discovered a sense of loyalty that could lead them to risk their lives to save a colleague from the violence of their clients. There were also peer educators who displayed these forms of ingenuity, cleverness and inventiveness in their intervention practices related to HIV prevention. Boff e Boff point out that practices geared to the "poor" generally favour strategies to help them by treating them as collective objects of charity and not as subjects with the capacity for their own liberation.[1] Typically, aid projects take the form of band-aid solutions applied to the social diseases of the poor. It is in this way that there is an omission in the view we generally have of people who are seen as poor, which occludes their capacity to resist, to understand their rights, to organize and to transform their dehumanizing condition.

These strategies also draw on Mendel's notion of practical rationality, which is usually denied as a form of intelligence vis-à-vis scientific rationality and dominant techniques.[2] He explains how the philosophical birth of human beings 25 centuries ago expelled the "act" from intellectual

reflection. Mendel structures his critical thinking around a distinction between thinking that surrounds action from that of its implementation. He limits "action" to the thinking that precedes, accompanies and evaluates acts visualized in the mind as ideas, and eh reserves "act" to speak about a forgotten process, namely, the struggle of ideas to transform an external reality. This insertion into a dynamic is, for Mendel, an adventure, a risk and a gamble and, as such, necessarily unpredictable. In this view, his critical strategy is to see discourse about action as having a descriptive as well as an ideological function, which is to shift attention from "what is happening" to "what we would like to see happen". Our [Western] culture is built on a triumphal vision of the human spirit and on the erroneous base of a capacity for total domination of nature and, with help from philosophies of history, for mastery of society.[2]

INDUCTIVE STRUCTURE: EXPERIENTIAL VIGNETTES OF POPULAR EDUCATION

Vignettes illustrate here the experiential learning pathway in popular education. This pathway is engendered by an engagement in Brazilian social movements, which has greatly influenced my professional nursing practices in public health programs. "A vignette is a focussed description of a series of events taken to be representative, typical or emblematic in the case you are doing".[3:81] Dating from 1994 to 2000, the following vignettes were produced from processed field notes, correspondence and reports of nursing practices in north region of Brazil.

Collaboration with a women's association

As a nurse and community member, a community facilitator role is gradually constructed on the basis of local requests, observation and attentiveness to needs, and active participation in social and collective activities in the region. This role took shape in community actions aimed at: identifying needs and organizing the training of natural community health workers; giving value to the local population's knowledge about traditional care practices; and supervising volunteers. A request by women in riverside communities indicated a desire for the facilitation of local committees within a women's association. As part of educational activities conducted, several documents were produced and adapted to Amazonian culture. The major themes of these documents were: domestic violence; the "Observe-Judge-Act" method of analysis (a precursor of participatory action-research); political education, specific health care for women; use of medicinal plants; organizing neighbourhood committees; and organizing democratic elections. The things learned with these women's groups raised several questions about the role of facilitation and community education in community nursing, such as the formalisation of this function in public health services (Vignette 1). How can organizational support be integrated via interventions in an autonomous social structure that needs to be treated more as a partner than as a service request? What kind of informal (or formal) organization defines their existence as collective action that is different from and at times opposed to the objectives of pre-established services?

Vignette 1: engaging with a women's association – learning a nurse's role as a community facilitator in neighbourhood committees.

Distributed among five neighbourhood committees, the women were fighting to obtain greater visibility in the community and to make their rights known while seeking to improve their living conditions. There was resistance to their project. For example, some members favoured by radical groups and viewed as leftist (Workers Party, Human Rights Defence Centre) advocated adopting a hard stance vis-à-vis local authorities. In collaborating with these women, I realized that they were demanding leisure activities, using inventive opposition strategies such as asking for Women's Police and a Health Station, which necessarily involved making compromises with politicians. My view is that the struggle for social justice did not mean renouncing ideals; rather, it involved tempering their discourse with a view to obtaining their concrete demands. By making gains in improving their living conditions, their actions were more effective than those undertaken by the Human Rights Defence Committee, who viewed them as "hypocrites without convictions." Although I was initially angered by this kind of "quiet" revolution, I came to appreciate the judiciousness of their "art" of living for the long term and of raising children in an oppressive setting" (From my personal correspondence as a popular community health educator to a Non-Governmental Organization, summer 1996).

Peer-educator training in a prevention program in prostitution zones

A new public health program had been established, and I was invited to participate in this Sexually Transmitted Diseases (STD) and Acquired

Immunodeficiency Syndrome (AIDS) prevention project among sex workers in rural prostitution zones near my home. This information comes from my nursing field report on August 25th 1999. The team of peer-educators asked for a worker to accompany them to these areas to provide STD/AIDS consultation services in a small health unit. There had been no clear description of the nursing activities. Each day, I observed the work accomplished by five peer educators in the field of sex work and participated in bi-weekly steering committee meeting with the regional authority responsible for this specific project (Vignette 2). The peer-group approach seeks effective contact where it would otherwise be impossible. Not all the peer educators were sex workers; some were members of the local community. This next information was found on my correspondence with the Brazil Field Director in 2000. As both a nurse and a peer educator, I worked with a team mates in facilitating the dissemination of information about safe-sex behaviour and the sale of low-cost condoms. We visited motels, all-night bars and nightclubs, riverside docks and restaurants.

Vignette 2: proximity to the "risqué", "on-the-ground" learning with multipliers.

At night, five minutes from my home, I started to walk with peer educators into prostitution areas and bars and discovered little by little a hidden world. There were many floating bars operating day and night to service sex workers, gangs, fishermen, and transients. Being present in these marginal areas meant coping with a number of social problems. Our function was not so much to change the situation, as it was to avoid the propagation of STDs; however, we cannot ignore the fact that walking in bars and prostitution areas at night moves feelings inside. I could feel that the peer educators had been able to approach sex workers in an extraordinary way. They were involved with them in a way that no other social group was. I noticed that when peer educators care about marginal health – even if it is just by offering one condom or pamphlet – they are saying: "you are somebody". This is the foundation of behavioural changes on both sides. Walking in prostitution areas also means hearing "live" gun fire, screaming of help from sex workers, and once a confronting young men armed with knives at the corner, all this with a professional awareness that life should be preserved" (From my nursing field report on February 28th 2000).

The educational activity consisted mainly in giving a short explanation about STDs, each week on a different theme, and finishing with a traditional demonstration of condom use on a rubber penis. That next information was also obtained from my nursing field report of February 28th, 2000. In the floating bars in the port area, this means stopping popular singers, a band or radio music, in order to catch the patrons' attention and then speaking through a microphone and giving live educational talks. Sex workers sometimes plied their trade in bars, and at others they passed through bars following the movement of their clients. We noticed that when they work for a floating bar, they have to get the owner's permission for time off for medical or nursing consultations. One of the nurse's responsibilities was to engage with owners and negotiate the care of their workers. During intensive fishing periods, we observed that sex workers would work weeks or even months offering their services on a boat. We had to adapt our preventive approach and nursing STD/AIDS consultation appointments to Amazonian sex workers' conditions. In addition to regular programs, there were many other related activities developed with the project. Working in marginal areas opened many possibilities, and over time we discovered more and more needs. My attitude was one of collaboration. One event that drew my attention was the Christmas celebration which included sex workers, colleagues, nurses, doctors, families, homosexuals, drag queens and the municipal health secretary. All the people from various walks of life found themselves together, laughing, embracing each other and dancing together. "Will this lead to a concrete result? How can statistics and numbers evaluate this work?" Building on those experiences, the professional nursing duties were constructed which included many roles: supervision with the Pan-American Health Organisation, supervision of peer-educators in prostitution zones, workshops with psychologist, Prevention Olympics at a high school, theatre's plays, participation in the national STD congress, accompanying a professional photographer in the floating prostitution zones, presentation of the project with the Mayor and the media, or a Christmas celebration with sex workers.

In a last nursing report, I wrote that this new job had involved more than "nursing" qualifications; it had developed my social consciousness (Vignette 3). The perfect profile description for this context was that of "social nurse," that is, someone who is able to confront his or her preconceived notions about the most marginal populations, sex workers, homosexuals, lesbians, delinquents, gangs, seropositives, drag queens, etc. I was in a progressive

conversion. Through this dark suburb of prostitution, I discovered over time the extraordinary colours of solidarity, friendship and human sensitivity around me. In one correspondence in between the Brazil Field Coordinator and me on January 2000, we tried to describe this nursing position for future health workers. This job required to accept invitations to speak about their work at national medical events and run training courses for a wide variety of visiting professionals, including student nurses and doctors from university extension programs. The nurse's role created here also included being committed for the sustainability of the work and plans to extend it to the whole state. This next information was obtained from my last nursing field report of January 30, 2000. In the first years, it was hard to define a nursing commitment in the field. The daily informal evaluations and comments from my colleagues encouraged me not to fall into the trap of comfortable routine. Through my nursing profession, the leading commitment was to turn away from myself and meet the others, to live and work in solidarity with people from another culture.

Vignette 3: skills sharing relationship: a constant spirit of transformation.

After three years of experiences in this area, my major goal was to attempt to establish a shift from "living with" to "living as" the rural Amazonian people around our home, a shift that called for many transformations and conversions. As a nurse, my decision to choose leprosy and STD/AIDS programs in the Amazonas interior was influenced by my desire to work very closely with the more marginalized members of Brazilian society: lepers, people without papers, sex workers, lesbians and homosexuals, drag-queens and people living with Aids. With their competences, spirit of initiative and creation, daily giving of themselves, my Amazonian colleagues had taught me to change my expectations as a nurse and international volunteer. A sane humility and a constant spirit of transformation had been built into this skills sharing relationship between us (From my final nursing self-evaluation field report, January 30, 2000).

But who were they? What did they do? How did they see themselves? What motivated them? What were their values? What action skills did they develop? Along with the practice, preoccupations for nursing research has risen related to the role of the people they dealt with – higher up and lower down – that is, the people in charge of the organizational aspects of their work, peers with whom they had to work as peers and in acknowledging their participation in a power structure (control of resources and possession of knowledge).

A CRITICAL AND DIALOGICAL READING OF THESE EXPERIENCES: SOME COMMON FEATURES

Theorizing on the basis of varied and intense popular education practices turns out to be complex. Engagement in "liberation" movements played a crucial role in the introduction of community nursing care practices and, subsequently, nursing research with riverside populations. Professional health practices have been influenced by Latin-American notions of popular education,[4-7] as well as by responsiveness to cultural meaning.[1] In the historical, social and cultural context of Latin American in the 1970s, the "liberation" current emerged out of the search for meaning by several people (theologians, social psychologists, sociologists, and others) who were concretely engaged in the cause of excluded and marginalized populations in various countries in particular, Brazil, Chile and El Salvador, that is, mainly in countries characterized at that time by dictatorships. The Conference of Latin American Bishops fostered this current in their Medellín (1978) and Puebla (1979) meetings. The various skills acquired during these experiences can be grouped into generative themes in order to share this experiential knowledge with an outside public.

Making a preferential option for the poor

The popular education framework includes the advantages of personal engagement in programs above and beyond the depersonalized functions of health professionals or researchers. The main actors in the area of popular education concur with regard to going beyond the technical dimension of health education. Indeed, it was the historicity of the experiential learning of grassroots education movements, such as *Pastoral da Saúde*, grassroots ecclesiastical communities, *Jeunesse Ouvrière Catholique* (Catholic Youth League) and the Women's Association, which considerably influenced my popular education practices in institutional public health settings. The popular education movement, which encouraged proximity to, and even living with local communities, influenced the creation of new professional and institutional practices. In situating them in the neighbourhoods where the lower classes live for primary health care.[5] Historically, these people's movements have incited professional educators (teachers, nurses and physicians) to return to the principles of popular education.[6]

Being close to the local environment enabled the project's insertion into the social movement, such that the community nursing diagnosis took into account the socio-cultural and socio-political context. It encouraged the health professional to insist that a multiplicity of actors be involved in the project's day-to-day aspects. These actors operated within the framework of unequal relations of control and influence – in a relative verticality of power – which exacerbated the health program's "context of unforeseeability". The notion of caring 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 socio-economic reality of community health practices. Action-power is a form of reflection in action that takes risks, in contrast to theoretical rationality, which remains at the level of ideas "without risk".[2] With a view to producing nursing knowledge, nurses draw out and give visibility to knowledge generated by fieldwork. Community health nurses practice within a local approach based on closeness to the community, enabling the construction of knowledge based on the experiences of local actors. Popular education approach acts as a catalyser for exchanging knowledge among nurses, the organized collective, and the local, regional, national and international academic community.

Many public health programs favour the empowerment of people living in vulnerable contexts. 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.[4] He believed in the possibility people have for becoming active, curious people able to take chances and become carriers of social change. This radical way of seeing people stands apart from the public health institutional conception of health education aimed at knowledge transfer to the community. What is involved here is a sharing in the transformation of knowledge, which goes beyond the simple notion of unilateral knowledge transferred from experts to a lay public. This calls for an exchange of knowledge in which experts also place themselves in the role of a lay public. However, the use of empowerment and participation in community health nursing 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. For example, how is practical rational knowledge used to feed a family on a wage of three dollars a day or to build a parade float out of leftovers from garbage dumps two hours before the start of the carnival parade? Although Mendel's theory is intended for professional practitioners, I want to throw out the challenge of believing in the capacity of the thought-in-action of Amazonian "practitioners", particularly those who live in floating houses, and of populations which health professionals characterize as "at risk," "vulnerable" or "underprivileged," all the while subtly suggesting that they are incapable of adequately managing their lives.[2]

Working in close proximity to the community brings out the existence of inequalities that can invalidate many empowerment and health policy participation approaches conceived by the upper levels of the network. While community health nurses can draw attention to theoretical inequalities, on the local level, they have to deal with concrete inequalities that determine the health of vulnerable populations. This fact engenders the necessity of basing community health nursing on discussions with other sectors, community groups and disciplines about the kinds of desired societies, economies and political systems, as well as the reasons for wanting them. It is in this light that I argue that the development of innovative approaches to care and conducting research would be enhanced by asking both "Why act?" and "Act how?" It would require the scientific and moral courage to act on answers that fall outside accepted and enforced parameters, which attain their clarity at the cost of selective restriction of "acceptable" data. This is a strong call for the assertion of the potential to choose for a nurse in a dangerous political context of research practice and provide options for the poorest.

Reducing the vertical distance of power between program agents and the people

Community health nurses often consider how to make health care accessible to groups living in contexts of poverty. While remaining critical with regard to the political implications of partnerships in public health programs, nurses can put in perspective a more equal collaboration between

administrators, researchers, professionals and users, clients, participants. To better take into account local actors directly involved in change, the starting point for community health care consists in a mediating function based on practices inserted into the community. This mediating function involves coaching as a strategy for mobilizing nurses in the community network. Nurses become mediators between the community and academia, with a view to the collective construction of knowledge going from the base up, such that research activities take this knowledge into consideration and give it visibility.

Latour sheds light on the foundations of this kind of an analysis in his distinction between intermediaries and mediators. For this author, an intermediary "is what transports meaning without transformation";[8:39] 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".[8:39] According to this distinction, nurses are not mere intermediaries (passive transmitters) of knowledge connecting academia and public health networks to community. Rather, they have the autonomy required to adapt the communication according to the context and situations. Dubet also talks about mediators, which in his view are in cultural proximity to the populations with which they work.[9] They are essential for their "being," for "what they are," and for their "personal characteristics," capable of engaging with others through their natural skills.

There are different situations in which nurses work and are included in more complex educational relationships between the so-called "popular" and their professional status. Education takes place in unconventional ways, formally and informally, consciously and unconsciously. The prevailing conception of knowledge or skill transfer has negative connotations that imply that power is in the hands of the one who has the skill whereas the other one who lacks it is "rightfully" placed in a dependent position. The concept of "skills sharing" can be more creative and flexible, employing different ways of achieving it such as meetings and other types of social events. In Brazil, I learned how to bring together people into small discussion groups using these frameworks. Without having any prior notions about social service and education, I thus learned "as I went" how to draw out knowledge in collective situations (e.g., valuing popular knowledge about medicinal plants in a riverside community, or the capacity to demand Women's Police in an area in my city). At night, I read literature produced by grassroots ecclesiastical communities or Brazilian popular movements – Pastoral da saúde, Centro de Defesa dos Direitos Humanos, Movimento Popular de Saúde – and thought about experience in practice. It was in this way that I developed knowledge, know-how, knowing how to act and be, with a view to drawing out ideas and encouraging consequent action with collective groups. I do not know what to call this profession. Is it a profession?

Observing, judging and acting

Using the principles of liberation theology in medical practice, Farmer explained how primary care and preventive services might be provided in local community in manifesting a "pragmatic solidarity" in caring for HIV/AIDS patients in Latin America.[10] He recuperates the popular education methodology "Observe, Judge and Act" as a methodology to make community health problematization with its members. The steps are commonly shared by health professional and people: collect information from community and practices (observe), then analysis it collectively (judge) in order to pose a concrete collective action (action). There is no magical answer to the challenge of understanding the dialectical relationship between the local and the universal. The possibility and the limits of experience transfer and of empirical knowledge generalization are faced with problems equal to those encountered by attempts to impose abstract solutions produced in very different societies and with other interests than those that characterize the concrete research situation. Proximity enables the perception of details, but increasing distance makes it possible to place it in a global meaning context (a critical interpretation of practices). Academic settings too often confuse proximity and subjectivity, on the one hand, and distance and objectivity, on the other. This owes more to an unreflective use of language than to rigorous analysis; in order to know and to act, closeness and contact are necessary. That this closeness could be a source of convergence of interests is no truer than the fact that distance can breed indifference and incomprehension.

The premise of the popular education approach is to accept the costs of this putting thing

into perspective and to learn how to work in a genuine egalitarian horizontal structure. This approach rejects the false consciousness with regard to relations between educators and those who are taught or between researchers and subjects which holds that the intellectual's power to control, manage and authority makes participation something symbolic, a gift rather than a right and necessary condition of programmed action. To speak of the neutrality of education is to express a desire to mystify and to increase the educator's unique power. Education is a political and collective act involving the creation of effective equality, something, which is always difficult in bureaucratic structures, where the power to control reflects accountability obligations.[5] The experience of popular education in Brazil has demonstrated its contribution to deconstructing traditional relations of medical authority and its alternative potential for the participatory management of community groups in public health policy.[11]

Talking about theory as part of the problem and the possible consciousness

The premise of popular education is the actor's self-production. What comes first: personal experience or a reading in terms of a theory which leads to proposing or imposing an order of meaning? People become producers of the meaning of their reality despite the fact that they do not use of a literature review. The tendency is to reject the potential of evidence drawn from unpublished or unpublishable experience. What does an Amazonian riverside dweller know about militancy, politics or nursing care? In the latter case, knowledge evaluation allows participants in popular education to fully participate with their experiential knowledge in the construction of a collective knowledge about community health.

Latour explained that the task of "defining and ordering" the social should belong to the actors, not the researcher analyst: "we won't try to discipline you, to make you fit into our categories; we will let you deploy your own worlds, and only later will we ask you to explain how you came about settling them".[8:23] Going beyond the technical dimension of education about drugs, behavioural changes or the risks associated with health determinants, Vasconcelos sees popular health education as a dialogue with, proximity to and mutual transformation of the companions (researchers and participants) in this collective experience.[11] Conducting evaluations in a given environment presupposes that nurses and researchers bear in mind the historicity of the social and cultural organization in which the participants are immersed. Local insertion optimizes the analysis of social and historical relationships between the participants, groups and local research institutions with which the researcher was in contact.

Gilbert stresses the primordial nature of "openness and a willingness to stay present in the process, through differences, similarities and unknowns",[12:134] in intercultural communication. There are also cultural communication variations and the incorporation of modifications that can be viewed from the perspective of other cultures or social classes as "unforeseeable". National and international health aid agencies are not always able to decode the local contingent factors of variability; they tend to view them as obstacles rather than as healthy requests for adjustment. Before being assassinated in El Salvador, the psycho-sociologist Martín-Baró advocated that science should be dynamic and transformative according to their historical context. History unfolds by presenting new aspects of human reality for which scientific understanding must evolve by acquiring new information and by modifying certain prior values.[13] In situations characterized as uncertain, practitioner-researchers act as experimenting agents who seek to reframe the situation while remaining alert to reactions and open to experiencing a confused situation rife with new uncertainties. In reflecting upon action, practitioners become researchers who no longer depend on categories derived from theory or from a pre-established model. Rather, they draw out a new theory of the particular case.[2]

CONCLUSION: THE EPISTEMOLOGICAL POSITION SERVING AS A BASIS TO EMBRACE POPULAR EDUCATION IN HEALTH CARE

To come back to the initial premise, popular education cannot be viewed as a technology, a special field of action, by marginalizing the fact that it is a framework for viewing and evaluating all intervention action, which can be structured by analysis and organizing resources and actions, but which cannot be limited to this technical core. Chaudhary writes about an opposition between dominant knowledge and what he calls "popular" knowledge, which can

include professional and practical knowledge that, because it is not codified or evidence-based in an acceptable form or language, is simply ignored.[14] The inclusion of knowledge emerging from experiential learning and practices serves as a basis to embrace popular education into health care. It means a complementary epistemological position that includes a proximity to context and politic in the play of knowledge construction. Acknowledgement and acceptance of the recontextualization of knowledge production for its use in health care are argued by several authours.[15]

Using participatory research and social commitment in nursing gives a voice to people who are "voiceless" and excluded from social participation in public health programs decision-making. The systematization of experiences is an important perspective of popular education to discover significations and knowledge from practices. Emerging from Latin American popular education,[7] this methodology creates a possibility for these populations to participate is an attempt to provide the conditions necessary for collaboration between scientific intelligence (rational-theoretical) and practical intelligence (practical-rational) to occur in an egalitarian dialogue. This dialogue is possible by integrating oneself in the community with a view to becoming a vulnerable actor, because we recognize people have knowledge to share that we do not have.

The social and political requirements of professional actions recognized by political authorities can impose a silence over actions taken and implicitly based on one's personal values and political ideologies. Nurses must identify in themselves the institutional elements that oppress the creation of a space of options for creative and innovative behaviour in these practices, undertaken for the most part in shifting and uncertain situations. The popular education approach fosters the visibility of these disguised elements. As an elderly Peruvian bishop once said to me in commenting on my ardent desire to help. In this beautiful and vast Amazonia, you will gradually discover that a falling tree makes more noise than the silent growing forest. But it is the forest that is life.

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