Original Article

The meaning of healthy living in a socially vulnerable community in southern Brazil*

Significado de viver saudável em uma comunidade socialmente vulnerável no Sul do Brasil

Significado de vivir saludable en una comunidad socialmente vulnerable en el sur de Brasil

Marli Terezinha Stein Backes[1], Dirce Stein Backes[2], Alacoque Lorenzini Erdmann[3], Andreas Büscher[4]

ABSTRACT

Objective: To understand the significance of healthy living for users, professionals and managers of the Family Health Strategy (FHS) team. **Methods:** Research of a qualitative nature, based on grounded theory. For data collection, interviews were conducted with 25 participants, including users, professionals and managers of a FHS team, during the period between March and December, 2009. **Results:** The collection and analysis of data was conducted in a systematic and comparative manner, demonstrating that healthy living can be characterized as a self-organizing process, mediated by the action of the FHS team professionals, especially by the community health agent, through creation of bonds of trust and stimulation of interactions and community associations. **Conclusion:** We concluded that healthy living is a singular phenomenon, complex, interactive, associative, political and social, coupled with the active involvement and participation of the users and by the engagement of effective and socially responsible professionals, managers and established political authorities.

Keywords: Qualitative research; Vulnerable groups; Community health nursing

RESUMO

Objetivo: Compreender o significado de viver saudável para usuários, profissionais e gestores de uma equipe Estratégia Saúde da Família (ESF). **Métodos:** Pesquisa de natureza qualitativa, baseada na grounded theory. Para a coleta de dados foram realizadas entrevistas com 25 participantes, dentre eles usuários, profissionais e gestores de uma equipe ESF, no período entre março e dezembro de 2009. **Resultados:** A coleta e a análise dos dados, conduzida de forma sistemática e comparativa, evidenciaram que o viver saudável pode ser caracterizado como um processo auto-organizador, intermediado pela atuação dos profissionais da equipe ESF, especialmente, pelo agente comunitário de saúde, por meio da criação de vínculos de confiança e estímulo às interações e associações comunitárias. **Conclusão:** Concluiu-se que o viver saudável é um fenômeno singular, complexo, interativo, associativo, político e social, conjugado pelo envolvimento ativo e participativo dos usuários e pelo engajamento efetivo e socialmente responsável dos profissionais, gestores e autoridades políticas instituídas.

Descritores: Pesquisa qualitativa; Comunidades vulneráveis; Enfermagem em saúde comunitária

RESUMEN

Objetivo: Comprender el significado de vivir saludable para usuarios, profesionales y gestores de un equipo de la Estrategia Salud de la Familia (ESF). **Métodos:** Se trata de una investigación de naturaleza cualitativa, basada en la grounded theory. Para la recolección de los datos se realizaron entrevistas a 25 participantes, entre ellos usuarios, profesionales y gestores de un equipo ESF, en el período comprendido entre marzo y diciembre de 2009. **Resultados:** La recolección y análisis de los datos, conducida de forma sistemática y comparativa, evidenciaron que el vivir saludable deve ser caracterizado como un proceso auto-organizador, intermediado por la actuación de los profesionales del equipo ESF, especialmente, por el agente comunitario de salud, por medio de la creación de vínculos de confianza y estímulo a las interacciones y asociaciones comunitarias. **Conclusión:** El vivir saludable es un fenómeno singular, complejo, interactivo, asociativo, político y social, conjugado por el involucramiento activo y participativo de los usuarios y por el compromiso efectivo y socialmente responsable de los profesionales, gestores y autoridades políticas instituidas.

Descriptores: Investigación cualitativa; Comunidades vulnerables; Enfermería en salud comunitaria

---

** Study conducted in a socially vulnerable community located in the Central Region of Rio Grande do Sul, Brazil.*

[1] Post-graduate (Doctoral) Student of the Doctoral Course in Nursing of the Post Graduate Program in Nursing at the Federal University of Santa Catarina – UFSC – Florianópolis (SC), Brazil.

[2] Doctor of Nursing. Professor of the Nursing Course at the "Centro Universitário Franciscano - UNIFRA" – Santa Maria (RS), Brazil.

[3] Doctor of Nursing Philosophy. Adjunct Professor of the Department of Nursing of the Post Graduate Program in Nursing at the Federal University of Santa Catarina – UFSC – Florianópolis (SC), Brazil.

[4] Doctor of Nursing at the „Institut für Pflegewissenschaft na Universität Bielefeld" - Germany.

Corresponding Author: **Marli Terezinha Stein Backes**
Rua Gonçalves Chaves, Nº 65 / Aptº 304 Bloco A
96015-560 – Pelotas/RS
E-mail: marli.backes@bol.com.br

Received article **13/11/2010** and accepted **29/06/2011**

INTRODUCTION

Each individual experiences healthy living in a unique manner. Therefore, it is necessary to take into account factors such as the individual's life history, socio-economic-cultural context, and interactive possibilities, among others. In the process of healthy living, in addition to organic-functional components, there are also elements of a social and cultural order and those of a subjective nature related to the way in which each individual, in his/her unique manner, processes the different day-to-day movements and events.

Considering the different factors involved in daily and imaginary lives of individuals and families, one may infer that the understanding of healthy living is not a simple process or one that is easy to decipher, particularly when associated with social vulnerability. This concept is related to a process of exclusion, discrimination or weakening of legally or politically fragilized groups, individuals, or communities in the promotion, protection or guarantee of their citizenship rights[1,2].

From this point of focus, the concept of health and healthy living needs to be gradually enlarged in the sense of understanding the multiple determinant and conditioning dimensions that are part of the health-disease process [3]. Various studious persons have enlarged the concept of healthy living[4-7], by attributing not only rational and objective significance to the health-disease process, but also a social, emotional, economic and spiritual dimension, associated with both internal and external factors that interfere in the real and concrete imagination of individuals.

Bearing in mind the multiple factors and subjacent dimensions of health and/or healthy living, the challenge of developing actions of interdisciplinary care, in which dialogue or negotiation are a driving key, has been shown to be fundamental. This construction is particularly, important for the effective implementation of the Family Health Strategy - ESF ("Estratégia Saúde da Família – ESF"), in which full care consists of one of the main pillars on which the Brazilian national health service SUS ("Sistema Única da Saúde – SUS") is based [8-10]. Interdisciplinary construction refers to both the integrated and articulated organization of the services at their distinct levels of attention, and the perspective of understanding the individual as a singular and multidimensional subject – protagonist of his/her own story[11,12].

As a strategy for reformulation of the health system, focused on basic attention, the ESF is an important initiative, capable of facilitating access to health services and broaden interactive and associative possibilities. Only with expansion of the ESF and its political reorientation as strategy, will it be possible to emphasize proposals such as territorialization, vigilance in health, the reception, tie, programatic actions and organized offer, among others [13,14]. Important steps have been taken with regard to social participation, integrality and universality in health. Nevertheless, the social conditions of inequality, under which a large portion of the Brazilian population live, are an aggravating factor that has direct repercussion on the healthy living of individuals, particularly the socially vulnerable groups.

Integral, articulated care of the real needs of individuals, families and communities, in this sense, is an important resources capable of contributing to broadening the health/and or healthy living concept, in addition to making it possible to provide elements for consolidation of the ESF. Thus, the present study has the following question to research: What is the meaning of healthy living to users, professionals and managers of an ESF team, more specifically, in a socially vulnerable community?

For this purpose theoretical basis was sought in some ideas of complex thought. Born in France, in 1921, recognized worldwide in academic and scientific media as one of the most important contemporary thinkers, Edgar Morin – author of complex thought – has dedicated himself to the investigation and systematization of, among other themes, an epistemology of complexity. Thus, a mode of complex thought is considered necessary for the construction of multidimensional knowledge, in agreement with the complexity of reality. It proposes a reform in thought, in the sense of integrating humanity and the cosmos, in a vision that is not linear and reductionist, but totalizing and integrating, simultaneously considering the qualities of the parts and of the whole, as well as their relationships, interactions and associations[15,16].

Healthy living, from this point of focus should/must be understood as a complex phenomenon whose understanding implies accepting its multiple dimensions, interactions and associations, by the abstraction of data at more comprehensive levels, as well as the recognition of conditions of the environment in which the human being is included and in which he/she will concretely experience living with or without health[12,17]. It presupposes attributing new meanings to practices in health/care, by apprehension of the uni- and multiple, of the local and global. Said in another manner, it means apprehending healthy living as a unique and multidimensional process that cannot be apprehended and defined as something objective, static or as an end in itself.

As a dynamic, unique and self-organizing process, healthy living reaches the complexity of the human being. Comprehending this process, based on the acquisition of knowledge and competencies, related to the conviction of a new referential that copes with the intersubjectivities, interactions and dynamicities, opens space for new forms of thinking and acting in care/health, capable of recognizing and appreciating both the active involvement

of users, and the effective engagement of professionals, managers and different social sectors.

Based on the foregoing discussion, the aim of the present study was to understand the meaning of healthy living to users, health professionals and managers of an ESF team, more specifically in a socially vulnerable community.

METHODS

This is a qualitative study, guided by Theory-Based Data (TBD). TBD is characterized by a systematic process of data collection and analysis, with the object of generating a theory that will have meaning in the area under investigation. Differently from other methods, the theoretical sample is not defined prior to data collection[18,19].

Data were collected by means of the individual interview technique. In total, the theoretical sample consisted of 25 interviews held between Mach and December 2009, with users (n=12), professionals of an ESF team (n=08) and health managers (n=05), of a socially vulnerable community located in the Central Region of Rio Grande do Sul, Brazil. The community consisting of approximately, 24 thousand inhabitants, is shown to be vulnerable from the social and economic, political, environmental and health points of view.

Interviews were held both with users and ESF professionals and managers, based on the following guiding questions: What does healthy living mean to you? Which are the elements that interfere in healthy living? How do you perceive the actions of the ESF? Participants were also encouraged to relate their expectations and difficulties with regard to inclusion in a socially vulnerable community.

The first group of participants chosen by the researchers was composed of users registered in the ESF team, which were selected by lottery drawn from their record charts, located in the local basic health unit. After this, a new group was formed, composed of ESF team professionals directly involved in the care of the users drawn in the first group. Lastly, the group of health managers was formed, considering as inclusion criteria, the management of ESF services in the region delimited for the study. Among the interviewees, there were: Nurses, doctors, social assistants, community health agents and health service users. The interviews were recorded on cassette tapes and afterwards transcribed by the researchers.

Data collection and analysis was performed in a systematic and comparative manner, as foreseen by the method. After every interview, the data were transcribed and the text was meticulously revised. Then identification of the conceptual units began. The data were coded line by line, compared among them and assigned to categories. In the next stage, the researchers chose an open codifying category – first stage of coding – and placed it as the central theme, comparing it with the other categories. In the next phase, also called axial coding, the data were grouped in new forms, seeking to expand and compact the central category based on the theoretical connections[19].

After explaining the objective and proposal of the study, all the participants signed the Term of Free and Informed Consent. The project was approved by the Research Ethics Committee of "Centro Universitário Franciscano (UNIFRA)", Protocol No. 333/2008.

To maintain confidentiality of the information, the participants in the research were identified throughout the text by the letter "U" (users), letter "P" (professionals) and letter "M" (managers) followed by a number corresponding to the speech.

RESULTS

The systematically and comparatively analyzed data resulted in five categories, namely: Healthy living associated with basic conditions of survival; Healthy living related to opportunities of inclusion and participation; Healthy living associated with interactive and associative possibilities; Healthy living associated with political and social articulations, and Healthy living related to strategies of reorienting the health model. This process, as a whole showed that healthy living was a unique, complex, interactive, associative, political and social phenomenon, conjugated both by active involvement and participating by users - social actors, and by the effective engagement of professionals, managers and political authorities instituted in the concrete reality of the individuals, families and communities.

In their declarations, the interviewees showed evidence that healthy living is not translated into a given or static process, or as something that can be bought, passed on or transferred from one system to another. In another manner, healthy living is the fruit of personal, family and community conquests, which involve a set of existential, emotional, social, political, environmental, factors, among others, which in turn involve intersectoral responsibilities and articulations. In this direction, healthy living involves the active and participative/sharing participation of the users and the effective engagement of health professionals in the reality of the communities. It equally involves the development of inclusive and resolutive social, economic and health policies, in the sense of broadening opportunities and potentiating the resources and competencies of individuals as protagonists in their own story. According to the professionals, however, the social and health policies are still strongly marked by assistentialism.

The social policies leave a great deal to be desired. What I see is an assistentialist policy. The government gives the fish and

does not teach the person how to fish... I have the right to a family financial aid grant/ bolsa família. So, why would I make an effort to improve the conditions of life, improve education for my children? In the PSF, as well, I think there is a lot of assistentialism (P1).

In the results, it was also evident that the organization, reorganization and/or self-organization of personal, family and community daily life for healthier living, would only be possible by the continual negotiation and articulation of the different actors and social sectors responsible for the integrated and integrating actions in care/health. The strategies of negotiation and integration are expressed in the home visits of professionals, in the community and/or residents' associations, in group and educational activities and collective manifestations, among others.

In general, the users point out the importance of social relationships and interactions for healthy living, when they mention that in anonymity –, "*staying closed up in the hose"*, they end up bothering themselves about their children and neighbors, limiting themselves to the domestic routine and not rarely taking ill. Others, however, mentioned the lack of stimulus "*to get out of the house and interact with neighbors and friends*". They therefore perceive that they need outside stimulus; that is to say mediation capable of instigating self-organization. In this sense, both the health community agent and visits by the university students were cited as sources of stimulus, as evidenced in the following statement:

One is very happy when the health agent or the University students make their visits... one starts talking about other things and it seems to improve one's spirits. Now I have started participating in the living meetings... today I am a different person (U9).

In general the users demonstrated that their day-to-day life is tiring and lonely; that is, motivated by the order of domestic chores. At the same time, they allow a certain accommodation and alienation from the existential, family and community reality to show. Few challenge themselves and/or are challenged to seek the new, different and unexpected.

The users' statements are confirmed in the health agents' statements when they emphasize that their work, particularly in the home visits, is appreciated and recognized by the users. They perceive that their practice transforms and is transformed, even if it is only by actively listening or simply exchanging information. The health agents understand that their main intervention with users is to understand and receive the necessities of the moment and transform them into challenges. In addition to the professional tie, the community agents as well as the other professionals of the ESF team, are a reference for the different individual, family and community movements/events. They equally reflect that, in addition to a punctual and linear action, the health professional needs a attitude of solidarity, contextualized within the users' reality irrespective of the conditions in which they are found.

It is to listen, share knowledge, ... when you leave there, the woman is a different person. Sometimes, one listens to complaints for 3 hours. What was bothering her was something she needed to tell someone. We need to be listeners rather than talkers. There are people who leave the house only to go to the group... (P5).

In understanding the health managers, it is necessary to invest in the education and qualification of professionals that are active/work in the ESF. They recognize that the ESF is a process that needs to be constructed together with the family – responsible for its self-organization, in the sense of recognizing uniqueness and conjugating the different areas of knowledge and cultures involved in the process. They recognize the structural and organizational problems of the ESF and perceive that the professional team has interdisciplinary difficulties, emphasizing that health care needs to be extended, by the understanding of new meanings; that is, by reorienting the health model based on opener and more flexible references. From this perspective, they ask: How should health professionals be prepared for a broader and more flexible activity, capable of appreciating and contemplating the different cultures and contexts? How should health professionals be prepared for a broader understanding of the concept of health?

In this direction, the managers pointed out that healthy living is a unique, interactive and dialogic process, constructed by means of integrating the uncertainties, disorder and the unexpected, and by articulation of different fields of knowledge, contexts and realities of life, as expressed in the statement:

How does one change and stimulate the question of healthy living if each one has his/her own culture? How can I say that my way is right and the other is wrong? Sometimes we run into some conflicts/opposition(?), because we think we are right. It is necessary to conjugate professional knowledge with the family's knowledge. Care is still fragmented. The ESF is something that must be constructed together with the family (G2).

The interviewees, especially the health professionals understand that it is necessary to awaken to the new; that is, waken to a new culture and/or approach to health, by means of strategies that instigate a new family and community organization, self-organization or reorganization. They perceive that the community health agent, by means of receiving and the tie of confidence established during the "*tea-drinking circles/rodas de chimarrão*" or in information conversations, it is possible to arrive at greater understanding of family and community needs. But for this to happen, the health agent needs to be duly instrumentalized, in the sense of dealing strategically with the different situations he/she encounters from day-to-day , particularly in socially vulnerable communities. Moreover, they emphasize that in this process, the health agent is an element of aggregation and instigation, capable of supporting the integration of all the parts, and the parts of the whole.

They create an empathy that one is unable to understand. The agent is that link and has an empathy and reception of families?/ is received by the families(?). They create an interactive chain with the families and fee this with "tea" and conversation. At the center, we are unable to do this. We don't talk to the neighbors and have no time for anything. They are able to achieve this integration (P7).

Both the professionals and the health managers pointed out the need for creating a culture of collective co-responsibility, in which the users are active and participative actors and the professionals are mediators of new knowledge, without however, imposing their instituted knowledge and truths, but, capable of integrating and conjugating professional knowledge with popular knowledge. From this point of focus, they apply/remetem para self-reflection, motivated by referentials capable of broadening the process of human living, process of work, and above all, understanding of that which is unique, different and multidimensional.

It is necessary to motivate workers and users to assume co-responsibility.. Everyone needs to feel part of a network. Everything is an enormous gear, a large web. Everyone needs to participate in planning and needs to be heard. Quite often we think we are very powerful, with our truths and we have difficulty in entering the reality of the family. It is necessary to know how to potentiate the good things of another person and construct together/co-create(?) (G5).

Healthy living, according to the meaning attribute, forms part of a complex system of gears, in which different areas of knowledge, cultures and interests co-exist, but they need to converge in creative and participative co-responsibility, and the understanding of the human being as a protagonist of his/her own story.

Recognizing and discussing the complexity of healthy living

Self-organization or (re)organization of the individual, family and community day-to-day life is possible by means of dialogic processes and continuous negotiation of care actions. Constructing the healthy living process from this point of focus, involves the broadening of professional and systematic relationships, interactions and associations, driven by the interconnection of all the parts, from the uni- to the multiple, and vice-versa, to which we apply the perspective of complexity, understood as a fabric formed of different threads that are transformed into a single thing. That is, where all the threads criss-cross and are interlaced to form a unit of complexity[20,21].

Complex thought therefore asks to negotiate with uncertainties, dialogue with adversities, and receive disorder as a possibility for the creation of a new order[21-23], that is; a new organization. It means saying that disorder and disorganization cannot be apprehended as less important phenomena, but as creative possibilities for the construction of a new organization, provided that the competences and other resources of human beings themselves - social actors are potentiated, while they are protagonists of the very process of healthy living.

In this direction complex thought is antagonistic and complementary, contradictory and ambivalent, unique and multiple, unitary and diversity, local and global, sustained by an interdependent, interactive and inter-retroactive fabric[22]. Therefore, they constitute a process of potentiation of new interactive and associative possibilities, necessary for self-organization of healthy living, irrespective of the situations in which the human being, family or community are included.

From this perspective, the different threads of the process of healthy living need to be woven jointly, in order to guarantee the vitality and dynamism of integral and integrative care in health, even under socially vulnerable conditions, related to exclusion, discrimination or weakening of social groups and their capacity to react[2,7]. Health practices gradually need to go beyond the punctual and assistentialist actions; that is, they must develop intersectoral strategies capable of emancipating the human being as the subject of action and reaction.

Complexity is positioned in the face of questions and not answers, in the face of questioning and not ready-made referrals, challenges and not established conditions[22]. For this purpose, dialogue and negotiation are inevitable in the sense of promoting co-responsibility of the different social actors. In other words, it means dialogue with users - subjects who live through their day-to-day in a vulnerable reality, frequently marginalized by blindness to scientific knowledge.

Because it is characterized as a unique, dynamic, interactive and associative movement, healthy living necessarily demands a dialogic and reflexive dimension from the different actors and sectors involved in the process, above all the groups in socially vulnerable situations. In this sense, the health-disease process needs to gradually overcome the disciplinary frontiers proposed by simplified thinking and advance in the direction of integral and integrative care/health. It needs to go beyond the simple sum of threads/parts and reach higher levels of integration and articulation of fields of knowledge, in order to compose a complex network of interactions, fed by multiple dimensions that involve the dynamics of healthy living[24].

To determine healthy living based on a unique, interactive and associative process, means to produce a complex knowledge in health, in order to attain understanding of the care of human life, as a phenomenon that transcends punctual actions of an emergency or assistentialist nature. It means understanding the human being as a complex entity capable of continually self-organizing and/or reorganizing him/herself by the dynamics of being alive. To sum up, it means considering the dimensions of vulnerability resulting from the criss-crossing of individual and

subjective behaviors and experiences, as well as the social, political, economic and cultural conditions, articulated by the actions of health promotion and education.

CONCLUSIONS

Healthy living, according to the meanings attributed to it by health system users, professionals and managers forms part of an interactive and associative gear system in which there are in absolute truths or simple responses to be decoded. There are, nevertheless, questions that are only understood, as we apprehend the human being as complex entity and healthy living as a unique and multidimensional process.

When appealing to complex knowledge, the healthy living process points out different areas of knowledge; that is, it points out the dialogic dimension of professional knowledge integrated with and articulated by popular knowledge. In this sense, the professionals that are part of the ESF team play an important role in instrumentalization and mediation of new opportunities and possibilities in the process of self-organization of healthy living. Professional knowledge, however, must take into account the knowledge or meaning that each human being, family and community attributes to his experience, that is, to their healthy living.

Health/nursing professionals could/should therefore be considered mediators of the process of healthy living by dialogue between formal and informal care, broadening the interactive capacities and possibilities, the process of potentiation of the users' own resources – social actors and above all, and by continual negotiation of strategic care actions, capable of broadening the network of interactions with different actors and social sectors.

Healthy living could/must be characterized as a unique, complex, interactive, associative, political and social phenomenon, conjugated both by active and participative involvement of the users – social actors, and by the effective and socially responsible engagement of instituted professionals, managers and political authorities. It is important for researchers, professionals, and studious persons to consider the human being and family as protagonists of their own story. That is, as subjects exposed to all orders of conflicts, uncertainties, instabilities and chaos, but capable of continually organizing and reorganizing themselves, supported by multiple family and social interactions, relationships and associations.

Healthy living is a unique and complex process that goes beyond the elements of cause-effect emphasized by the traditional health-disease concept. It was therefore concluded that the construction of knowledge about healthy living necessarily needs to consider the multiple dimensions and factors that involve living day-to-day life for each individual in particular, based on his/her context of concrete reality.

Acknowledgement and Thanks

The authors thank the "Fundação de Amparo à Pesquisa do Estado do Rio Grande do Sul – FAPERGS" for providing financing for the research.

REFERENCES

1. Resolução do Parlamento Europeu, de 17 de Junho de 2008, sobre o impacto da política de coesão na integração de comunidades e grupos vulneráveis (2007/2191(INI)) (2009/C 286 E/01). [citado 2012 Jan 21]. Disponível em: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:286E:0001:0005:PT:pdf
2. Nichiata LY, Bertolozzi MR, Takahashi RF, Fracolli LA. The use of the "vulnerability" concept in the nursing area. Rev Latinoam Enferm. 2008; 16(5):923-8.
3. Menicucci TMG. O Sistema Único de Saúde, 20 anos: balanço e perspectivas. Cad Saúde Pública. 2009; 25(7):1620-5.
4. Meirelles BH, Erdmann AL. A interdisciplinaridade como construção do conhecimento em saúde e enfermagem. Texto & Contexto Enferm. 2005; 14(3):411-8.
5. Scherer M, Andrade S, Mello AL, Bonetti A. Healthy living and non-healthy living: the meaning for mature and active women. Cad Saúde Colet (Rio J). 2007; 15(1):273-9.
6. Pelzer MT, Sandri JV.. O viver e ser saudável no envelhecimento humano contextualizado através da história oral. Rev Gaúcha Enferm. 2002; 23(2):108-22.
7. Backes DS, Backes MS, Koerich MS, Baggio MA, Carvalho JN, et al. Significado de viver saudável para jovens que integram um projeto de inclusão social. Rev Eletrônica Enferm.[Internet]. 2009 [citado 2012 Jan 10]; 11(4):877-83. Disponível em: http://www.fen.ufg.br/revista/v11/n4/pdf/v11n4a13.pdf
8. Vasconcelos EM. Complexidade e pesquisa interdisciplinar: epistemiologia e metodologia operativa. 2a ed. Rio de Janeiro: Vozes; 2002.
9. Guanais FC, Macinko J. The health effects of decentralizing primary care in Brazil. Health Affairs. 2009; 28(4): 1127-35.
10. Magalhães R, Bodstein R. Avaliação de iniciativas e programas intersetoriais em saúde: desafios e aprendizados. Ciênc Saúde Coletiva. 2009; 14(3):861-8.
11. Witt RR, de Almeida MC. Identification of nurses competencies in primary health care through a Delphi study in southern Brazil. Public Health Nurs. 2008; 25(4):336-43.
12. Backes DS. Vislumbrando o cuidado de enfermagem como prática social empreendedora [tese]. Florianópolis: Universidade Federal de Santa Catarina; 2008.
13. Paim JS. Vaitsman J, Moreira MR. Entrevista com Jairnilson da Silva Paim: "Um balanço dos 20 anos do Sistema Único de Saúde (SUS)", por Jeni Vaitsman, Marcelo Rasga Moreira e Nilson do Rosário Costa. Ciênc. Saúde Coletiva 2009; 14(3):899-901.
14. Teixeira CP. Saúde da família: limites e possibilidades para uma abordagem integral de atenção primária à saúde no Brasil. Ciênc Saúde Coletiva. 2009; 14(3):783-94.
15. Morin E. Introdução ao pensamento complexo. 3a ed. Lisboa: Stória; 2001.
16. Morin E. A cabeça bem feita: reformar a reforma reforça o pensamento. 10a ed. Rio de Janeiro: Bertrand Brasil; 2004.

17. Noronha KVMS, Andrade MV. Desigualdades sociais em saúde e na utilização dos serviços de saúde entre os idosos na América Latina. Rev Panam Salud Publica. 2005; 17(5-6):410-28.
18. Büscher A. Negotiating helpful action: a substantive theory on the relationship between formal and informal care [thesis]. Finland: University of Tampere, Department of Nursing Science; 2007.
19. Strauss A. Pesquisa qualitativa: técnicas e procedimentos para o desenvolvimento de teoria fundamentada. 2a ed. Porto Alegre: Artmed; 2008.
20. Morin E. Os sete saberes necessários à educação do futuro. São Paulo: Cortez; 2000.
21. Morin E. Complexidade e ética da solidariedade. 3a ed. Porto Alegre: Sulina; 2002.
22. Morin E. Ciência com consciência. 10a ed. Rio de Janeiro: Bertrand Brasil; 2007.
23. Plsek PE, Greenhalgh T. The challenge of complexity in health care. BMJ.2001; 323(7313):625-38.
24. Erdmann AL, Sousa FGM, Backes DS, Mello ALSF. Construindo um modelo de sistema de cuidados. Acta Paul Enferm. 2007; 20(2):180-5.