interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Review

Situated Learning Theory and communities of practice: subsidies for the social rehabilitation of people with stomas*

Situated Learning Theory e as comunidades de prática: subsídios para a reabilitação social de pessoas com estomias* (resumo: p. 18)

Situated Learning Theory y las comunidades de práctica: subsidios para la rehabilitación social de personas con estomias (resumen: p. 18)

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* The article derives from the thesis entitled "Evaluation of the program of specialized care for people with a stoma in the Brazilian National Health System", defended in 2022 in the Fundamental Nursing Program of the School of Nursing of Ribeirão Preto, University of São Paulo.

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The objective was to discuss situated learning trajectories for social rehabilitation in face-to-face and online Communities of Practice (CoP) for people with a stoma. A comprehensive narrative review was carried out with an open timeline, with a sample of 18 international articles. The interpretation culminated in the conceptual pillars of the healthcare CoP, starting from identities and trajectories towards central participation, legitimate peripherality and reification; educational transfer in face-to-face and online settings with artifacts; examples and dilemmas of implementing collaborative designs or arrangements for different types of illness and the urgency of an interprofessional evaluation of the trajectory; finally, knowing about the existence of ethical communities, subsidies were proposed for communities of practice targeted at people with a stoma in the Brazilian National Health System, aiming at social-care participation and rehabilitation.

Keywords: Ostomy. Enterostomal therapy. Healthcare learning system. Social learning. Rehabilitation.

Júnior AJSC, Santana ME, Teles AAS, Prates PEG, Sonobe HM. Situated Learning Theory and communities of practice: subsidies for the social rehabilitation of people with stomas. Interface (Botucatu). 2024; 28: e230525 https://doi.org/10.1590/interface.230525

Introduction

Social rehabilitation of people with a stoma (surgical communication with the outside for elimination or respiration) encompasses stimulation to face the underlying disease and the new condition, psychoemotional rehabilitation, and facilitation of self-responsibility for care, including family members in the process[1]. Such rights of ostomates in Brazil are based on Decree no. 5296 of December 2, 2004, which recognizes them as disabled individuals and ensures social support, quotas, and free access to equipment and adjuvants. This is complemented by Directive no. 400 of November 16, 2009, which regulates specialized and interprofessional care in the Brazilian National Health System (SUS) and a specific Care Network that provides follow-up, assessment, and prevention of health problems[2,3].

Therefore, such users will depend on support offered throughout the treatment for the best prognosis and care, as rehabilitation is a process and, with time, it transcends the themes of ostomy self-care and handling of pouching systems and adjuvants, and culminates in ostomates regaining control of their life and being reinserted in society[4,5].

The literature approaches validations and interventions for self-management of digestive ostomy and long-term adaptation, which require cognitive and behavioral efforts[6,7]. Some examples are the construction and validation of a technology for ostomized women's self-care of sexual and reproductive health[8]; a virtual learning object on intestinal elimination stoma for undergraduate nursing students and permanent education[9]; reinforcement education in ostomy management during hospitalization without the need of many teaching lessons[10]; transtheoretical model-based intervention on the self-management of patients with colorectal cancer after ostomy surgery[11]; ostomy self-management training including four elements from the Chronic Care Model in telehealth: 1) identification of cultural resources; 2) promotion of well-being by planning the teaching of self-management; 3) self-management information among peers; and 4) educators in community-based support groups[12]. Also grounded on the Chronic Care Model, the chronic care ostomy self-management training is used by oncology nurses[6,13].

The studies mentioned above recognize the importance of professional mediation. However, they propose the hypothesis that the numerous care technologies may not penetrate groups and everyday lives due to the micropolitics of health services. This hypothesis originates the pertinence of learning situated in the micro-social dimension, a concept from Situated Learning Theory, created by Étienne Wenger and Jean Lave, which designates "learning by doing" in social practices within Communities of Practice (CoP). Although it emerged in the social sciences, the correlation between the theory and healthcare was cited in two contexts: in the sharing of practices concerning prenatal care, difficult births and orientations in postpartum visits among Mexican midwives, and in Alcoholics Anonymous groups that reconstruct life histories, mental health, and behavior patterns when individuals become abstainers[14].

In the area of health, CoP is conceptualized as a group that:

> [...] shares a common domain of interest in which healthcare workers collaborate to enhance the practice, promote professional expertise, and augment institutional knowledge[15]. (p. 70)

However, definitions that include users in the CoP remain scarce. A recent review pointed out the existence of social networks, but no CoP, for people with a stoma[16].

To further explore the theme, we propose, in an introductory fashion, care between peers (significant others) to counterbalance disengagement, aiming at a healthcare CoP, and state that we are against self-responsibility.

Theoretical framework

Cohn[17] criticizes the transfer of responsibility for illness and treatment to the individual. Self-responsibility emerges due to the weakening of the State's capacity to provide and manage public good and general needs. In addition, the author condemns the strengthening of the transnational market that defends health as a good offered to be consumed as a private need. In the scope of collective mobilization, there are non-governmental organizations (NGOs), philanthropic entities, and communities. Bauman[18] states that *engagement* is triggered by the bonds of a community of interests, which is the opposite of ghettos.

> [...] ghetto means *impossibility of community*. This characteristic of the ghetto makes the politics of exclusion be embedded in spatial segregation and in the immobilization of a doubly safe and risk-proof choice in a society that can no longer keep all its members participating in the game...[18]. (p. 171)

Focusing on the learning process, Wenger theorized that the area of Computer Sciences was able to manage the information process of a CoP, but it needed Anthropology to analyze and explain meanings in the world. Computer Science treated learning as biological - the brain and its electrical impulses in an "organic machine" -, in addition to algorithms that predict human behavior (and its future). Wenger sought to integrate its multidisciplinary model into Anthropology, seen as a teller of stories[19].

To him, discussing problems is the beginning of mutual commitment and qualification, and roles are the point of departure for group concerns and goals. This process is not in a vacuum. It is guided by public policies and healthcare directives[20] and by a repertoire based on practice and negotiation. Implementing communities emerges in a context in which practice frequently does not favor a type of reflection that is grounded on everyday life and gives collaborative answers to problems[21].

The three fundamental aspects are the domain, the community, and the practice. Domain is not only about connections; there is an identity involved in adherence to shared competence(s). However, a webpage is not a CoP, as in the latter interactions are more important than online reports of problems or experiences one has when dealing with a problem. Thus, CoP is different from a community of interests[22,23]. Some concepts to understand it are[24]:

- Engagement: more closely related to a practice - activities, doing things, working alone or together, talking, using and producing artifacts. It enables a participative or non-participative identity;
- Imagination: creates relationships as significant as those derived from engagement. The images of the world locate us, allowing us to reflect on our situation and explore new possibilities. The world provides many imagination tools (one's interpretation of their participation), like language, stories, maps, visits, photos, TV programs, models, among others;
- Alignment: engagement in practice is rarely effective if it does not have a minimum degree of alignment with the context and coordination. It does not mean submitting to external authority or following a prescription; it is a two-way process of coordinating perspectives and actions;
- Situated activity: as an empirical attribute of the daily activity, it is an answer to those who do not believe in informal, experience-based learning;
- Central participation: it is not a linear movement of skill acquisition; it admits a physical, political or metaphorical center in the community in relation to the individual;
- Complete participation: defines full participation and suggests a closed domain of collective practice with measurable degrees of acquisition for newcomers;
- Full participation: diversity of relationships among members. Full participation is the opposite of peripherality and defines partial participation;
- Peripherality: considering that there may not be only central participation, it is suggested that there are multiple and inclusive ways of engaging. It can also be a common point between two related communities;
- Legitimate peripherality: involves power, specifically in intensive participation, and an empowering position.

Consequently, legitimate peripheral participation is not, in itself, a form of education, a pedagogical strategy or a technique. It constitutes *an analytical perspective* independent of educational format, context, or educational intentionality. It does not consider that intentional instruction in itself is solely the source or drive of learning; it is always necessary to consider three antagonistic aspects: legitimate versus illegitimate; peripheral versus central; and participation versus non participation[14].

Therefore, the present review aims to discuss situated learning trajectories for social rehabilitation in face-to-face and online Communities of Practice for people with a stoma.

Method

Comprehensive narrative review that is different from systematic reviews in that its selection of data sources is not exhaustive and it has a broad research question, in search of theoretical frameworks and knowledge reformulations[25]. The flexible review plan had seven stages[26]: questionings and possible axes for debate; identification of bibliographic sources; reading of the material; selection of excerpts; notes on main points; logical organization of the work; and writing.

The guiding questions were: How is Situated Learning Theory employed for professionals, users, and family members-caregivers in a context of healthcare learning after biographical ruptures? What insights from Situated Learning Theory and face-to-face and online communities of practice, even if theoretical, can be applied to the social rehabilitation and learning of people with a stoma?

The combination of the terms "Situated Learning" AND "Health" in the PUBMED database in an open timeline generated 131 results, with the last upload in the Rayyan web application on November 10, 2022. The exclusion criteria during screening were: not mentioning the health area; approaching exclusively teaching or education of undergraduate students or residents, without focusing on rehabilitation, as the objective is the use of the theory bringing together patient-professional-caregiver; and publications that approached the theory in a precarious way.

A total of 18 theoretical articles and primary studies was identified. It is important to mention that none of the selected international publications had people with a stoma as participants; thus, the collected material was complemented with texts from the enterostomal therapy area and texts by Étienne Wenger. The qualitative analysis was carried out in the following way: textual analysis of the reading unit in a broad temporal frame; thematic analysis in light of the research problem and objective; interpretation verifying the coherence of the central idea; problematization of the literature; synthesis[27] through a reflection in which the second research problem was addressed.

The order of presentation of the three initial debate axes corresponded to the intercommunicating and non-hierarchical concepts: Domain - recognition of a particular problem of interest to a group, inspiring participation, organization of knowledge, and identities in transition; Community - a critical element of the structure, it summons settings, artifacts, evolving and layered interactions, and recognition of central and peripheral voices; and Practice - requires implementation of language styles, guiding principles, stories, experts, and documents, aiming to achieve situated learning[14,28].

In the fourth axis, we added notes on Civil Society to support the discussion, arguing that communities go beyond business organizations. We defend that expert professionals and "champions of practice" (veterans) perform management by means of multimedia, idealizing the formation of national networks and/or local coalitions[28]. In addition, we applied Bauman's concepts of ethical and esthetic communities[18].

Results and discussion

The publications came from Australia (n=2), United Kingdom (n=3), Denmark (n=3), United States of America (n=4), Spain, Germany, Holland, Taiwan, Sweden, and Norway. There are 08 theoretical studies and 10 primary studies. The primary studies of a quantitative nature were: blog experiment, longitudinal study, stepped wedge trial, longitudinal study with a variable exposure to an intervention, responsive evaluation approach, and cluster randomized trial; the qualitative ones were: phenomenological approach, hermeneutic approach inspired in Gadamer (n= 2), and qualitative study with Facebook data. The 18 publications are described in detail in Dataset[29], Figshare: https://doi.org/10.6084/m9.figshare.23653755.v2.

Delimitation of a healthcare community of practice: reified identities and trajectories

Traditional instruction includes[30]: the teacher/instructor is the one who most speaks, teaches a whole class of students, time is clocked, the classroom is organized in desks and rows, knowledge is divided into subjects, and physical presence is necessary. By contrast, in online situated learning there would be: 1. Reflection on how knowledge will be used; 2. Access to specialists and process modeling; 3. Multiple roles; 4. Collaborative construction; 5. Articulation; 6. Assessment. Therefore, CoP theory derives from the intersection between the Social and the Learning theories. However, Wenger was more influenced by social scientists like Giddens and Bourdieu than by Learning theorists[19].

CoP is a context to acquire identity using a trajectory, depending on management of knowledge and responsibilities. Wenger calls the interaction regarding identity "learning citizens", as the person is not an insular and perfect entity[19]; in the community, transfer considers personal knowledge and cognitive theorization[31,32]. Trajectories and interactions are neither solely mental nor generic like noises; rather, they are attitudes outside the classroom. Therefore, tired students and non-dynamic teachers result in non-significant and non-linear learning[33].

Finding a network of experts is the gain of the horizontal communication of digital CoPs, which use Information and Communications Technologies (ICTs) and gather interactive discourses outside verticality, in a multi-directional way - before this, a superior entity used to transmit the message and people listened passively. The facilitator will need to stimulate interprofessionality and manage projects, languages, and co-creation of rules[34,35]. A member is designated to give orientations outside the CoP (face-to-face) or in a restricted area of the CoP (online), when there is knowledge that reverberates more around a specific component[35].

In the sociocultural perspective, this mutuality enables to revisit beliefs and allows transfer to occur from identifiable factors. In the event learning occurs in an institutional context, the most feasible transfer is to these same spaces, as acquisition circumstances dictate the cognition for this practice. Having said that, forms of orientation for proximal and distal experiences need co-construction and evaluation[31]. The design of the online interface will prioritize the familiar-instructional aspect and the teacher will not be the only source[30].

The participations negotiate the replacement of a stigmatized identity with that of a new woman, new man, mother, father, student, among others. There is a concept that has been little explored in the trajectories: reification - transformation of bad events into material strategies (treatment strategies after a diagnosis or "doing something with what has been given to me" due to the label of chronic condition), generating new reified identities. At this point, there is an exception: stigmatized identities should not be reified, as this hinders the experience of legitimate participation and engagement[36].

Thus, CoP helps identities in crisis after biographical ruptures when people are no longer capable of being or doing, and in their incapacity to adopt the new role. This was found in a research on the chronic fatigue syndrome, which revealed professionals' skepticism concerning symptoms and marginalization inside the community itself, culminating in an illegitimate, disabling and psychosomatic trajectory. Thus, when this reification occurs, participation was useless[36].

There is no educational transfer without situated knowledge, artifacts and setting

Legitimate peripheral participation involves cognition situated in an activity distributed in the socio-environmental dimension and conducted by peers who know a little more about the topic, facilitating the evolution of the identity until the modification of the self[33]. With Situated Learning Theory, the organization of the instructions is distributed, for example, over a six-month time continuum: in the first-second months, one weekly instruction, in the third-fourth months, one instruction every two weeks, in the fifth-sixth months, every three weeks[37].

In situativity, situated cognition or sitcog, knowledge and thinking integrate in an evolving way in games, project artifacts or peer writing, having spontaneity without scripting and thinking-action that does not come from one single participant concerning contents[33]. CoPs are characterized by abstraction and transpersonal knowledge ("thinking together")[32] during replication, and it is known that transfer away from where the practice was created is rare, as is transfer from formal to popular education environments. The term knowledge was not approached initially in the theory; however, its role establishes "indwelling" - knowledge added to learning, meaning and identity. Thus, total and peripheral participations cannot be artificial[31].

In interactive landscapes of practice, wisdom demonstrated by transferring knowledge[19] does not discard artifacts: devices that amplify human capacities, distributing cognition in educational modules that address actions in order to improve the activities of daily living, self-care, and food and money management. Other examples of artifacts are: computers, psychoeducational materials, exercise books in view of adaptation difficulties, and applied activities, all of them used to the group's benefit. The existing obstacle is to document and evaluate this moment of adaptation and how to include individuals with relevant experiences and few years of formal education[33,38].

Face-to-face or online barriers are: passive receivers, who always need intermediaries; persistence in using exclusively the traditional pedagogy in cyberspace, even with ICTs; selecting the veteran member who will check the information; individualized communication; negative understanding of the disease; always the same people being present; and a sense of monotony. Thus, refining the topic for discussion and the debated practice is fundamental[15,30,34,35,39]. Finally, for educational transfers to occur, professionals must ask themselves: How do users prioritize their participation in different practices? How do they reconcile different regimes of responsibility? What are the mechanisms of knowledge negotiation and obtention of legitimacy?[19]

Implementations of healthcare communities of practice: situativity in communication, clinical assessment and rehabilitation

In the search for online medical information, websites and the social media have been pressed to have health professionals as consultants[39]. These environments should not be abstract or decontextualized; they should have a responsive evaluation[35]. To increment them, the collaborative design of Anchored Instruction (audiovisual media, narrative structure and problem-solving) includes:

- Modeling - Construction of models to solve problems[40];
- Coaching - A facilitator solves the initial steps of the problem[40];
- Scaffolding - Cooperation for problem-solving, assigning responsibilities[40] until a possible central participation is achieved;
- Fading - The facilitator gradually withdraws[40];
- Articulation - Facilitators make targeted questions and knowledge is stated in answers and in the resolution of the problem[40];
- Reflection - What was individually retained? What was the strategy to solve problems?[40];
- Exploration - Students need to keep participating and interacting[40].

Debate-action groups with artifacts[33], blogs or platforms with texts about health problems using alerts of different severities are propositions[39]. Sharing how life has been going through knowledge related to colostomy/ileostomy and prevention of complications provides the opportunity to share self-care diaries in instant messaging groups, allowing the program to adjust according to the diaries. There are specific times for video call responses. The team reminds patients of days and times of follow-up appointments, explains about rectal cancer treatment, and posts health tips, funny texts, and inspirational videos[41].

Face-to-face in the groups, the "icebreaker" moment uses colorful stickers for patients to write a question or a comment on what was said. Positive remarks[35] and directive dialog[34] are crucial. These rehabilitation strategies through bonds are extremely necessary, as lack of support leads to refusal to attend follow-up appointments. Thus, implementations enable to screen cases, learn about difficulties related to small practices, conceive and manage how contents will be taught, perform activities with assessments of effectivity, and provide presentations open to comments[30,35,42].

Wikis, forums and blogs (informal networks) for CoPs help through "one to many" and "many to many" communication, using a visible alert activated whenever someone has a problem and providing a set of informative links[15,34]. Depending on this and on the inspirational design, some contexts increase or reduce capacities to reach new horizons[14,43].

Giving neuro-physiological and neuro-psychological orientations as short instructions has helped elderly individuals with hypotonic lower limbs, uncoordinated movements and reduced balance to solve problems like disorientation, physical and verbal aggressiveness, dysphagia and aphasia. In the physiotherapeutic context of traumatic brain injury, it has encouraged hygiene, bandages, coughing exercises, and tooth brushing, respecting personal limitations and fatigue, as these individuals will have different skills in the stage of adherence to routines, acquiring (or not) full participation. This rehabilitation/neuro-rehabilitation lists alterations, evaluating environmental stimuli, independence, and trajectory through interprofessional tests[44,45].

Positive clinical implications, like people with dementia handling electronic artifacts independently, clearly reveal an environmental adaptation deriving from usual practices[46] or, in the case of a clinical domain for those who had a transient ischemic attack, content on opportune care. In this example, participation in Meet chats updates members on artifacts, like a website, and cases are discussed with veteran members, when questions are asked so that engagement becomes more tangible. Subsequently, a chat can provide a quick assessment of practices and symptoms in kickoffs (meeting with interested parties defining the elements of the case) and/or hubs (spaces to work with projects)[47].

Finally, we present some myths regarding implementations of CoPs: not all of them are informal; self-organization is rarely seen; they are not centered exclusively on acquisition of knowledge and problem-solving; they do not substitute work networks. It is assured that the domain will guarantee that they are obtaining something in return[22].

Possibilities for the social rehabilitation of ostomates with the subsidy of communities of practice and ethical communities

According to the literature, social rehabilitation has established a trajectory guided by Situated Learning depending on the reception of the Care Network, research initiatives, and material support. However, in Brazil, realistically speaking, the bond in Primary Care seems to be weak. This is due to the need of its professionals' participation in qualification courses and to lack of research on lines of care that perform micro-social actions inducing such communities or situativity, in order to provide comprehensive oncological care and ostomy care[48].

In this axis, we adopt, for healthcare communities, the concepts of ethical communities (those that seek long-term commitments) and esthetic communities (fleeting and spontaneous). A dilemma for CoPs is the establishment of common interests - a cause they defend. Without this, bonds do not last long (esthetic), causing occupation of increasingly restricted public spaces. Contestation and social learning directed towards a cause allow for a critical appropriation of reality and, perhaps, resolutions (ethics). In turn, demobilization - the predominant theme - does not allow for engagement in participatory culture[18,49].

Decree no. 5296 of December 2, 2004, on accessibility for people with disabilities or reduced mobility, addresses accessibility as a right to citizenship and conceptualizes ostomy as a physical disability. Regarding communication with the significant others, chapter III of Article 8 approaches the overcoming of difficulties in accessing information[2]. To solve the problem, practice settings based on the 4G network of Android mobile phones would focus on remote diagnostic impressions about complications, providing appropriate orientations. This would imply the upload of stoma images and instantaneous communication between patients and doctors. This information would be transmitted in the 4G diagnosis network in which the specialist physician logs in, downloads and unzip files like medical records and images in the mobile phone. A technical professional would be in charge of managing users' information[50].

As we explained here, the need of intervention programs is an obstacle. Appendix 1 of Directive 400/2009 addresses individual activities of the Care Services for Ostomates 1 and 2 and lists actions of nursing, medical, and social work appointments, as well as group activities[3], which are related to Situated Learning Theory and operating groups[28]. During rehabilitation, autonomy must start to be developed in the hospital and, more than this, in a self-management program if the underlying disease persists[5]. Coordinated instructions in Specialized Care would evaluate progress, quality of life and psychological status, reducing complications after discharge[41].

However, we draw a distinction here. Participatory culture requires commitments in order to persist in liquid and pernicious contexts like those of capitalism. Limitation of individual freedom in choices, actions and codes has eroded the notion of collectivity. Bearing in mind that Primary Care is the field of full social participation and the macro-social setting of mass individualization causes disintegration[49], in evolving interactions and group reifications, learning care practices in micro-social settings would vivify social participation.

Wenger[14,28] defends mobilization in social organizations. Therefore, in a healthcare CoP, referring users to treat clinical problems, compare techniques and debate the challenges of the service is connected with a structure of mutual understanding[35] that deals with subjective demands in relation to themselves and to an informal and formal support network in rehabilitation/adaptation[42,51]. To be successful, not only the health system but also family members[52] must participate in the understanding of the normal peristomal pattern, in conversations about new concerns, and in the perception of body control[42,52].

The Care Services for Ostomized People level II are considered the theoretical point of departure for the rehabilitation of people with a stoma in CoPs within the SUS, due to the completeness of their technical and care structure and to their specialized interdisciplinary nature. Such services are responsible for the permanent education of the healthcare network teams[3]. Care for Ostomized People I offers supported self-care, prevents complications, and provides equipment and adjuvants, while Care for Ostomized People II offers, in addition to everything that is performed in the Care Services for Ostomized People I, professional qualification. An online CoP would gather the social actors from services I and II and, perhaps, offer qualifications in its private spaces for professionals from the other levels of care, like Primary Care and hospital units that assist people with peristomal complications.

Concerning rehabilitation, Category 2 is responsible for: III) inclusion of people with a stoma in the family and in society; IV) planning of quantitative and qualitative acquisition and supply of pouching systems and adjuvants; V) permanent education in the network points for referral and counter-referral; and, finally, VI) qualification in specialized techniques for professionals from hospital units and health teams of the Service of Category 1, which would be facilitated in the CoP.

Decree no. 5296 of December 2, 2004, in its Article 8, addresses technical aid concerning "products, instruments, equipment or technology for the functional improvement of people with disabilities or reduced mobility, promoting personal autonomy, total or assisted"[2]. It is worth thinking about the social control that would be performed if this information were in the private space of the online CoP, providing transparency for the service indicators[28]. In the educational aspect, a systematization of the compensatory rehabilitation of altered or lost skills would be implemented. Short texts approaching conditions that limit or potentialize learning would be provided, as well as activities, content, materials, and spaces where they can report what has changed in their life[45] and talk about anxieties or spirituality. Furthermore, information on receipt of pouching systems and adjuvants free of charge from the SUS[51] would be supplied. All of this is tacit and professional knowledge that generates indwelling[32].

In addition, communication via blogs, web 2.0, videologs, wikis, forums, podcasts, and other feedback channels[34] shows that CoPs do not have only esthetic-technological commitments, but are also connected with the potential for struggle, social contestation[49], and situativity.

The limitations of the evidences described here were: the articles were international, with care network arrangements and professional interventions that are different from the Brazilian arrangement (in Brazil, Primary Care is the front door and the matrix support); non-utilization of the descriptor "ostomy" due to the previous recognition of lack of studies; non-inclusion of studies indexed in Latin American databases; and limited access to ICTs by people with a stoma in the case of online CoPs.

On the other hand, the strong point of this study is the possibility, still unexplored, of transferring evidences from online and face-to-face CoPs to the Program of Care for Ostomates. Figure 1 reports family members-caregivers as one of the driving forces, together with the "champions of practice", and suppliers of artifacts or knowledge as senior components[28].

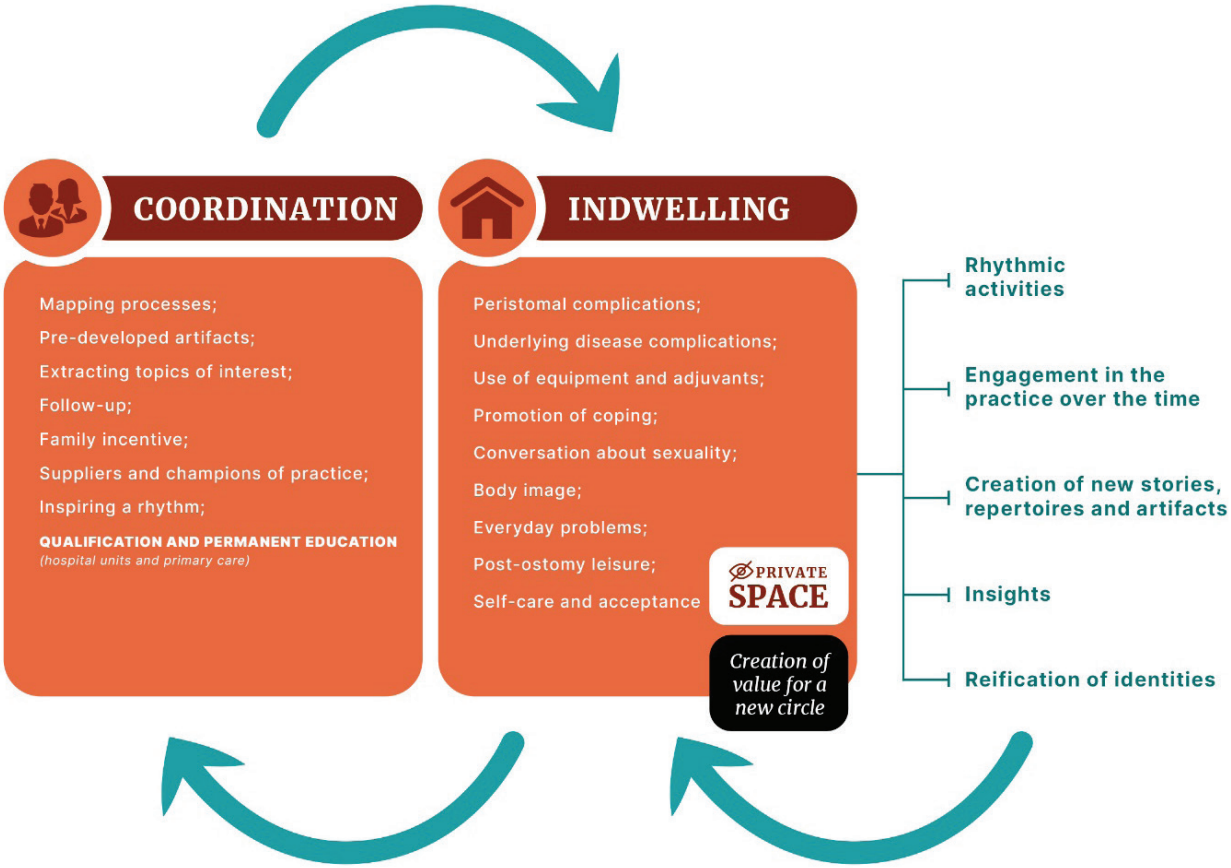

Figure 1. Subsidies for communities of practice targeted at people with a stoma.
Source: The authors.

Final remarks

It is possible to conclude that health services and professionals would benefit from the longitudinal interprofessional design that prioritizes the experience of veterans, the trajectory of newcomers, and the facilitation of specialists. Situated Learning Theory is one of the solutions for transfer of knowledge in health education concerning rehabilitation, as it engenders a social infrastructure for the expansion of capacities. This theoretical proposal, which synthesizes studies of different natures and from different countries in the area of social rehabilitation, advocates community arrangement and social participation, proposing that services I and II of the Healthcare Program for Ostomates in the scope of SUS should not be limited to fragmented appointments and product dispensing.

Social rehabilitation and the possible establishment of self-care are a chain of meanings connected with occupation of identities, reifications, and expectations. Therefore, "the walking path" from periphery to full participation says a lot about the identity of the person in recovery, transition, adaptation, and adjustment. Face-to-face and online situated approaches would only reverberate by means of a community-based, citizen participation in the SUS, bearing in mind the cohesion difficulties of Support Groups, professionals, managers, and Local Health Councils. In addition, we conclude that the fluidity of relationships and of the globalized political space produces fruitful interactions, but it is a context that will need to be confronted by apparatuses that produce life and subjectivities.

Afiliation

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Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Funding

The research was funded by CNPQ (National Council for Scientific and Technological Development) (Process 443021/2019-8).

Conflict of interest

The authors have no conflict of interest to declare.

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Editor
Antonio Pithon Cyrino
Associated editor
Pedro José Santos Carneiro Cruz

Translator
Carolina Siqueira Muniz Ventura

Submitted on
03/22/23
Approved on
09/29/23

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Objetivou-se discutir trajetórias de aprendizagem situadas na reabilitação social em Comunidades de Prática (CoP) presenciais e *on-line* para pessoas com estomia. Foi realizada uma revisão narrativa compreensiva com linha temporal aberta e amostragem de 18 artigos internacionais. A interpretação culminou nos pilares conceituais da CoP em saúde partindo de identidades e trajetórias rumo à participação central, à perificidade legítima e à reificação; transferência educacional em cenários presenciais e *on-line* com artefatos; exemplos e dilemas de implantação de *designers* ou arranjos colaborativos para diversos tipos de adoecimento e premência da avaliação interprofissional da trajetória; e, por fim, sabendo da existência das comunidades éticas, foram propostos subsídios para comunidades de prática destinadas às pessoas com estomias no Sistema Único de Saúde, tencionando a participação social-cuidativa e a reabilitação.

Palavras-chave: Estomia. Estomaterapia. Sistema de aprendizagem em saúde. Aprendizado social. Reabilitação.

El objetivo fue discutir sobre trayectorias de aprendizaje situado para la rehabilitación social en Comunidades de Práctica (CoP) presenciales y online para personas con estomia. Se desempeñó una revisión narrativa comprensiva con línea de tiempo abierta para el muestreo de 18 artículos internacionales. La interpretación culminó en los pilares conceptuales de la CoP en salud, partiendo de las identidades y trayectorias rumbo a la participación central, perificidad legítima y reificación. Transferencia educativa en escenarios presenciales y online con artefactos, ejemplos y dilemas de implantación de diseñadores o arreglos colaborativos para diversos tipos de enfermedad y la urgencia de la evaluación interprofesional de la trayectoria y, finalmente, conociendo la existencia de las comunidades éticas, se propusieron subsidios para comunidades de práctica destinadas a las personas con estomias en el Sistema Brasileño de Salud, con la intención de la participación social-cuidadora y la rehabilitación.

Palavras-chave: Estomia. Estomaterapia. Sistema de aprendizaje en salud. Aprendizaje Social. Rehabilitación.