

Health education in primary care: a look under the perspective of users of the healthcare system

Educação em saúde na atenção primária: um olhar sob a perspectiva dos usuários do sistema de saúde

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Abstract

This article aims to analyze the action of health education in primary healthcare, under the perspective of users of the healthcare system, in view of Bourdieu's social action theory. It is qualitative research held in two Primary Healthcare Centers in the municipality of Rio de Janeiro. Participant observation and semi-structured interviews were used as research techniques. A total of twelve interviews were conducted, with three analytical categories: autonomy and vulnerability: the agent's social trajectory; extended health care: meanings and tensions experienced from symbolic capitals; and bonding, trust and affection: the social support network. The analysis of the interviews featured Bardin's content analysis as theoretical framework in its thematic aspect. The collective actions opened space for dialog and appreciation of everyone's ideas, and the coordination of the concepts of Bourdieu's sociology of action with health education contributed to the understanding of the user's perspective about these social practices. Finally, effective and transforming actions by using dialog and interaction with the dynamics of the lives of the common people are proposed.

Keywords: Health Education; Primary Health Care; Qualitative Research.

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Resumo

Este artigo tem como objetivo analisar as ações de educação em saúde na atenção primária, sob a perspectiva dos usuários do sistema de saúde, à luz da teoria da ação social de Bourdieu. Trata-se de uma pesquisa qualitativa, realizada em duas Unidades Básicas de Saúde no município do Rio de Janeiro. Utilizou-se como técnicas de investigação a observação participante e a realização de entrevistas semiestruturadas. Foram realizadas doze entrevistas, com três categorias analíticas: autonomia e vulnerabilidade; a trajetória social dos agentes; cuidado ampliado em saúde; significados e tensões vivenciadas a partir dos capitais simbólicos; e vínculo, confiança e afeto; a rede de apoio social. A análise das entrevistas contou com o referencial teórico da análise de conteúdo de Bardin. As ações coletivas propiciaram espaço para diálogo e valorização da fala de todos, e a articulação dos conceitos da sociologia da ação de Bourdieu com a educação em saúde contribuiu para o entendimento da visão do usuário sobre essas práticas sociais. Por fim, são propostas ações efetivas e transformadoras por meio do diálogo e da interação com a dinâmica de vida popular.

Palavras-chave: Educação em Saúde; Atenção Primária à Saúde; Pesquisa Qualitativa.

Introduction

Health education has been recognized by managers and professionals as a fundamental instrument in the challenge of dealing with the population illness, and health education in primary care (APS) is a privileged place for the development of educational activities. The Family Health Strategy (ESF) attributes—family approach, bond formation, longitudinal care, cultural competence—allow health professionals to be closer to the population and community, making it possible to develop educational strategies with the potential to generate critical and reflective thinking, stimulating individuals' autonomy and self-care (Pereira; Oliveira, 2013; Ferreira et al., 2014; Brasil, 2017).

Thus, for educational processes to be effective, it is necessary that they be built from the individuals' role and co-responsibility. In this perspective, several public health policies were developed from the need to focus the actions on the user. However, there are still difficulties and challenges for the full implementation of strategic guidelines and axes corresponding to this concern (Fittipaldi; O'Dwyer; Henriques, 2021).

In fact, despite the changes observed in public policies in the last 40 years, the educational approaches carried out in health units remain, in general, restrictive, emphasizing technical knowledge to the detriment of knowledge and experiences acquired by individuals throughout their life history. Therefore, such approaches do not contribute to the construction of autonomy nor to the search for alternatives for a better quality of life, which makes the debate on the redefinition of health practices urgent and necessary (Assis, 2017; Madeira et al., 2018).

There are only a few studies that analyzed the educational approaches in health from the health system user's perspective. These studies addressed mainly the field of popular education in health (EPS) and/or Paulo Freire's pedagogy, which demonstrates the strengthening of this field of knowledge. However, despite presenting reflections on the importance of considering popular knowledge in the process of health learning through dialogic educational practices, it is not evident that this path

has been effectively used in the daily work (Sampaio et al., 2014; Reis, 2016; Oliveira Júnior et al., 2017; Almeida et al., 2019; Rego et al., 2019).

Remembering Victor Valla's studies in the 1990s, one identifies a crisis of interpretation and understanding of what popular groups have to say (Valla, 1996), discussion that remains relevant today. This crisis stems from the professionals' and researchers' difficulty in considering that poor people, residents of the peripheries of large cities and rural regions, are capable of producing and sharing valid knowledge and making consistent decisions. Such thinking creates a cultural division between professionals and users, which makes communication and co-responsibility difficult for proposed therapeutic interventions.

In an attempt to overcome this crisis of interpretation and communication to better understand the daily limitations and obstacles experienced by users, one emphasizes the need to expand the studies that promote educational space for popular groups and consider them active agents in the process of health teaching-learning (Mentrup et al., 2020). In this sense, coming closer to Bourdieu's theory of social action provides us with new elements for the study on health education, expanding the scope of the approaches already adopted by qualitative research that brings together the social and human sciences in the health area. Thus, the objective of this

article is to analyze the health education in primary care, from the perspective of health system users, in light of Bourdieu's theory of social action.

Methods

This article was produced based on an excerpt from a doctoral thesis in public health, whose methodological path was theoretically based on the sociological perspective of Pierre Bourdieu (Bourdieu, 2007a; 2011).

It is understood that Bourdieu's thinking, as a sociologist who developed important and recognized studies in the area of education, can contribute to the analysis of the process of understanding APS users based on health education actions. Thus, the concepts of habitus, symbolic capital, field, and symbolic power, described in Table 1, are powerful in understanding the influence that objective and subjective aspects exert on users' actions, impacting the constitution of their autonomy and their role in health care (Bourdieu, 2007a; Bourdieu 2011).

According to Bourdieu, to understand the agents' social action, it is important to reconstruct the elements and aspects that escape their consciousness, combining objective and subjective meanings, which involve the agent and the structure, as well as the habitus and the field in which they are inserted. (Bourdieu, 2007a).

Chart 1 – Pierre Bourdieu's sociological tools

Sociological tool	Definition
Habitus	Matrix that generates perceptions, appreciations, and practices, created by the agent's social experiences in their social interaction process, shaping their subjectivity and guiding their actions, their way of being, thinking, feeling, and acting. It is the social world incorporated into individuals, as durable dispositions.
Field	Space where agents and institutions are inserted. A part of the social space that presents a certain autonomy and its own social rules. Every field represents a space of forces, of power struggles for its conservation or transformation.
Cultural capital	A set of resources, skills and knowledge accumulated throughout life, which provide social mobility to agents.
Social capital	A network of relationships that represents a support strategy for agents to act in the social space in which they live.

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Chart 1 – Continuation

Sociological tool	Definition
Economic capital	Represented by the acquisition of various material goods such as books, equipment, and also financial profits.
Symbolic Power/Symbolic Violence	A hidden power, exercised by the ruling class and which does not appear explicitly as power. For the fact that it has been naturalized, incorporated into interactions in social space, individuals do not perceive themselves as dominated or coerced. Symbolic power becomes symbolic violence when there is a structure of domination of one class over another.

Source: Elaborated by authors based on Bourdieu (2007a; 2011)

Qualitative research was conducted in two Basic Health Units (UBS) located in the city of Rio de Janeiro, in a region of great social vulnerability. The health units selection criteria was the presence of collective practices developed by ESF teams, as well as the teams’ interest and availability in hosting the research.

Participants were male and female UBS users, over 18 years old, who participated in one or more collective practices. To this end, participant observation of collective actions and semi-structured interviews were used as research techniques (Minayo, 2010; Bardin, 2011).

Participant observation aimed to understand the dynamic of the collective practices developed, in addition to inviting users to participate in the research and respond to the interview. Interview analysis and interpretation stages relied on the theoretical framework of content analysis by Bardin (2011).

It is important to highlight the role of the interview as an integral element of the educational process. When the participant is invited to answer the research questions, they think of their answers based on the topics discussed and situations experienced in collective practices. Participants find a space to talk about themselves, about their lives and experiences, and, from this speech, they have the opportunity to think critically about what they experienced and about their place in this learning process, bringing to light and revealing knowledge that may be latent.

From this perspective, Bourdieu highlights the interview power, especially its meaning for the interviewee:

certain respondents, especially the most disadvantaged, seem to grasp this situation as an exceptional opportunity offered to them to testify, to make themselves heard, to carry their experience over from the private to the public sphere; an opportunity also to explain themselves in the fullest sense of the term, that is, to construct their own point of view both about themselves and about the world and to bring into the open the point within this world from which they see themselves and the world, and become comprehensible and justified, at first for themselves (Bourdieu, 1997, p. 704).

Results and discussion

Characterization of educational actions

Participant observation was carried out during 13 meetings of six educational actions: *Grupo café sem danos* [Harmless coffee group], aimed at users of alcohol and other drugs; *Grupo de plantas medicinais* [Medicinal plants group], aimed at sharing knowledge of the medicinal use of plants and planting a community vegetable garden; *Reencontro com a autoestima* [Rediscovering self-esteem], aimed at mental health users; *Grupo de hipertensão e diabetes* [Hypertension and diabetes group], for guidance on care in the treatment of these diseases, and *Grupo de artesanato* [Craft Group] and *Quem dança é mais feliz* [Those who dance are happier], both with the aim of providing integration, socialization, and relief from stress and anxiety symptoms through dance and art.

All groups observed were held by means of conversation circles, with exception of *Quem dança é*

mais feliz. After the main topic was presented by the professionals, participants were invited to express their impressions, make their comments, and also clarify their doubts. At times, the conversation was directed to other topics, reflecting the several doubts that arose, and the changes were accepted and well received by everyone.

Educational actions proved to be spaces for health education beyond the specific care objectives of the area, and among which it is possible to identify: opportunities for listening and speaking; demonstration of affection; formation of bonds; strengthening of relationships; sharing of knowledge, and collective construction of knowledge, besides being a space where popular and scientific knowledge can come closer to each other. It is known that the creation of socialization spaces has a positive impact on the population's quality of life (Bay et al., 2020).

During the conversation circles, the formation of an emotional and behavioral connection was observed based on interpersonal relationships between professionals and users, triggered and fostered during collective meetings. This process can contribute to encouraging autonomy and co-responsibility in health care, in addition to giving new meaning to the prescriptions and guidance received during clinical consultations. There are statements from participants during educational activities that express this meaning:

Do you want to see me wake up happy? When it's Monday and I come here. Did you know that there is embroidery [classes] at the clinic? Oh no, I didn't know. Then, I've got completely happy. I was in a process of enormous frustration as a woman, as a person who suddenly loses everything [...]. Then, suddenly, they say: there's an embroidery group, there's a yoga group. Yay! Count on me.

Health education based on the perspective of the users interviewed

From the groups observed, 12 semi-structured interviews were carried out, and the following categories were identified for analysis and discussion of the results: (1) autonomy and vulnerability: agents'

social trajectory; (2) expanded health care: meanings and tensions experienced from symbolic capital, and (3) bond, trust and affection: the social support network.

Autonomy and vulnerability: agents' social trajectory

The interview analysis based on this empirical category covered the concepts of habitus, cultural capital, and economic capital (Bourdieu, 2007a; Bourdieu 2011). Thus, one sought to demonstrate some influences that the interviewees received throughout their life path and which represented objective and structuring elements of their actions. Such influences are formed from the dynamic of social practices that integrated the habitus configuration, impacting their ability to develop autonomy, as well as the cultural capital accumulation.

Initially, the interviewees' education level was considered an important element of their social trajectory. Those who only had primary education or were not even literate represented the majority of interviewees: *"No, I've never studied, I had to work when I was seven years old"* (E8); *"People send me things on zap [sic] and I don't know how to read anything"* (E4).

Furthermore, the educational level of the interviewees' parents was the subject of investigation, and one sought to understand its influence on the cultural capital accumulation. Half of those interviewed reported that their parents were not literate, and those who studied did not complete primary education: *"my mother was completely illiterate, she couldn't read or write. My father, from the age of 50, almost 60, it was when he became literate, when he learned to write his name and read"* (E5).

Bourdieu's theoretical conception of sociology of education is based on the relationship between social origin and academic performance, mainly based on social classes. For the author, the school would have the role of reproducing the current social structure and, therefore, social inequalities. Thus, it would lead to low performance or school dropout among the popular classes, favoring the dominant classes, which would already enter the education system with a great advantage (Bourdieu, 2007a). In this

conception, academic performance would not depend solely on individual aptitudes inherent to particular biological and psychological constitutions, but, mainly, on the favorable or unfavorable conditions of people's social origin.

According to Bourdieu (2007a), the family and the educational institution are mainly responsible for the constitution of the agents' cultural capital. The family, as well as the school, transmits to its children a certain ethos, a set of values and ways of behavior, not always explicit, but responsible for shaping the individuals' identity and character. Thus, it is in the family that the configuration of the primary habitus occurs, the first and deep impression of social life on the individual. Then, other impressions are formed from the countless social interactions that occur throughout life.

In this way, aspects of formal education and family context can accompany individuals throughout their lives, influencing their possibilities of acting, as well as their ability to make choices and modify their reality. Such reflections appeared in the statements, often linked to the interviewees' living conditions and life stories: "[...] *She didn't send anyone to school. [...] She was not that person who encourages. We've learned things from people. We didn't have that literacy stuff*" (E10). "*It's not easy to come here every Thursday. [...] When I arrive here, I know that I've overcome some barriers. [...] I know that these were struggles that I've won to be here*" (E5).

It was therefore observed that the interviewees were aware of their limitations and understood their vulnerable situation. It is noteworthy that vulnerability involves not only individual, but also social aspects, influencing, for example, the population's exposure to the risks of illness (Ayes, 2014).

Thus, the individual component of vulnerability refers to the access that subjects have to information about health and illness, their ability to understand and incorporate this information into their daily concerns, and the interest and possibilities of turning these concerns into tools for modification of their reality. In other words, it is the subjective component, which is directly related to the habitus and the symbolic capital accumulation.

The social component concerns the education level, the type of information to which one has access, the power of political role, as well as the presence of material resources, elements that influence the possibility of incorporating changes into one's daily life. Such aspects have an impact on autonomy, as well as on the possibilities of implementing self-care. Thus, subjects' choices and their ability to "act freely" are limited by living conditions (Ayes, 2014; Madeira et al., 2018).

As aspects of social vulnerability, the interviewees described situations related to the social context of the place where they lived, which were related to their illness process: "*it's a tense place. It's because you have to come cross criminals all the time, every time. They have a lot of guns, you know? That corner full of heavily armed men, lots of drugs. I don't think that's cool.*" (E10)

In the highlighted statement, armed violence and the constant conflicts that occur in popular communities arising from organized crime were emphasized. These factors, in addition to representing a risk of imminent death, have a major impact on the residents' mental health, who live with moments of tension and fear on a daily basis (Ribeiro et al., 2020). In the context presented here, the level of vulnerability and economic capital emerged markedly as limiting elements of the interviewees' choices and autonomy. The enjoyment of autonomy, on the other hand, is related to access to consumer goods, health care, leisure, work, housing conditions, and it is limited by the absence or restriction on this access: "*I only buy [medicine] when there is a shortage here, and when there is a shortage here I know what to do so I don't run out of my husband's and mine medicine*" (E8).

The development of autonomy, expressed in the possibility of acting in the world through social and political participation, impacts positively the individuals' quality of life. It involves their living conditions, as well as their support networks and spaces available for socialization (Bay et al., 2020). "*I even fight against using the word user, I prefer sheltered, I prefer welcomed, because a user is the one who uses, goes away and that's it. No, we use it, we think, we change something that is possible and we move on. [...] It's also a space for action*" (E7).

“What has changed is that I try, [...] I think about fixing my life, and when I leave the shelter - I don't want to continue in that shelter [...] - I have to try to do the right thing.” (E2)

For Bourdieu (2011), cultural capital, together with economic capital, is responsible for structuring the individuals' social actions, experienced in different ways in the social space. Thus, the symbolic dimension of life is as important and structuring as the existing material aspects.

Individuals' choices and social dispositions are not simply limited to individual wills (primacy of action) nor are they macro-determinations of coercive arrangements (primacy of structures). They are mainly the result of their entire cultural and social heritage, acquired through family and school, which, in an inter-relational manner, define their attitudes, determined by culture, in a game that involves acceptances and refusals, as well as negotiations in structures, which are structured and structuring (BOURDIEU, 1989).

Another aspect that can be problematized in relation to autonomy and vulnerability is religiosity. Mentions of faith and religion permeated the interviewees' statements, who related them to the way they deal with illness and the difficulties of everyday life. Religiosity is considered an integral element in the healing and self-care process: *“Because I believe in God, because I believe that God can be a great partner, the greatest partner in someone's recovery, whatever that person's limitations may be” (E5).*

The great demand for religious practices signals the search not only for solutions to physical problems, but also for maintaining balance in the body-mind, or body-soul, unity. Thus, churches offer support and motivation in coping and alleviating suffering, making lives more meaningful and tolerable, providing a sense of autonomy and control over one's own destiny (Targa, 2019).

The construction of habitus, which occurs throughout the social trajectory of each individual, also manifests itself in the collective life experience of the group in which they live and which they identify with. In this sense, it was observed that the interviewees shared similar objective living conditions, whether due to their religiosity,

the territory where they lived, or their characteristics as users of APS Units in popular communities in a large city. Consequently, as they belong to a similar social environment, the construction of a common identity was observed, responsible for creating a certain harmonization of the habitus, what Bourdieu calls the *class habitus*.

Therefore, knowing some aspects of the experiences acquired in the interviewees' social trajectory contributed to the understanding of their possibilities of developing autonomy and self-care in health.

Expanded health care: meanings and tensions experienced from symbolic capital

The analysis based on this empirical category aimed to understand the interrelationships between the different aspects of the agents' symbolic capital in the social space of educational meetings. It covered the theoretical framework of the concepts of field, symbolic power, and symbolic violence (Bourdieu, 2007a; Bourdieu 2011).

The statements demonstrated that the knowledge shared in practices, as well as the exchange of experiences, were important and integral to therapeutic care. There is a dynamic of cooperation between collective actions and individual clinical care: *“I came here because of the treatment, but there was always embroidery [classes], there was a place where people were making [sic] medicinal plants and taking care of the land and creating conversation groups with the community” (E7).*

The elements addressed in collective practices considered the precepts of the expanded and shared clinic, which provides for the stimulation of autonomy through the integration of different knowledge and experiences, to meet differences and singularities (Brasil, 2014). Thus, they had a positive impact on the participants' lives, in aspects such as the recovery of self-esteem, pleasure, and well-being, which affect health in a direct manner: *“My self-esteem went through the roof [...]. I feel lighter. In the past I didn't do these things, I felt tired, I stayed at home thinking: ‘jeez, is this life, just watching television?’ [...] The day I come to dance, the day goes by like that, quickly” (E3).*

The themes proposed by professionals to be problematized during collective practices were of interest to those interviewed and aroused feelings and reflections: *“These are topics of interest to me and topics that make us rethink a lot about our quality of life, existential quality and how we position ourselves in the face of life difficulties, [...] in a healthier way”* (E7).

By accepting the themes that were presented by the professionals, and which, in general, were not previously agreed upon, the interviewees were in agreement with what Bourdieu (1989) calls the “feel for the game.” According to the author, there is a synergy between the agents’ action and the rules of the game in a given field, in which the agent does not always present their action consciously, and it is rarely the result of pure reason. On the contrary, their action is a consequence of the internalization of conventions and values that govern the field and which are the result of an asymmetric relationship of power and the inequalities that exist between the different types of capital that agents have. In this way, professionals and users establish a relationship of dominant and dominated that is not always perceived. The user accepts their role as dominated in this field of power, which is the field of health, believing that they are not in an equal position in terms of possession of the symbolic capital of knowledge (cultural capital) compared to health professionals.

The differences between the levels of symbolic capital produce tensions that manifest themselves differently in daily care. One of them occurs through symbolic power, which is established in a way that is not always perceived by agents. This power often produces symbolic violence, and the user does not feel dominated in this unequal power relationship. There is domination of one class over another when the health professional, with their scientific knowledge—the knowledge acquired in academic studies and recognized as dominant and hegemonic knowledge—exercises the power to decide on what is best for the other’s (user) life.

This type of decision involves subjective issues, and when this aspect is not considered in the context of the proposed interventions, symbolic violence takes place. Deciding how others should eat and how they

should behave on a daily basis to avoid behaviors considered risky involves considerations that go beyond scientific knowledge of the health-disease process. On the other hand, the user who “suffers” this symbolic violence does not realize it. As opposed to that, they validate and naturalize the guidance received as something produced by someone who knows more than them, who has a broader cultural capital, and, therefore, has the right to interfere in their lives. This interference is “permitted” because, as Bourdieu (1989) points out, the agents’ actions, influenced by objective and subjective aspects, are not always completely conscious. In this way, interference, even if permitted and accepted, can be somehow and at some time subverted.

Therefore, if the guidelines offered and shared are based on the power presented in the interaction between users and health professionals, they will probably be doomed to failure: *“And I didn’t take the medicine. I said: ‘I won’t take any medicine.’ Because... let’s suppose this one gives me a reaction too? Because I had never taken medication until then... [...] then, on my own, I took responsibility that I wasn’t going to take it”* (E1).

In contrast, when themes worked on in the groups considered the participants’ interests previously and allowed dialogue, it led to further reflections: *“Take advantage of what I’ve learned here and paid attention to in conversations. [...] I can’t keep coming here, participating in lectures just for the sake of participating, that’s not what I want. I want to take something useful to me”* (E2).

In this way, agents’ strategies for conserving or subverting structures depend on their position in the field, their incorporated dispositions (*habitus*) and their ability to activate and mobilize the symbolic capital they have accumulated (Moreira, 2017).

Bond, trust and affection: the social support network

The results from this category of analysis highlighted aspects of the interviews that are consistent with the concept of social capital (Bourdieu, 2007b). The interviewees found in collective practices, in addition to answers and technical guidance on health care, a space of

welcoming, affection, and listening. Thus, the bond with health professionals and other group participants was created or strengthened, forming a social support network: *“The people who serve us respect us, they care for us. They give us hugs, they give us a word”* (E2). *“I had this opportunity and permission from God, in the midst of a health crisis, to have doctors who were looking us in the eye. They were also in a conversation circle”* (E7).

In the statements, it was observed that collective practices provide dialogue between professionals and users, representing a rich and powerful opportunity to exchange different experiences and knowledge: *“I’m really thirsty for these listening sessions in the phytotherapy conversation group, when they bring knowledge that is more hegemonic, it is in a construction that belongs to the academy in contrast to our popular knowledge”* (E7).

Thus, the professional’s appreciation and respect for the other’s knowledge, for their previous experiences, as well as the affection and attention given during collective practices, encouraged the user to, through listening, produce knowledge that generated changes in behavior.

These results are corroborated by the study by Mentrup et al. (2020), which demonstrated that participants were more receptive to behavioral changes when information was shared in a dialogic, non-critical manner, with clear and objective language, honesty and empathy.

According to the EPS principles, educational practices should be carried out with joy, commitment, stimulating curiosity, hope and with conviction in real possibilities for change. Meetings should be based on dialogue, tenderness, and affection for participants, to promote awareness, without which there is no transformation of reality (Freire, 2011; Pedrosa, 2017). Educational approaches that follow these principles are advancing in Latin America, where professionals are taking on the challenge of modifying their practices to provide spaces for solidarity, building networks of meetings and interdisciplinarity (Jara, 2020).

It was observed that the interviewees’ expectations regarding collective practices were influenced by their vulnerable conditions. Such conditions made them prone to seek (albeit unconsciously) in collective

meetings a support network to face the health and illness situations they experienced. Some diseases have social causes, and/or aggravating factors of social origin, such as isolation. In this way, social support offers material, cognitive, affective, and emotional support for coping with illness (Canesqui; Barsaglini, 2012).

It is important to highlight that the formation of social support networks, created during collective practices, represented for the interviewees an opportunity to accumulate social capital, providing a form of access through interrelations and the contacts and support network that was established: *“Yes, yes, when I don’t come for a long time, I feel the symptoms of not coming [...]. You can’t imagine, it’s pain in the back, it’s pain in the legs, it’s swelling in the feet. [...] But it’s really a lack of enthusiasm, a lot of lack of enthusiasm”* (E6).

Each agent’s contribution in this exchange interrelationship depends on two main factors, which can act alone or together: (1) the volume of social capital that each agent has, which is related to the extent of the support network that he or she has access to or can mobilize, and (2) the volume of cultural and/or economic capital that each agent has. Thus, each individual, with their volume of symbolic capital, which is exclusively theirs, can add it to the other’s symbolic capital, forming a network of mutual support and bonds that may or may not be permanent, but which are useful due to the multiplier effect that exercise collectively (Bourdieu, 2007b).

For Bourdieu, the network of relationships and support does not happen spontaneously. On the contrary, it is a deliberate social action, the product of strategic work to establish and maintain conscious or unconscious social investment, in the short or long term, to provide symbolic profits. The establishment of recognition of the inclusion of an agent in a group is subjectively felt, through the exchange of feelings of respect, friendship, solidarity, and love that occur collectively, as well as guaranteed by institutions objectively, as a citizen’s right (Bourdieu, 2007b; Fittipaldi; O’Dwyer; Henriques, 2021).

Bourdieu (2007b) highlights the intangibility of social capital, since it resides in the structure of social relations. Social capital would also be a path to the accumulation of cultural capital, through

contact with different knowledge and experiences that are shared collectively. The profits acquired are symbolic and originate from the feeling of belonging to a group, whose existence is made possible based on respect, friendship, and solidarity.

Final considerations

Collective actions provided space to develop critical and reflective thinking through dialogue between participants, as well as valuing everyone's speech. However, it is considered that the context of individual and social vulnerability formed from the interviewees' life trajectories limits their power of choice and their ability to develop autonomy and self-care completely.

The reflections presented here express a scenario of educational actions that differs from the hegemonic practices of health education that are carried out in APS. A perspective of change is represented, which envisions the possibility of promoting the development of educational practices in line with the ideas of Popular Health Education. It is a powerful alternative for raising awareness, transforming reality and improving quality of life.

It is understood that it is impossible to reflect on health education, as a care tool, without addressing the objective social issues that influence directly the individuals' lives, interact with their subjectivity and permeate the interviewees' statements in this research. In other words, how can we talk about health education when there is a lack of basic formal education, work, housing, food, that is, decent subsistence conditions?

By identifying that the issues surrounding the population illness are crossed and influenced by the conditions determined by social structures, the necessary inclusion of reflections pertinent to the field of sociology is emphasized. From this perspective, Bourdieu's sociological tools were chosen as an analytical theoretical framework, which mediate subjective and objective aspects, highlighting that social structures operate in two ways with subjectivism. Thus, the articulation of the concepts of Bourdieu's sociology of action with health education contributed to the understanding of the user's view of these social practices, as well

as their experiences, interests, and motivations. This corroborates Bourdieu's perspective, although habitus plays a notable role in social actions, structures are determinants, facilitators or limits of these actions.

The study limitations are the context of field research, which was crossed by the Covid-19 pandemic, with the interruption of collective educational actions, and a consequent decrease in access to APS users. Therefore, it is suggested that new studies should be carried out to make it possible to expand the object of this research to new fields and different scenarios and contexts.

In this sense, by presenting the experiences and meanings attributed to educational actions by its users, we hope to contribute to the field of health education in APS, suggesting that it be should guided by the principles of Popular Health Education, through dialogue and interaction with the dynamics of popular life. It points out a path that, although already followed by some professionals, needs to be expanded, so that collective alternatives can be found to face the complexity of issues that make the population ill. In this way, it will be possible that effective, transformative, and lasting health education actions be proposed.

References

- ALMEIDA, M. S. et al. A Educação Popular em Saúde com grupos de idosos diabéticos na Estratégia Saúde da Família: uma pesquisa-ação. *Revista Ciência Plural*, [s. l.], v. 5, n. 2, p. 68-93, 2019. DOI: 10.21680/2446-7286.2019v5n2ID16954
- ASSIS, M. Uma nova sensibilidade nas práticas de saúde. In: VASCONCELOS, E. M.; PRADO, E.V. (org.) *A saúde nas palavras e nos gestos: reflexões da rede de educação popular e saúde*. São Paulo: Hucitec, 2017. p. 41-43.
- AYRES, J. R. Vulnerabilidade, direitos humanos e cuidado: aportes conceituais. In: BARROS, S.; CAMPOS, P. F. S.; FERNANDES, J. J. (Org.) *Atenção à saúde de populações vulneráveis*. Barueri: Manole, 2014. p. 1-25.
- BARDIN, L. *Análise de conteúdo*. São Paulo: Edições 70, 2011.

- BAY, A. A. et al. Effects of a health education and research participation enhancement program on participation and autonomy in diverse older adults. *Gerontology and Geriatric Medicine*, [s. l.], v. 6, 2333721420924952, 2020. DOI: 10.1177/2333721420924952
- BOURDIEU, P. *O poder simbólico*. Rio de Janeiro: Bertrand Brasil, 1989.
- BOURDIEU, P. (Coord.). *A miséria do mundo*. Petrópolis: Vozes, 1997.
- BOURDIEU, P. Escritos de educação. In: NOGUEIRA, M. A.; CATANI, A. (Org.). *Pierre Bourdieu: escritos de educação*. Petrópolis: Vozes, 2007a.
- BOURDIEU, P. O capital social: notas provisórias. In: NOGUEIRA, M. A.; CATANI, A. (Org.). *Escritos de educação*. Petrópolis: Vozes, 2007b. p. 65-69.
- BOURDIEU, P. *Razões práticas: sobre a teoria da ação*. Campinas: Papirus, 2011.
- BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização. *Cadernos HumanizaSUS*. Brasília, DF: Ministério da Saúde, 2014.
- BRASIL. Ministério da Saúde. Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Brasília, *Diário Oficial da União*, 22 set 2017. Disponível em: <https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html>. Acesso em: 6 fev 2019.
- CANESQUI, A. M.; BARSAGLINI, R. A. Apoio social e saúde: pontos de vista das ciências sociais e humanas. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 17, n. 5, p. 1103-1114, 2012.
- FERREIRA, V. F. et al. Educação em saúde e cidadania: revisão integrativa. *Trabalho, Educação e Saúde*, Rio de Janeiro, v. 12, n. 2, p. 363-378, 2014.
- FITTIPALDI, A. L. M.; O'DWYER, G.; HENRIQUES, P. Educação em saúde na atenção primária: as abordagens e estratégias contempladas nas políticas públicas de saúde. *Interface*, Botucatu, v. 25, e200806, 2021. DOI: 10.1590/interface.200806
- FREIRE, P. *Pedagogia da autonomia: saberes necessários à prática educativa*. São Paulo: Paz e Terra, 2011.
- JARA, O. Desafíos para la educación popular en América Latina hoy. *Interface*, Botucatu, v. 24, e200151, 2020. DOI: 10.1590/interface.200151.
- MADEIRA, F. B. et al. Estilos de vida, *habitus* e promoção da saúde: algumas aproximações. *Saúde e Sociedade*, São Paulo, v. 27, n. 1, p. 106-115, 2018. DOI: 10.1590/S0104-12902018170520.
- MENTRUP, S. et al. Patients' experiences of cardiovascular health education and risk communication: a qualitative synthesis. *Qualitative Health Research*, [s. l.], v. 30, n. 1, p. 88-104, 2020.
- MINAYO, M. C. S. *O desafio do conhecimento: pesquisa qualitativa em saúde*. São Paulo: Hucitec, 2010.
- MOREIRA, C. O. F. A sociologia da ciência de Pierre Bourdieu: ferramentas e pontos de vista. In: MARTELETO, R. M.; PIMENTA, R. M. (Org.) *Pierre Bourdieu e a produção social da cultura, do conhecimento e da informação*. Rio de Janeiro: Garamond, 2017. p. 179-189.
- OLIVEIRA JÚNIOR, G. E. et al. Individualização dos cuidados em saúde e apassivação dos usuários no âmbito da educação em saúde na Estratégia Saúde da Família. *Trabalho, Educação e Saúde*, Rio de Janeiro, v. 15, n. 2, p. 453-467, 2017.
- PEDROSA, J. I. S. Gestão participativa, controle social e educação popular em saúde: socializando saberes e práticas. In: VASCONCELOS, E. M.; PRADO, E. V. (Org.). *A saúde nas palavras e nos gestos: reflexões da rede de educação popular e saúde*. São Paulo: Hucitec, 2017. p. 167-185.
- PEREIRA, I. C.; OLIVEIRA, M. A. C. Atributos essenciais da atenção primária e a Estratégia Saúde da Família. *Revista Brasileira de Enfermagem*, [s. l.], v. 66, p. 158-164, 2013. Edição especial.
- SAMPAIO, J. et al. Limites e potencialidades das rodas de conversa no cuidado em saúde: uma

experiência com jovens no sertão pernambucano. *Interface*, Botucatu, v. 18, n. 2, p. 1299-1312, 2014. Suplemento. DOI: 10.1590/1807-57622013.0264

REIS, M. J. *Educação em Saúde na atenção primária à saúde no Brasil: um olhar sobre os conteúdos divulgados nas revistas científicas de saúde coletiva de 1990 a 2015*. 2016. 120 f. Dissertação (Mestrado em Saúde Pública) - Escola Nacional de Saúde Pública Sérgio Arouca, Rio de Janeiro, 2016.

REGO, L. S. et al. As atividades de grupo na perspectiva dos sujeitos em uma Clínica da Família. *Physis*, Rio de Janeiro, v. 29, n. 3, e290316, 2019.

RIBEIRO, F. M. L. et al. *Sumário executivo: violência armada e saúde: investigando os sentidos e os impactos da violência entre*

moradores e trabalhadores da saúde e da educação em Manguinhos/Rio de Janeiro/RJ - estudo de caso. Rio de Janeiro: Fiocruz, 2020. Disponível em: <<https://www.arca.fiocruz.br/handle/icict/43349>>. Acesso em: 10 fev. 2021.

TARGA, L. V.; OLIVEIRA, F. A. Cultura, saúde e o médico de família e comunidade. In: GUSSO, G.; LOPES, J. M. C.; DIAS, L. C. *Tratado de Medicina de Família e Comunidade: princípios, formação e prática*. Porto Alegre: Artmed, 2019. p. 74-80.

VALLA, V. A crise de interpretação é nossa: procurando compreender a fala das classes subalternas. *Educação & Realidade*, Porto Alegre, v. 21, n. 2, p. 177-190, 1996. Disponível em: <<https://seer.ufrgs.br/index.php/educacaoerealidade/article/view/71626>>. Acesso em: 14 out 2023.

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Fittipaldi was responsible for text conception and drafting. All authors are responsible for analyzing and interpreting the results, article writing and critical review, and approval of the version to be published.

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