Lifestyle, *habitus*, and health promotion: some approaches[1]

Estilos de vida, *habitus* e promoção da saúde: algumas aproximações

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Abstract

Healthy lifestyles (LS) are hegemonically interpreted as a set of individual behaviors capable of promoting health, which is understood as an eminently biological phenomenon. The theoretical framework of Health Promotion (HP), however, adds the concept of social determination to the discussions on the relationships between LS and health. Aiming to overcome the model of individual culpability focused on the epidemiological risk approach in the discussions on LS, we retrieved the concept of *habitus* from the work of sociologist Pierre Bourdieu. This article aims to summarize several approaches that historically permeated the discourses about LS and HP, introducing the concept of *habitus* as a mediator, which allows for a reflection on the topic from the existing social conditions and the historically constructed individual actions. This reflection is important because it conceptually strengthens HP ideas and promotes comprehensive, inclusive, participatory, and social empowerment actions, as opposed to prescriptive actions focused on disease prevention or control, which still prevail in the health praxis.

Keywords: Health Promotion; Social Sciences; Risk; Health Policy; Social Theory; Public Health.

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Resumo

Estilos de vida (EV) saudáveis são interpretados hegemonicamente como um conjunto de comportamentos individuais capazes de favorecer a saúde, entendida como fenômeno eminentemente biológico. O referencial teórico da Promoção da Saúde (PS), contudo, acrescenta o conceito da determinação social às discussões acerca das relações entre EV e saúde. Visando a favorecer a superação do modelo de culpabilidade individual centrada na abordagem de risco epidemiológico nas discussões sobre EV, recuperamos, na obra do sociólogo Pierre Bourdieu, o conceito de *habitus*. O propósito deste artigo é exercitar uma síntese das abordagens que, historicamente, permearam os discursos sobre EV e PS, introduzindo o conceito de *habitus* como mediador, o qual possibilita uma reflexão sobre o tema a partir das condições sociais existentes e das ações individuais historicamente construídas. A relevância dessa reflexão reside no fortalecimento conceitual do ideário da PS, e no favorecimento de ações integrais, inclusivas, participativas e de empoderamento social, como contraponto a ações prescritivas focadas na prevenção ou controle de doenças, ainda marcantes nas práxis em saúde.

Palavras-chave: Promoção da Saúde; Ciências Humanas e Sociais em Saúde; Risco; Políticas de Saúde; Teoria Crítica; Saúde Coletiva.

Introduction

Scientific productions focused on the epidemiology of risk behaviors associated with chronic non-communicable diseases (Morris et al., 1953; WHO, 2015), such as physical inactivity, inadequate diets, smoking, and excessive consumption of alcohol, put lifestyle (LS) as a priority topic in contemporary political agendas, especially in the field of public health (Brasil, 2006; 2015; UN, 2016; WHO, 2015).

Traditionally, the theoretical basis that supports these publications understands LS as a set of behaviors constructed by each person and, therefore, individually modifiable, depending on the choices of each subject. This form of treatment, still in force, accompanies the approach to risks and the standardization of so-called "healthy" behaviors, by promoting a social regulation that, at the level of everyday practices, blames subjects and populations for their health problems (Castiel; Guilam; Ferreira, 2010; Ferreira; Castiel; Cardoso, 2017), disregarding the subjective dimension and the socio-historical context in which such practices are inserted.

Thus, criticisms to this approach to LS take place because it does not embrace a deeper perspective on the topic, so as to consider social aspects, such as the economic model and culture, which affect the collective construction of the practices. Nevertheless, many publications explicitly acknowledge the effects that the social context can exert on human behavior (Cockerham, 2014; Ferreira; Castiel; Cardoso, 2017; Menéndez, 1998). However, roughly speaking, LS is not considered a construct derived from dialogic and historical processes, and the modes of subjectivation from which the several LS derive are excluded from analyses, as well as the processes of globalization and homogenization of behaviors, which are increasingly present in hypermodernity (Cockerham, 2014).

To overcome such limitations, the theoretical framework of Health Promotion (HP) introduces the concept of social determination, which adds other levels to the model focused on the biological subject to discuss the relationship between LS and health (Czeresnia, 2009; WHO, 1986). It shows economic, political, environmental, and cultural factors as determining or conditioning the illness processes and highlights the power of "empowered" groups in the construction of healthy LS (Czeresnia, 2009; Marcondes, 2004). Although this model helps us overcome the discourse of individual culpability focused on the epidemiological risk approach and highlights the social role of individuals in the construction of their everyday reality, it still gives little attention to subjectivity in discussions about LS.

It is in this perspective that we approach the concept of *habitus*, by Pierre Bourdieu (2011), whose extensive work has been recognized as a highly relevant contribution to study the socially incorporated expressions of individual practices (Assumpção; Golin, 2016; Cockerham, 2005; Montagner, 2006; Setton, 2002). Based on theoretical reflections about the conflicted relationship between structure and agency and between external social structures and subjective experiences, his studies help us denaturalize concepts and understand LS as a product of the *habitus*, collaborating to identify and question the ideologies embedded in people's ways of living (Bourdieu, 2011).

Such considerations show implications in the health concepts that guide not only intellectual productions but also health training and practice (Czeresnia, 2012). As physical activity and feeding are phenomena that undergo "healthy" standardizations and are LS objects of the praxis of several health care professions, it is important to build such approaches to emphasize the subjectivities and transformations of living conditions as central in HP processes, aiming to overcome normative and blame-inducing discourses of changes in habits, which are considered in a reduced and reductive way (Bagrichevsky; Estevão, 2012; Ferreira; Castiel; Cardoso, 2017).

History in the theoretical field: the concepts of lifestyle and health promotion

The term "lifestyle" and its main developments derive from the human and social sciences, such as Sociology and Anthropology, from references such as Marxism, Weber's interpretive sociology, psychoanalysis, and American anthropological culturalism. For these sciences, LS are group standards, on which the social structure exerts significant influence in the production of behaviors (Cockerham; Rütten; Abel, 1997; Menéndez, 1998; Montoya; Salazar, 2010).

Nevertheless, in the health field, LS is mostly an object of study of epidemiology, in a restricted and fragmented perspective, in that it reduces what is complex to variables, to identify behaviors that protect and risk health and their associations with chronic diseases (Castiel; Guilam; Ferreira, 2010; Menéndez, 1998). The hegemony of this approach favors deterministic interpretations, based on cause-and-effect relationships, in which risks of illness are mainly associated to individual choices, offering foundations to discourses focused on individual culpability (Castiel; Guilam; Ferreira, 2010; Menéndez, 1998).

By omitting social determinants from its analysis model, thus abstracting the political and economic dimension, this theoretical construct works as an ideological instrument that "cools" the claims of health as a social right, strengthening the notions of private health care and privatization of health services. In addition, it moves away from the original interpretations of LS formulated by the social sciences (Breilh, 2006; Cockerham; Rütten; Abel, 1997; Menéndez, 1998).

A portion of the health field, led by the social and human sciences, points the framework of HP as a movement that sought to discuss LS, from its initial documents – such as the Lalonde Report (1974) and its view of accountability of subjects for disease prevention – to the overcoming of this approach with the Ottawa Charter for HP (WHO, 1986), document that summarizes the First International Conference on Health

Promotion, considered a milestone by its more contemporary perspective, replacing the preventive and individualistic view of HP (Czeresnia, 2009; Marcondes, 2004; WHO, 1986).

Thus, HP theoretically advances prioritizing health and the construction of public policies and environments that promote healthy choices. It highlights the strengthening of community action, the reorganization of health services with a focus on primary health care, and the development of personal skills. It also starts to discuss and incorporate values related to the culture of peace, equity, and justice (Czeresnia, 2009; WHO, 1986).

Trying to follow the conceptual evolution of HP, LS is then defined by the World Health Organization as the "set of habits and customs that are influenced, modified, encouraged, or inhibited by the prolonged process of socialization. These habits and customs include the use of substances such as alcohol, tobacco, tea, or coffee, and dietary and exercise habits" (WHO, 2004).

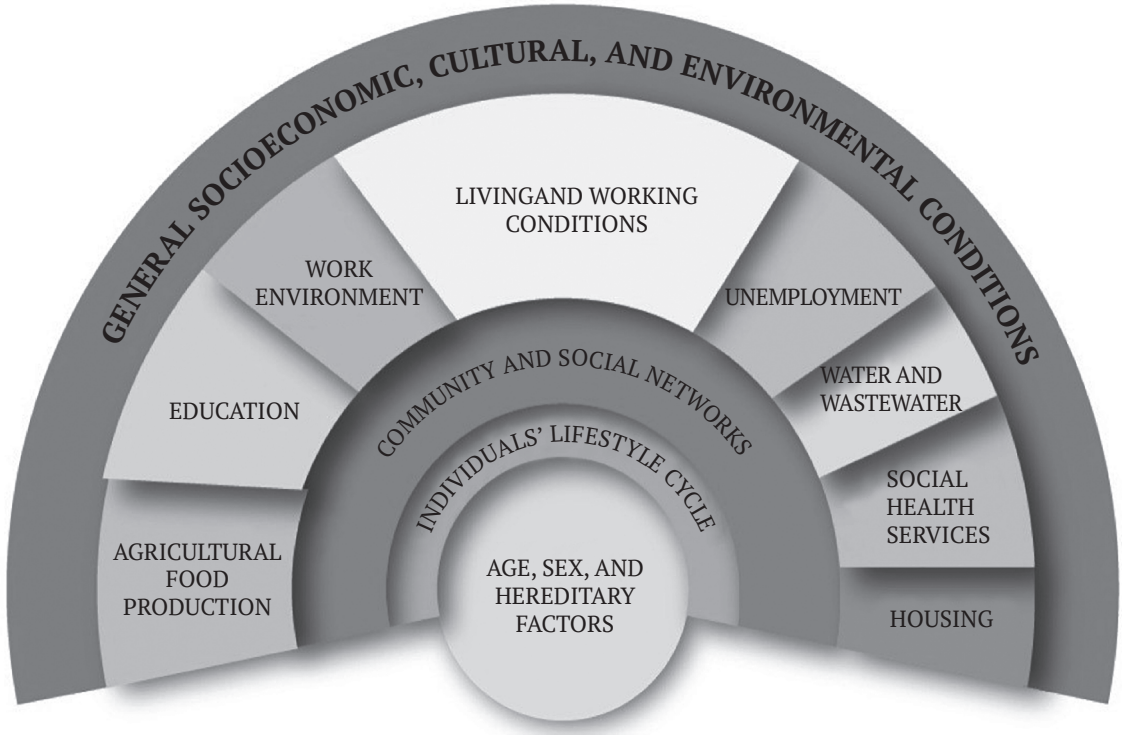
In Brazil, paradigm shifts in health were essential to consolidate the health reform. The health policy defined in the Constitution of 1988 and regulated by the Organic Law on Health (*Lei Orgânica da Saúde*) of 1990 advanced in broadening the notion of health considering the following aspects as its determining and conditioning factors: nutrition, housing, sanitation, environment, work, income, education, transportation, recreation and access to essential goods and services, among others (Brasil, 1988; 1990). The Brazilian Unified Health System legitimizes this expanded concept by focusing the health care model on its promotion at the community and primary level, seeking to shift the centrality of health from the doctor to the citizen and from treating diseases to reformulating environments for promoting health (Brasil, 1990).

With a big boost since the 2000s, HP was strengthened in Brazil with the publication of the National Policy of Health Promotion (PNPS – *Política Nacional de Promoção da Saúde*) in 2006. At that moment, this policy conceptually introduced HP in its most contemporary perspective and highlighted seven priority actions: healthy eating; body practice and physical activity; prevention and control of smoking; reduction of morbidity and mortality from abuse of alcohol and other drugs; reduction of morbidity and mortality from traffic accidents; prevention of violence and incentive to a culture of peace; and promotion of sustainable development (Brasil, 2006). Once again, ambiguously, healthy behaviors are indicated as aspects of HP, without clarifying their relations with macrostructural aspects of society (Rocha et al., 2014). To overcome this ambiguity, the recent review of PNPS, published in 2014, resumes the discussion on the principles, values, and guidelines that must subsidize the actions in HP, understood as a set of strategies and ways of producing health, and having the principle of equity as the basis for distribution of opportunities, considering individual and collective specificities (Brasil, 2015; Rocha et al., 2014).

Despite the limitations of any schematic representation, an interesting visual model of the interrelationships between individual and macro determinant factors was proposed by Dahlgren and Whitehead (1991), in which choices, behaviors, and LS are located on the middle layer between socioeconomic, cultural, environmental, and political determinants and individual aspects such as age, sex, and genetics (Figure 1). According to the model, behaviors are choices made by individuals, but they may be conditioned by access to information and services, peer pressure, and cultural patterns that shape the chances of people being healthy (Buss; Pellegrini Filho, 2007). Thus, thinking about choices and LS leads us to a complex territory that still demands analysis and, above all, conceptual investments.

To enrich the discussion on LS and HP, and seeking to dialogue with and put into dialogue the two prevailing approaches – one that blames the individual by the adoption of unhealthy behaviors and another that emphasizes the interaction of people with their context in the definition of behaviors, habits, and LS (Cockerham, 2005; Gómez, 2013) –, we present below the foundations that help us strengthen the view that, beyond the materialization of a special narrative of self-identity, LS is socially and collectively constructed (Cockerham, 2005).

Figure 1 – The social determinants of health: Dahlgren and Whitehead's model



Source: adapted from Buss and Pellegrini Filho, 2007

Habitus: a complex approach to the understanding of lifestyle

Habitus is a central concept in the thinking of sociologist Pierre Bourdieu (1930-2002) in his studies on the individual-society relationship, in which it exerts a strong explanatory and analytical power. It is important to recognize the Aristotelian origin of *hexis* and its long course in Western thought, related to the moral character that guides feelings, desires, and conducts, as well as the contribution of classical authors of sociology, such as Durkheim, Marx, and Weber, for its approach (Wacquant, 2007). Wacquant (2007) says that the term *habitus* was translated into Latin only in the 18th century by Saint Thomas Aquinas, and incorporated into the *Summa Theologiae* with the meaning of lasting and suspended disposition.

According to Bourdieu (2009, p. 87), *habitus* can be understood as

> systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them.

The *habitus* derives from particular conditions of existence. Thus, it is both individual and collective, which means it can generate and unify collective practices with peculiar features, resulting in the approach focused here, in a single LS. Thus, LS can be understood as a product of the *habitus* historically constructed by the experiences that are "unconsciously" modeled and incorporated from the social relations that make up living conditions and the position of the agents (Wacquant, 2002). In other words, *habitus* produces actions and is constantly assimilated, being updated in the practices and representations, that is, in the objective and subjective dimensions.

In examining Bourdieu's intellectual trajectory, we can see a focus on the theory of practice and on the analysis of the mechanisms of domination of the production of ideas and of the genesis of behaviors. In the perspective of knowledge that Bourdieu names as praxeological, the "object is not only the dimension of objective relations [...] but also the dialectical relations between these structures and the structured dispositions in which they are updated and that tend to reproduce them" (Ortiz, 1983, p. 40). His work presents the concepts of field, *habitus*, and capital as key concepts for the mediation between social agent and society (Bourdieu, 2011). For the purposes of this article, we approach Bourdieu's contributions, particularly the concept of *habitus*, to promote the understanding of the "social determination of LS," in line with the social determination of health, which is an important idea to HP.

The concept of *habitus*, given its dialectical character, converges the personal perspective of "free-acting," quite widespread and accepted in contemporary times, with the perception of the influence of context in decisions and in the reproduction of behaviors, considering that the will of the "free-acting" is related to the environments, also called "structuring structures," which can be favorable or unfavorable to certain behavior choices and changes (Bourdieu, 2011), relativizing these acts regarding their autonomy. In addition, it is a premise that must act as basis for the planning of health actions, which are often culturally out of context in the diversity of territories and in which one can observe the exclusion of subjects, or rather of the intersubjectivity that must be present in health policies (Caliman; Tavares, 2013; Castiel; Sanz-Valero; Vasconcellos-Silva, 2011).

It is also important to consider that the proximity between certain social groups makes their objective needs be operated by the same *habitus*, presenting similarities in speeches and behaviors, which results in distinct and distinctive LS between groups or populations (Bourdieu, 2011). The concept of *habitus* helps to understand the sense of homogeneity of some health behaviors and perceptions of groups that have shared life stories, but Setton (2002) emphasizes the understanding of the complexities and changing elements in the health experiences that make up the LS of the social agents, indicating that *habitus* is a system under construction and mutation.

Thus, to understand the *habitus*, one must analyze the trajectory of socialization and subjectification of individuals throughout life, and understand social practices from the historical integration between past and present. It is linked to a long-term socializing process, started in what is called "primary socialization," with the unconscious dimension, in the sense of subliminal and thinking-free adherence, as one of its pillars (Setton, 2002). In addition, it is essential to clarify that other concepts, such as capital and its unequal distribution and field and social space, motivate social practices, as Bourdieu (2011) well explained in his "theory of practice," as well as the critical tradition. The social space is "this invisible reality, which we cannot show nor touch and which organizes the practices and representations of the agents" (Bourdieu, 2011, p. 24).

Montagner (2006) underlines the innovative character of the concept, which enables the theoretical mediation between the structures and the historical context in which the social agents are inserted, and states that the *habitus* works on the edge of three distinct logics: retention, which concerns the body *hexis*, the physical capital accumulated over time and that singularizes body shapes and postures that mark the trajectory of the individual or groups of individuals; mediation, which is revealed in the worldview that individuals shape from their everyday experience; and classification, in which individuals design their singularities marked by the social trajectory, in its turn constructed in social spaces permeated by unequal relationships between individuals that have different social capitals. The concept of field, which will not be analyzed in detail here, is transversal to Bourdieu's work and explains the accumulation of different types of capital.

From these concepts, some authors advance in the discussion of the relationships between LS and *habitus*. For purposes of illustration, we cite William Cockerham (2005), who combines the notion of *habitus* with Weber's classical theory to analyze the phenomenon of LS from the assumption of the dialectical relationship between choices and opportunities of life. For the author, a LS is formed by collective patterns of health-related behaviors based

on choices of options available to people according to their chances of life. Humans have the ability to choose their LS, but their choices are limited by their living conditions. Breilh (2006, p. 46) goes further and states that "this dynamic relationship between way of life, LS, and *habitus* is rooted in a powerful influence of tastes and choices of everyday life, which, always within the margin of possibilities and practical realities of the way of life, contribute to determine the organic states and the genotypic and phenotypic conditions."

Current considerations about *habitus*, lifestyle, and health promotion

Thirty years have passed since the Ottawa Charter (WHO, 1986) adopted an advanced definition of HP, considering the larger perspective of the health-disease-care process, going beyond the preventive approach and the individual "culpability." Several public policies and programs recognize and foresee the creation of environments conducive to health, which meet health needs by intersectoral measures, community empowerment, and development of personal skills favorable to health in all stages of life.

However, the hegemony of a Cartesian and biomedical model in the health sector and the interests to which it is linked keep hindering the translation of this theory, creating ambiguous and sometimes contradictory documents with effects not only on theory, but on the materiality of the Brazilian health system, preventing or delaying the transition of health practices to more comprehensive and participatory models (Ceccim; Feuerwerker, 2004; Czeresnia, 2012). The fragmentation of behaviors and their classification as "risk factors" can stimulate changes in individual behaviors, but limits the understanding in terms of LS. Analyses and interventions, for example, on behaviors of sedentary and obese people should not be reduced to the risk itself; they must also consider the conditions under which the subjects (re)produce their lives (Castiel; Sanz-Valero; Vasconcellos-Silva, 2011; Menéndez, 1998) and the subjective modulations related to their body and feeding.

At least part of the problem lies in the production of knowledge and in the training of health professionals, when they are based on a causal and one-sided view and on an understanding of the relationship between LS and HP that disregards the social determination of these phenomena (Ceccim; Feuerwerker, 2004; Chiesa et al., 2007; Haddad et al., 2010). It is not a question of denying the "free-acting" that makes up the LS, but of problematizing it, of putting it into perspective before discourses that are constructed from simplifying readings.

In contemporary times, it makes no sense to allow analyses that defend the autonomy of individuals over their behaviors in a disconnected way from their socioeconomic reality, in which changes in habits would be, first of all, the result of intimate decisions and "willpower," often unfolding in attitudes that generate stigma in everyday care (Caliman; Tavares, 2013; Castiel; Guilam; Ferreira, 2010). One must recognize that the actual LS is affected by various social transformations, from the multiculturalization of the offered content to mass consumption, both stimulated by globalization and by new technologies (Bauman, 2003; Cockerham, 2014).

Hegemonic scientific productions in health help build narratives that blame individuals and privatize solutions to problems arising from unhealthy LS (Castiel; Sanz-Valero; Vasconcellos-Silva, 2011). In this scenario, health education and HP strategies have limited effectiveness, since the health and the LS of the population and the very professional training in health are subjected to commodification (Gómez, 2013). This brings up the importance of conceptual discussions about "being healthy"; about the role of science in the production of this knowledge; and about the submission of science and politics to market laws (Cockerham, 2005; Caliman; Tavares, 2013).

The individual risk approach favors people from more privileged socioeconomic classes, with better educational level and easy access to consumer goods. Therefore, it is imperative to use a more comprehensive, ethical, and moral paradigm, which meets the needs of the less privileged classes (Gómez, 2013). Public health policies must, first of all, take place by coordinated actions that consider the principle of equity in income distribution, social policies, and access to goods and services (Buss; Pellegrini Filho, 2007; Marcondes, 2004).

This essay aims, therefore, to retrieve a concept that exposes some historical, epistemological, and intrinsically political roots of the tensions and gaps regarding the theories that support discussions such as the ones that address LS and HP, with extensive debates in the literature. In this perspective, the approximation of the health field to the concept of *habitus* can represent another subsidy to understand how external conditioning factors affect people's choice of behaviors; which personal routines have the specific features of a group or social class; and how the perceptions on LS and health are being formed. It also helps us to think about the relationship and the mediations between exterior social conditioning and people's subjectivity (Setton, 2002).

The reflection carried out within the limits of this space can represent an heuristic method to understand the complex and deeply rooted patterns of certain LS and behaviors that are routinely associated with problems prevailing in public health, which are objects of the scientific productions and of the practices carried out by the health field. This trajectory makes clear the several steps and facets involved in building healthy habits and the difficulties of creating theoretical models able to unravel the complexity and overcome the problems present in the approach to this challenge in the public health field.

Understanding LS as *habitus* means acknowledging that the habit has a dialectic and dynamic component and that the processes of subjectification cannot be left out of this model. Thus, changes can be triggered in various ways: the social agents can adopt new behaviors that will contribute to the better management of their LS and their health conditions (Setton, 2002).

If we really want to modify the health practice regarding LS, researchers, professors, students, professionals, and public health policy makers must understand the complexity of this phenomenon. There are theoretical frameworks in the health field that help us to see more accurately the many aspects surrounding the formation of the *habitus*, notably when we exercise processes of knowledge production and of "diagnosis and prescription," which are so present in the health practices.

This essay, far from intending to be exhaustive, sought to systematize some approximations between the concepts of LS, HP, and *habitus*, as a possible construct to promote the construction of health in its individual and collective perspective, in a sustainable and lasting way. It also sought to indicate certain tensions underlying the structures, which hinder the progress of these processes.

References

ASSUMPÇÃO, L. O. T.; GOLIN, C. H. Reflexão sociológica sobre o conceito de habitus relacionado à prática de atividade física. *Revista Brasileira de Ciência e Movimento*, Brasília, DF, v. 24, n. 3, p. 158-166, 2016.

BAGRICHEVSKY, M.; ESTEVÃO, A. O imperativo da epidemiologia dos fatores de risco em face das desigualdades sociais: agenciamentos discursivos sobre o sedentarismo. *Revista de Ciências Sociais*, Rio de Janeiro, n. 37, p. 89-102, out. 2012.

BAUMAN, Z. *Modernidade líquida*. Rio de Janeiro: Zahar, 2003.

BOURDIEU, P. *O senso prático*. Petrópolis: Vozes, 2009.

BOURDIEU, P. *Razões práticas*: sobre a teoria da ação. Campinas: Papirus, 2011.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. *Constituição da República Federativa do Brasil de 1988*. Brasília, DF, 1988. Disponível em: <https://goo.gl/HwJ1Q>. Acesso em: 18 jan. 2018.

BRASIL. Ministério da Saúde. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial [da] República Federativa do Brasil*, Brasília, DF, 20 set. 1990. Disponível em: <https://goo.gl/FDaPDc>. Acesso em: 18 jan. 2018.

BRASIL. Ministério da Saúde. *Política Nacional de Promoção da Saúde (PNPS)*. Brasília, DF: Secretaria de Vigilância em Saúde, 2006. v. 7.

BRASIL. Ministério da Saúde. *Política Nacional de Promoção da Saúde:* PNPS: revisão da Portaria MS/GM nº 687, de 30 de março de 2006. Brasília,

DF, 2015. Disponível em: <https://goo.gl/rZmZ5>. Acesso em: 18 jan. 2018.

BREILH, J. *Epidemiologia crítica*: ciência emancipatória e interculturalidade. Rio de Janeiro: Fiocruz, 2006.

BUSS, P. M.; PELLEGRINI FILHO, A. A. Saúde e seus determinantes sociais. *Physis: Revista de Saúde Coletiva*, Rio de Janeiro, v. 17, n. 1, p. 77-93, 2007.

CALIMAN, L. V.; TAVARES, G. M. O biopoder e a gestão dos riscos nas sociedades contemporâneas. *Psicologia: Ciência* e *Profissão*, Brasília, DF, v. 33, n. 4, p. 934-945, 2013.

CASTIEL, D. L.; GUILAM, M. C. R.; FERREIRA, M. S. *Correndo risco*: uma introdução aos riscos em saúde. Rio de Janeiro: Fiocruz, 2010.

CASTIEL, L. D.; SANZ-VALERO, J.; VASCONCELLOS-SILVA, P. R. *Das loucuras da razão ao sexo dos anjos*: biopolítica, hiperprevenção, produtividade científica. Rio de Janeiro: Fiocruz, 2011.

CECCIM, R. B.; FEUERWERKER, L. C. M. O quadrilátero da formação para a área da saúde: ensino, gestão, atenção e controle social. *Physis: Revista de Saúde Coletiva*, Rio de Janeiro, v. 14, n. 1, p. 41-65, 2004.

CHIESA, A. M. et al. A formação de profissionais da saúde: aprendizagem significativa à luz da promoção da saúde. *Cogitare Enfermagem*, Curitiba, v. 12. n. 2, p. 236-240, 2007.

COCKERHAM, W. C. Health lifestyle theory and the convergence of agency and structure. *Journal of Health and Social Behavior*, Thousand Oaks, v. 46, n. 1, p. 51-67, 2005.

COCKERHAM, W. C. The sociology of health in the United States: recent theoretical contributions. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 19. n. 4, p. 1031-1039, 2014.

COCKERHAM, W. C.; RÜTTEN, A.; ABEL, T. Conceptualizing contemporary health lifestyles: moving beyond Weber. *The Sociological Quarterly*, Berkeley, v. 38, n. 2, p. 321-342, 1997.

CZERESNIA, D. O conceito de saúde e a diferença entre prevenção e promoção. In: CZERESNIA, D.; FREITAS, C. M. (Org.). *Promoção da saúde*: conceitos, reflexões, tendências. 2. ed. rev. e amp. Rio de Janeiro: Fiocruz, 2009. p. 1-7.

CZERESNIA, D. *Categoria vida*: reflexões para uma nova biologia. São Paulo: Unesp; Rio de Janeiro: Fiocruz, 2012.

DAHLGREN, G.; WHITEHEAD, M. *Policies and strategies to promote social equity in health.* Stockholm: Institute for Future Studies; 1991.

FERREIRA, M. S.; CASTIEL, L. D.; CARDOSO, M. H. C. A. Does sedentarism kill? Study on comments by readers of a Brazilian online newspaper. *Saúde e Sociedade*, São Paulo, v. 26, n. 1, p. 15-28, 2017.

GÓMEZ, D. P. Estilo de vida saludable (EVS): limitaciones del enfoque biomédico. *Apuntes Universitarios*, Tarapoto, v. 3, n. 1, p. 9-26, 2013.

HADDAD, A. E. et al. Formação de profissionais de saúde no Brasil: uma análise no período de 1991 a 2008. *Revista de Saúde Pública*, São Paulo, v. 44, n. 3, p. 383-393, 2010.

LALONDE, M. *A new perspective on the health of Canadians*: a working document. Ottawa: Minister of Supply and Services Canada, 1974.

MARCONDES, W. B. A convergência de referências na promoção da saúde. *Saúde e Sociedade*, São Paulo, v. 13, n. 1, p. 5-13, 2004.

MENÉNDEZ, E. L. Estilos de vida, riesgos y construcción social: conceptos similares y significados diferentes. *Estudios Sociológicos*, Cidade do México, v. 16, n. 48, p. 37-67, 1998.

MONTAGNER, M. A. Pierre Bourdieu, o corpo e a saúde: algumas possibilidades teóricas. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 11, n. 2, p. 515-526, 2006.

MONTOYA, L. G.; SALAZAR, A. L. Estilo de vida y salud: un problema socioeducativo, antecedentes. *Educere*, Mérida, v. 14, n. 49, p. 287-296, 2010.

MORRIS, J. N. et al. Coronary heart disease and physical activity of work. *Lancet*, Londres, p. 1053-1057, 21 nov. 1953.

ORTIZ, R. (Org.). *Pierre Bourdieu*: sociologia. São Paulo: Ática, 1983.

ROCHA, D. G. et al. Processo de revisão da Política Nacional de Promoção da Saúde: múltiplos movimentos simultâneos. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 19, n. 11, p. 4313-4322, 2014.

SETTON, M. G. J. A teoria do habitus em Pierre Bourdieu: uma leitura contemporânea. *Revista Brasileira de Educação*, Rio de Janeiro, n. 20, p. 60-70, maio/ago. 2002.

UN - UNITED NATIONS. *Global Sustainable Development Report 2016*. New York: Department of Economic and Social Affairs, 2016.

WACQUANT, L. J. D. O legado sociológico de Pierre Bourdieu: duas dimensões e uma nota pessoal. *Revista de Sociologia e Política*, Curitiba, n. 19, p. 95-110, nov. 2002.

WACQUANT, L. J. D. Esclarecer o habitus. *Educação & Linguagem*, São Paulo, v. 10, n. 16, p. 63-71, 2007.

WHO - WORLD HEALTH ORGANIZATION. The Ottawa Charter for Health Promotion: first International Conference on Health Promotion, Ottawa, 21 November 1986. *WHO*, Genebra, 1986. Disponível em: <https://goo.gl/uD5cmd>. Acesso em: 20 nov. 2017.

WHO - WORLD HEALTH ORGANIZATION. *A glossary of terms for community health care and services for older persons*: WHO Centre for Health Development: ageing and health technical report. Genebra, 2004. v. 5. Disponível em: <https://goo.gl/vLUmxu>. Acesso em: 18 jan. 2018.

WHO - WORLD HEALTH ORGANIZATION. *Noncommunicable diseases progress monitor*: 2015. Genebra, 2015. Disponível em: <https://goo.gl/CMGwnc>. Acesso em: 18 jan. 2018.

Authors' contribution

Madeira was responsible for the design, initial writing of the manuscript, and adaptation to the journal's rules. Nogueira guided the study, organized and configured the text, and conducted the final review of the manuscript. Bosi and Filgueira contributed with the theoretical framework and conducted the critical review of the text. All the authors contributed to the writing and review of the manuscript and approved the final version to be published.

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