

## Nutritional care by foreigners in the More Doctors Project for Brazil

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We aim to investigate the influence of different sociocultural origins in both Cuban physicians participating in More Doctors Project for Brazil and Brazilian patients' diet and nutrition approach in primary health care services. The case study was made using triangulation method, ethnography, focus groups and interviews. It was applied Pierre Bourdieu's theoretical approach, in particular, the habitus (i.e. social and cultural origin) concept. The results showed that the diet and nutrition guidelines are highly influenced by the biomedical paradigm, attenuating possible influences of the habitus.

*Keywords:* More Doctors Project for Brazil. Habitus. Nutrition. Bourdieu.

### Introduction

A number of initiatives to increase access to primary health care, adjust the infrastructure of the national public health network, restructure medical school and residency programs, and provide physicians to areas of low or no presence of these professionals were created in 2013 under the name of the More Doctors Program (MDP). The component of emergency provision of these professionals was known as

the More Doctors Project for Brazil (MDPB)<sup>1</sup>. The debate around the MDBP garnered significant attention in Brazilian society when it was implemented. However, this debate was particularly polarized and neglected central aspects of the proposal. A study conducted by Luz et al. that analyzed printed reports by media with national circulation about the MDP showed that the media did not consider the goals of the law that created the program, illustrating that bias in publications of general circulation was one of the obstacles that compromised effective support from the society in general for discussions of the program and the project<sup>2</sup>.

Contributions from the scientific field inevitably require more time, and only recently have the first contributions been made by publication of empirical studies and research about the MDBP and the MDP. In accordance with the specific structure of Brazilian collective health, which is characterized by an intersection of both the scientific and bureaucratic fields<sup>3</sup>, this still-incipient debate in the specialized literature has been promoted by agents inserted into the management of the Brazilian National Health System (SUS), through which they have established links with academicians, relativizing the proposal in relation to the international context<sup>4</sup> or arguing about possible problems in the program<sup>5</sup>.

The debate on core issues of the MDP and MDBP – such as medical training, coverage and access in primary health care, among others – and the analysis of the effects of these issues may expand in the coming months, as indicated in a seminar conducted by PAHO<sup>6</sup>. However, other relevant aspects besides training, coverage and access should not be forgotten that are also part of the program and can significantly interfere in its development. We question the extent to which the different sociocultural, political and economic characteristics of expatriate physicians inserted in the MDBP, in relation to patients who are mostly Brazilians, may influence their understanding, prescription and behavior regarding habitual issues such as food intake practices.

The increasing importance of chronic conditions and guidelines for promotion and prevention have highlighted the role of food and nutrition in primary health care<sup>7</sup>. In this context, one of the challenges faced by health professionals in nutritional care

is the frequent perception of food problems as limited to facts, as well as conflicts between theory and practice<sup>8</sup>. These two challenges, which can be understood as related to the predominance of empirical practice in guiding food-related behavior<sup>6</sup>, result from the connection between food and culture, since we are all inevitably exposed, from the time we are born, to issues that involve the development of eating habits. The links between cultural aspects and food practices have been systematically addressed, and some authors have pointed to the emergence of a new and specific scientific field in this area in Brazil, related to food and culture<sup>9</sup>.

This study aimed to investigate the possible interference of the distinct cultural origins of the foreign physicians in the MDBP in understanding eating practices and their impact on approaches to nutrition. A case study approach was used to analyze the cultural aspects present in interactions between MDBP agents of various nationalities and their possible influence on healthcare actions in primary health care, focused on nutrition. The resulting information was analyzed based on the sociological theories of Pierre Bourdieu, especially the concept of habitus.

### **Habitus and hysteresis of expatriated physicians**

The concept of habitus, which is the foundation of the ideas of French sociologist Pierre Bourdieu (1930–2002), refers to the way individuals perceive the social world, that is, through cognitive and bodily manners; hexis represents one's posture, accent and ways of dressing<sup>10</sup>. In other words, habitus is a system of personal dispositions, acquired throughout the socialization process, showing unique gestures, postures, values and tastes when, in fact, these characteristics were introduced in the socialization process by the family and the social environment<sup>11</sup>. Conceived as a matrix of perceptions and behaviors generated by individual trajectories from the social conditions of existence, habitus structures agents and is simultaneously structured by society. Although habitus is a result of historical and social conditions, it is also a producer of non-mechanical or predetermined actions, allowing adaptation to the logic of a new social field where a given agent is eventually found<sup>12,13</sup>.

For Bourdieu, agent and the social structures interact with one another, creating an overlapping system of relationships<sup>14</sup>. Through the notion of habitus, Bourdieu seeks to overcome the polarization present in the dyad established by the objectivistic and phenomenological positions or between phenomenology and structuralism. In his praxeology, Bourdieu seeks, at the same time, to both consider and go beyond phenomenology, which is centered on the experience of the world by agents, disregarding the effective conditions of possibilities, and structuralism, which rejects the idea of agents endowed with intention as reproducers of these same structures.

The praxeology proposed by Bourdieu is defined by moving beyond the restricted analysis of social productions and reproductions focused on their products (opus operatum) towards an approach to the process involved in these same productions (modus operandi), allowing deeper understanding of the production of the social order as simultaneously integrated by the creativity of individual agents and the conditioning of collective structures<sup>15,16</sup>.

The act of eating represents a daily activity related to habitus, which acts as a practical operator that can apply behaviors mnemonically associated with food, influenced by agents' inventiveness and creativity. Eating habits and food-related health practices correspond to an economic or utilitarian, and mainly symbolic, code<sup>14,17,18</sup>. For Freitas<sup>19</sup>, food habitus corresponds to habits culturally established for generations, developed in the family and community, shared and updated in other dimensions of social life. Therefore, the concept enables addressing aspects related to eating practices through the objectification of social aspects shown individually and subjectively, such as tastes and preferences that constitute strategies of identity formation<sup>22,20</sup>.

In the case of the expatriate physicians of the MDBP, their habitus does not have the same objective conditions of their origin as that of their Brazilian patients. In this case, the relative inertia of habitus makes it difficult to adapt to the new context, characterizing the so-called hysteresis – the gap between the old habitus and the new conditions that are represented by a new country, a different social class, or a new field. In this way, the response to a new and significantly different environment will

initially be a function of the interpretation of experiences already assimilated in the primary habitus of the agent<sup>21</sup>. The immigration process requires adaptation to a new field, as well as reflection on the dispositions acquired when confronted with a new social environment, and it may influence the relationships between holders of distinct habitus.

In this study, we consider the eating habits<sup>22</sup> as a way to objectify habitus and understand any eventual hysteresis resulting from the immigration of foreign physicians – in this case, Cubans – to Brazil. We focus on their eating habits in their original culture and its impact on the way they address their Brazilian patients.

Cuban and Brazilian eating habits represent social spaces in which agents embody practical aspects of food, such as taste, knowledge and taboos. In addition, eating habits as a reference system and an essential part of the food habitus produces codes incorporated by agents and enables understanding of macrosocial and political aspects related to the production and acquisition of food<sup>23</sup>. Cuba and Brazil present similarities in the nature of their foods, given the influence of colonization by countries of the Iberian Peninsula and Africa and encounters with aboriginal populations, resulting in the adaptation and incorporation of new elements into the original foods and the creation of new food systems<sup>23</sup>.

In the last few decades, Brazil and Cuba have presented significantly distinct food systems, since the dissemination of transnational food industries has caused important changes in the eating habits of Brazilians, increasing the consumption of ultra-processed foods<sup>24</sup>. In Cuba, the economic crisis in 1989–1993 and the end of the Soviet Union led to drastic reductions in food imports. However, the creation of the agricultural market and the Basic Units of Agricultural Production in Cuba encouraged and guaranteed food security for the population through their own food production without agricultural pesticides<sup>25,26</sup>.

Regarding the health systems of both countries, which are the background for the issues addressed here, the two countries present convergences. Cuba was the first socialist country in Latin America, established in 1959, and Cuban medicine was historically a crucial element of the country's radical transformation<sup>27</sup>. The Cuban

health system is based on the principles of equity, access, and recognition of the state and social character of medicine for actions of health promotion and prevention, ensuring 99% population coverage<sup>28</sup>. Medical training and practice in Cuba has a significant component related to international aid and care humanization<sup>29</sup>, serving the populations of various countries. This internationalization of the work of Cuban physicians influences the creation of a specific habitus of the professionals in the country.

The national health project in Cuba is an essential part of the country's social policy, seeking to guarantee universality, equity, access and integrality through the management of the Ministry of Public Health<sup>28</sup>. The Brazilian National Health System (SUS), although inserted in the context of a distinct political and economic system<sup>30</sup>, was conceived by taking the same principles and directives into account<sup>31</sup>.

This paper analyzes the contact between professionals of a significantly different cultural, political and administrative system from those of Brazilian patients and its impact on fulfilling health needs and demands related to nutritional aspects, based on the notions of habitus and hysteresis.

## **Method**

We conducted a case study that was characterized by an in-depth analysis, taking into account the environment, agents and their interactions<sup>32</sup>. Information was collected<sup>33</sup> through observation<sup>34</sup>, focus groups<sup>35</sup>, and interviews<sup>36</sup>. The field work was conducted in a city in the countryside of the State of São Paulo that has approximately 120,000 inhabitants, and whose economy is based on a Petrobras petrochemical complex. This municipality has six traditional basic health units and 11 Family Health Strategy units. The municipality received four Cuban physicians through the MDP<sup>37</sup>. The definition of the municipality and territory where the analyzed USF (family healthcare unit) is located was an intentional sample, once we identified the conditions that were similar to those that justify the MDP: an insufficient number of physicians and/or physicians taking turns before the arrival of the Cuban physicians, and the

presence of significant social vulnerability and violence. The access to the team in general and particularly to the physician to be analyzed represented a factor that was added to the others in this definition.

The focus groups enabled understanding of the process of perception formation on a particular theme by specific groups; they were conducted at the beginning of the methodological stage to support the ethnographic work performed later. Two focus groups were created in the city of São Paulo, the first with ten participants and the second with eight, both with an equal number of men and women; all of them were Cuban physicians linked with the MDBP. The groups were created to evaluate a compulsory specialization course for physicians from the MDBP; we were able to add issues of interest for this study, through our direct participation in the coordination of these focus groups. The main issues discussed were: changes in eating habits due to immigration; practices in cases of hyperglycemia in diabetic patients; obesity; hypertension; challenges to encouraging breastfeeding; and beliefs about food in Cuba and Brazil.

Observation is a technique derived from ethnography, based on field experience and production of a researcher's diary. In total, 132 hours of ethnographic survey were conducted between March and April 2015 in one family healthcare unit. The survey consisted of follow-ups on medical visits conducted by the professionals from Cuba, generating forty pages of diary entries, mainly related to the routines in the multiple units studied, the services provided, dialogue between the researcher and the physicians, and patient reports.

Interviews were conducted with users of the units to capture their perceptions of the care provided by the foreign physicians and possible differences in ways of thinking and understanding regarding the treatments performed. The interviews, also related to ethnography, were conducted with the patients in the waiting rooms. We talked to all users who were waiting to be seen by the observed physicians. The following questions were asked of the five interviewees: Does your treatment with the physician involve any food issues? Have you noticed any difference when comparing this physician to a Brazilian physician? Do you believe that the guidelines are

appropriate to your reality? What do you have access to and what do you usually eat? Have you followed the guidelines? Were there any food restrictions?

The project was submitted to and approved by the Ethics Committee under protocol 921.169 on December 23, 2014.

## Results

Cuban physicians present ethnic characteristics, such as skin color, hair and facial features, that are similar to the patients they serve. Regarding their style of dress style, the physicians wore sports clothes that were, very similar to those of their patients, while the Brazilian physicians wore formal clothes. Their body language showed receptivity, such as upright posture and constant visual contact with patients.

The physicians remarked on the habitual practice in Brazilian society of eating meals outside the home, including main meals. They highlighted the food diversity in their country, as well as the excessive use of cooking oil in food preparation in Brazil. For the Cuban physicians, these factors had led to physical changes in their bodies, such as weight gain and high blood levels of triglycerides, in the first months after they arrived in Brazil.

I lived 48 years in my country. I'd never had high cholesterol or high triglycerides [even] eating pork. I arrived in Brazil and now they are all high. (...) People usually eat out here and, as we can't cook what we want... then the food sold on the street is oily and has many ingredients in excess.  
(Physician 3)

The previous international experiences reported by all study participants were factors that supported the adaptation of physicians in terms of eating habits in Brazil, helping them reproduce or adapt here the typical dishes of their country of origin. The occasions for special contact and exchanges between these physicians and their immediate social environment – usually consisting of members of their work teams – were in small parties with dishes from both countries. These meetings favored first



contact between the Cuban physicians and the eating habits of a certain segment of Brazilian society, in this case, non-medical workers from the basic units.

During medical visits, the significant number of overweight patients caught the attention of one observed physician. For him, the economic conditions of the population served, combined with the extensive advertising of foods and the absence of nutritionists in the teams, were the main causes of frequent overweight and obesity.

We have many obese patients here; in Brazil they drink a lot of soft drinks, in Cuba we drink water (...) There's advertising too, they show it all the time.  
(Physician 1)

Nutritional instructions were provided for weight loss by restricting carbohydrates and fats. The concern about proper body weight was significantly greater with pregnant women, who were systematically weighed in prenatal examinations. The instructions highlighted the interval between meals ("eat every three hours") and the correct food selection, but without specifying it ("eat with quality, not quantity"). Soft drinks were the only ultra-processed product that was regularly considered in the nutritional instructions. No other consideration of any nature was observed regarding ultra-processed foods. According to the observed physician, soft drinks are a common product in his country, and had been present there even before the Cuban Revolution.

The physician explained that soft drinks in Cuba were as common as in Brazil until the post-revolutionary period. In his words: "soft drinks are very expensive in Cuba, but when I was a child I used to drink them because they were imported, so after the revolution, they became more expensive. Now we drink water. (Field diary, March 18, 2015).

Assertiveness was a strong feature of the observed physicians, especially in the management of eating problems, assuming effective responsibility of patients for their

problems, and considering the limitations of drug therapy alone. Eventual challenges in adherence to prescribed dietary changes were interpreted as a personal matter.

For these physicians, the individualized care provided by nutritionists would address the subjective and psychological aspects of changing eating habits.

I think it is very important to have a nutritionist on the team. A nutritional psychologist. Yes, that's true, because in most cases of dietary transgression, the patients are not seen by a psychologist. (Physician 4)

The professionals highlighted a paradox that they observed in their practice, related to the cult of slenderness and the recurrent advertising of hypercaloric foods, both present in the mass media. For them, massive advertising of ultra-processed foods, and easy access to them because of their low cost and effective distribution, are obstacles to developing critical thinking in patients regarding potential food risks. Ultra-processed foods also have strong appeal, especially for groups that are more vulnerable to advertising, such as teenagers and children.

But there's also one thing that we can't ignore. If you see something on the media too... television, media, radio. If you show a beautiful roasted chicken for 22 reais and a snack for five reais, you'll buy the snack! (Physician 10)

The physicians criticized the dissemination by the media and pediatricians of dietary formulas for the first years of life that, combined with the relatively shorter period of maternity leave in Brazil (when compared to Cuba), contribute to an exclusive breastfeeding period of less than six months.

We instruct them on it [breastfeeding], but then they have to work, what can we do? They'll introduce other types of milk (...) because (...) there's no legal instruction telling mothers that they can stay home. (...) In addition, there are many types of milk here, products found at the drugstore, the media

channels advertise this product very frequently, saying they are excellent, very good” (Physician 7)

Physicians in Cuba have guidelines related to specific diets for diseases produced by the Ministry of Domestic Trade and the Ministry of Public Health. These guidelines regulate food distribution to patients with fragile health conditions. Recommending specific products for certain diagnoses, these guidelines prioritize foods to be consumed, instead of strategies for healthy eating practices. The physicians reported that the Cuban diet is a reference for food and nutritional guidance to patients, regardless of the country they are in. The food and nutritional guidance adopted by them in Brazil is partly based on this material, which favors the intake of natural or minimally processed foods, since the *Dietario Médico Nacional* (National Medical Dietary) created in 1982 reflects the profile of the Cuban population and the conditions of the country<sup>38</sup>.

Nutritional care was considered by the observed professionals, regardless of the location and sociocultural context, since chronic conditions such as diabetes, hypertension and obesity – which are more directly related to food – require the same conduct regarding drug and diet prescription. That is, besides the sociocultural issues involved, the prevailing concepts consider food and nutritional aspects from a biomedical perspective.

Diabetes, hypertension, they are the same anywhere around the world, the same medicine for the treatment” (Physician 2)

## **Discussion**

The results showed that medical training in Cuba, linked with the socialist political project of the country, gives professionals the power to provide care that emphasizes social determinants of health production, including the complex factors and disputes present in the patients’ life contexts. These aspects favor close contact between physicians and patients, and better understanding of the social determinants

involved in each case. However, strategies related to nutritional care prioritize restoration to standards of normality, such as weight loss. That is, when it comes to food and nutritional aspects, comprehensive understanding includes rationalizing and superficial guidance. Strategies for returning to weight and laboratorial standards are mainly guided by objective guidance about what one should or should not eat. However, the exclusion of foods does not ensure critical reflection on patients' own diets, since polarization between right and wrong or good and bad foods makes it difficult to adopt practices that are focused on food balance and pleasure<sup>39</sup>. This situation involves a potential risk of considering food to be restricted to its physiological function in the body, making it equivalent to medication in medicine<sup>40</sup>.

Reference documents for Cuban physicians, such as the Dietary Guidelines for the Cuban Population<sup>41</sup> and the National Medical Dietary<sup>38</sup>, consider ultra-processed foods as cured and smoked products, but do not have guidelines for the usual foods of Brazil – ready-made spices, instant noodles, stuffed cookies, and frozen products. This difference between the two countries may constitute a problem for the clinical management of these issues in clinics, especially considering that the supply of these products grows each year in Brazil and their consumption is associated with negative impacts on health, food self-sufficiency, the environment and culture<sup>24,42,43</sup>.

Food guides increase people's understanding and awareness of food choice<sup>44</sup> and are reference materials for health professionals who directly or indirectly deal with food issues, like physicians. The Cuban Medical Dietary used by the observed professionals is a reference guide for nutritional guidelines and prioritizes the food itself, rather than preventing food-related diseases.

However, guidelines such as these, that highlight food groups and nutritional values, have been superseded by food guides based on the importance of the context in which the food will be consumed<sup>45</sup>. The 2016 Dietary Guidelines for the Brazilian Population present advances in strategies for health promotion and changes in eating habits. It is a document containing knowledge that can be debated with foreign health professionals who may have a chance to work in the Brazilian public health system,

since it can help the work of these professionals with patients, in particular regarding the promotion of health, and the work of nutritionists in cases of specific diseases.

The knowledge of the observed Cuban physicians in terms of eating habits in Brazil was promoted through socialization in the work environment, which is an important factor in contact with Brazilian foods and detection of the eating practices of patients. Commensality represents food sharing, and in this situation, expatriate and Brazilians physicians were able to talk about their food value systems. These exchanges enable the definition of the social identity of agents, considering that foods represent the social origin, territory of origin, and history based on which one person or a group of people have created their habitus<sup>46,47</sup>.

In this context, the physicians were able to update food arrangements in a process in which their original food culture was confronted by new food habits and techniques, types of food, and eating habits. Conscious reflection on this new environment allowed both exteriorization and better identification of previous arrangements, as well as internalization of new practices, promoting the process of hysteresis<sup>11,48</sup> referred to earlier. Therefore, the confrontation of these two food systems of different origins, in small celebration parties that took place in the work environment, besides contact with patients and meals in commercial establishments, among others, promoted, at the same time, changes and reaffirmation of both Cuban and Brazilian food identities. This adaptation influenced the management of nutritional care, since it allowed the visualization of common food practices in Brazil and showed inducing aspects in access to and choices of food in Brazil, such as the influence of the media and the food industry on eating habits.

The contact between Brazilians and Cuban physicians was favored by similarities in eating and cooking habits of both countries and by aspects of the corporal hexis of Cuban physicians. In this sense, the external aspects of clothing, facial expressions, posture, and ethnic characteristics of Cuban physicians presented more similarities to the habitus of the Brazilian social class they served in basic health units than to Brazilian professionals, who usually have the habitus and hexis of the ruling class. Bourdieu<sup>46</sup> recognized that the body is a mnemonic principle in which

mannerisms, style of dress, and body expressions create and show the fundamental principle of class. The body is the transfer system that makes each corporal technique work according to the ethos of the system to which it belongs. The similarity between the Cuban habitus and the habitus of the Brazilians they served seems to have enabled special contact between these agents.

The recognition of the influence of the media and the food industry shows an important aspect of the habitus of Cuban physicians, reflecting a reference system in which the notion of health and body are not predominantly influenced by the vectors of a capitalist economy, as is the case in Brazil. The physicians attributed food and psychological problems to a group of distinct values and lifestyles that are created and intensively disseminated by media vehicles, inhibiting the critical thinking they consider essential in the adoption of truly healthy practices. In this sense, the professionals indirectly referred to the food and dietary polyphony produced by various agents – the state, organized consumers, different medical specialties, and the food industry, among others – through mixing, confrontation and fusion of discussions of gastronomy, recipes and nutrition guides, creating a true food cacophony, in which individuals end up defining their food choices through contradictory and incoherent stimuli<sup>49</sup>.

Adaptation to the health context and to the Brazilian food system was influenced by an internationalist character, which includes humanitarian aid as an attribution of Cuban physicians<sup>29</sup>. This aspect allows a balance between the arrangements of the original and new environments<sup>48,50</sup>, because the regular periods spent in different countries as part of the Cuban medical identity favors the adaptive ability shown by the observed professionals. Various sociocultural environments seem to favor the expansion of arrangements initially acquired from the family and society of origin, giving agents new possibilities that will be shaped in singular ways<sup>51</sup>. In addition, some similarity between the basic principles of Cuban and Brazilian foods<sup>23,52</sup> – a mixture of elements from the Iberian Peninsula, Afro-descendants and Aborigines – combined with greater contact between the professionals and patients through the corporal hexis, helped mitigate the barriers imposed by different origins on the

general practice and aspects related to food and nutrition in particular. However – and paradoxically – the food and nutritional approach, which was mainly based on the biomedical paradigm, excluding sociocultural aspects, determined the guidance provided. That is, even if sociocultural aspects favored avoiding obstacles arising from the different habitus of physicians and patients, they were effectively overcome by using a supra-cultural reference, represented by the predominance of the biomedical conception of food.

## Conclusions

This study showed the presence of multiple factors in the constitution of the habitus of Cuban physicians. Considering that habitus is not flexible, but instead, is the result of continuous interaction between individuals and the social environment, we refer here to the notion of hybrid habitus, when different contexts derived from the multiple experiences of professionals – such as insertions in other countries, a common experience among Cuban physicians – create a system of actions based on different socialization environments.

The nutritional approach of Cuban physicians in the context of the More Doctors in Brazil Project is not predominantly influenced by the Cuban habitus. Given the greater weight of technical and biological aspects in the provision of care and guidance, rather than sociocultural issues, the determinants of the different habitus appear as a secondary element in the relationship between foreign doctors and Brazilian patients.

We could say that the medical habitus, with all that it implies in terms of hegemony of the biomedical paradigm, supersedes the influence of the habitus of Cuban origin. Thus, a more universal language, represented by the medical concept of food as an equivalent to medicine, would tend to standardize and enable speech between physicians and patients, although it could disregard an area that is particularly sensitive to sociocultural factors, such as food. However, it should be noted that, although the medical habitus prevailed, aspects related to the habitus and

hexis of the Cuban physicians and the social population served in the basic health units made a significant contribution to closer contact and dialogue between agents of significantly different origins.

### Collaborators

Amanda Massi Soares and Juarez Pereira Furtado participated in all development stages of this paper.

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