

Public Health as a Social Science: Reflections on the Possibilities of a Comprehensive Public Health

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Abstract

Close historic relationships between medicine and public health have implied, as a consequence for the latter, the inheritance of epistemological traits traditionally characteristic of a positivistic conception of science on which a major part of the theoretical development of modern medicine has been supported. From the point of view of this ontological, epistemological and methodological reference of positivism, health has been reduced to deterministic, linear and causalistic explanations that systematically cancel any reference to the life world (Lebenswelt), both for the researcher and for the "objects" of research. The scientific pretensions of public health have become protruding over its political and ethical commitment, even widening the gap between scientific knowledge and the specific conditions of existence of social actors and their relation to health. This paper presents some reflections around the conditions of possibility for a comprehensive approach of public health problems. These reflections are based on a conception of health as a social phenomenon, that is to say, as an emergent element from the complex web of inter-subjective relationships among social actors, in a specific social and historic horizon. Epistemological, ethical and political implications of this perspective for research in public health are also discussed.

Keywords: Public Health, Epistemology, Comprehension, Social Sciences.

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A. INTRODUCTION

The historical kinship between medicine and public health has implied, for the latter, the inheritance of epistemological features typical of modern medicine, which has resulted in an attempt to address the health problems of communities based on the same ontological, epistemological and methodological assumptions of the natural sciences from which the problems of medicine have been studied. This tradition of analytical empirical thought entered the nineteenth century with the dreams of the Enlightenment as its banner, hand in hand with the bourgeoisie and with the aim of developing a knowledge that allowed the domination of nature and material progress (Mardones, 1991).

Positivism, the dominant paradigm in medicine and modern science, had indicated the criteria for demarcation of what is considered worthy of science and those of what should only be considered as speculation, poetry or rhetoric, leaving aside the problems that were irreducible to statements susceptible of measurement and experimental control. Under this aegis, modern medicine has assumed health and disease as phenomena related to a mechanical, ahistorical, analyzable organism that can be explained by laws that allow establishing cause-effect relationships (*erklären*). From a positivist perspective, health is reduced to disease, to the

individual, to the plane of empirically observable phenomena and to the one-dimensional simplicity of a mechanically determined order (Breilh, 2006).

Public health has also been forced to adopt such a model to explain the health of human groups, assuming the metaphor of the "collective organism", subjected to a set of determining factors from which it can be explained, predicted and control your object of study. The success of medicine on individual disease generated an atmosphere of optimism that led to consider the possibility of founding a "social sickness", called public health, trying to explain collective disease as the sum of individual diseases, and looking for causes of disease that are outside the body machine, taking as its field of research and action the calculation of risk and disease prevention (Ugalde, 2008).

In the middle of the 19th century, the controversy between the sciences of nature and the so-called "sciences of the spirit" broke out, promoted, among others, by Wilhem Dilthey, who proposed to establish the foundation of history and the other sciences that relate to man as long as it is historical and social. The object of the sciences of the spirit will not then be that which is external to man (objective facts), but rather the environment in which man is inserted (Mardones, 1991).

This situation configures a new "geopolitics" of science, an organization of its territories, traversed by processes of colonization, attempts at independence and all kinds of struggles and tensions, in order to defend the epistemic identity of each domain of scientificity. However, this geopolitics of science only generated the widening of the gap between science and knowledge and the fragmentation of reality into disconnected objects of study that make it impossible to tackle complex phenomena that go beyond disciplinary watertight compartments.

Although this experience of crisis was initially a characteristic attributed to the social and human sciences —such as sociology and psychology, among others—, the natural sciences have also been shaken to their foundations today, and many of them are in the process review and discussion of its fundamental assumptions (Martinez, 2000).

Public health has faced a particularly intense struggle in this process of organizing its "domains of scientificity", given that its territories have been vigorously disputed, its borders hardly demarcated, and its epistemic magna carta extremely blurred. Public health has built its territories right in the place where the gap between the natural sciences and the spiritual sciences opens up and, therefore, in the space of the *globus intellectualis* where the terrain is more shaky and insecure. At the same time, the territory of public health has been governed by competing paradigms that have widened the gap between the various conceptions of man and the world in the attempt to colonize the territory of the object "health". And while the natural sciences and the social sciences dispute the legitimate citizenship of their object of study, the living conditions of people and human groups become more and more critical and the voice of scientists, more and more timid and inoperative .

Given the impossibility of reducing knowledge of public health problems to mathematical explanatory models, it is essential to adopt comprehensive approaches

that make possible the recovery of the world of life as a horizon for understanding health, which has become blurred in the objectification generated by the discourses of medicine and traditional public health (Ugalde, 2008).

The question about the scientific conditions of public health is not only an epistemological question, but, above all, an ethical and political issue based on the unavoidable commitment to self-reflection that allows to reveal the interests that underlie the processes of knowledge generation and the possibilities offered by said knowledge in the transformation of social realities that put a brake on individual and social development and that affect the health conditions of human groups.

The purpose of this paper is to outline the possibility of a comprehensive public health and its epistemological, methodological and ethical implications, in which understanding is not assumed as an antinomy of explanation, but as a democratic alternative to address health - from research and practice - as a social phenomenon.

B. METHOD

The way to understand the object and answer the problem formulation is by using methods. The method used must be precise and in accordance with the characteristics of the object of study and the nature of the research. So, this study uses a qualitative descriptive method, namely the data obtained will be described to understand and know the phenomena in the study. This method aims to understand the underlying meaning of human behavior. In addition, qualitative methods are also used to produce in-depth data and get a comprehensive picture. This research was conducted using library research, which is research conducted by examining data sources in the form of books, papers, articles, and other research results that are still relevant to the object of research.

C. RESULT AND DISCUSSION

1. Health as a Social Phenomenon

The question about the scientific status of public health is linked to the nature of its object of study. While some authors propose the existence of a scientific public health, based on the existence of a defined object of study and a set of theories and methodological procedures for the development of their research (Cardona & Franco, 2005), others contradict this position and affirm that there is no single object of study for public health, which is evidenced in the coexistence of different currents (the institutional current, Latin American social medicine, collective health, among others), and therefore, they argue that public health cannot be considered an autonomous scientific discipline, but rather as a field of trans-disciplinary knowledge and practices (Gonzales, 2007).

From the Kuhnian perspective of the sociology of science, the existence of multiple objects of study denotes a state of immaturity, given the lack of agreement on the disciplinary matrix and the shared examples of a scientific discipline (Kuhn, 2019). If public health pretends to be a science, following the guidelines of Kuhn's

sociology of science, it would have to ensure the unity of its object of study and, furthermore, epistemologically and methodologically support the possibility of "scientifically" addressing said object. .

This obstinacy with the model of the natural sciences brings with it at least one of two consequences for public health: the mutilation of its object of study and / or the definitive impossibility of becoming a science. The mutilation of the object of study refers to the intentional abandonment of a set of problems that cannot be addressed following the methodological foundations of natural sciences, that is, those phenomena of a semantic nature that escape the possibilities of measurement, control, generalization and prediction. This process of "artificial selection" of its fundamental problems could lead public health to precisely define the limits of its object of study in order to meet the demarcation criteria of the positive sciences, but it would simultaneously lead to the exclusion of a group of fundamental problems for the understanding of public health as a social and political phenomenon. However, the commitment to these problems of a semantic nature raises suspicions among those who maintain a naturalistic conception of science and question the possibility of affirming without hesitation that public health is an "authentic science".

Faced with this crossroads, it is necessary to rethink the problem in order to overcome the extreme defense of a modern ideal of scientificity, which is increasingly worn out and weakened. Two considerations would make it possible to redirect the problem: first, public health has an object of study that defines its field of knowledge, but said object of study is a "plural object"; secondly, public health finds new possibilities of realization in the field of social sciences to tackle problems that are unthinkable in the framework of natural sciences.

When speaking of "a plural object of study", reference is not made to many objects of study, but to a set of problems of diverse nature that are articulated among themselves, not only by their logical relationship, but also by their political, social and ethical relationships. In general terms, it can be affirmed that the articular axis of the problems that make up the objective sphere of public health is the set of health and well-being conditions of the population groups in each particular historical social context (Cardona et al. 2008), taking into account considering both the conditions of the objective world and the conditions of the social world and the subjective world. It is possible, for example, to carry out an epidemiological analysis to establish the factors associated with adolescent pregnancy in an "objective" way, without this nullifying the possibility and the need to approach the phenomenon from a comprehensive perspective that allows the constructions of meaning around the experience of the body, of the relationship with the other, of fatherhood and motherhood, among others.

This plurality of the object of study of public health is not a basis to affirm the impossibility of becoming a scientific discipline, but, on the contrary, it is an indicator of the complexity inherent to the phenomena related to health, which they cannot be reduced to a single perspective. And it is precisely in this irreducibility of

health to the natural continent of *globus intellectualis* that a new possibility emerges: the assumption of public health as a social science.

This statement represents a break with medical conceptions of health and disease and is built on the assumption that health is a social phenomenon. Thinking about health in this way implies opening up to new problems, developing new methods, and new ethical and political reflections on research. Some public health perspectives, such as alternative public health (Ugalde, 2008) and critical epidemiology (Breilh, 2006) have advanced significantly in this direction.

Unlike natural realities, which can be reduced to causal, objective explanations of a deterministic nature, social reality is made up of the set of all cultural objects and social institutions that give rise to the daily existence of men, which they make possible the experience of a world not private, but inter-subjective, common to all men, which implies intercommunication and language; in this sense, the objective of the social sciences is to achieve an organized knowledge of said social reality (Schutz, 1974). Comprehensive public health requires an understanding of health from life itself, and not only from the calculation of the risk that occurs outside and before the disease occurs in the body machine (Ugalde, 2008).

According to Schütz, "the world of nature, as explored by the natural scientist, does not 'mean' anything to molecules, atoms and electrons. But the observational field of the social scientist, social reality, has specific meaning and a structure of significance for the human beings who live, act and think within it" (Schutz, 1974). From the perspective of natural sciences, health is a phenomenon determined by conditions that, being outside or inside the organism, are, in any case, outside the subject, that is, the universe of meaning that men construct and women in the interaction with said conditions; From the perspective of social sciences, on the contrary, health is assumed as a significant phenomenon, which is not external to man, culture and society, but is constitutive and constitutive of the human, what cultural and social. Health, understood as a social phenomenon, can only be understood as a symbolic construction - of a linguistic nature - that emerges in the set of social relationships between subjects who, in a particular historical context, share values, meanings and practices around the body, well-being, illness, life and death.

2. The Problem of Understanding in Public Health

Within the classical disjunction between the sciences of nature and the spirit, explanation and understanding are presented as two opposite and irreconcilable poles: the explanation constitutes the claim to account for the world in terms of laws that establish relations between causes and effects for the prediction and control of phenomena (natural or social), while understanding seeks to understand the meaning and significance of human actions

This distinction is supported by the idea that there are two different "orders" of reality: the first —that of explanation— refers to an objective, material reality, determined by laws that can be logically expressed, that exists independently. of the

subject and that constitutes the "natural world". On the other hand, understanding refers to a subjectively and inter-subjectively constructed universe, in which reality is nothing other than a network of meanings that emerges in the relationships of subjects with themselves, with others and with things in a context determined historically.

This dichotomy is as weakened today as other of the many supports of modernity (body / mind, spirit / matter, quantitative / qualitative, health / disease). Between the social and the natural, there can only exist relationships marked by distinctions, since the natural only exists —at least as phenomena— insofar as it is traversed by language, in the same way that such language only becomes possible by the natural conditions of an organism in a given biochemical environment. "Understanding" is not a substitute for explanation, nor is it a lower or higher level of it; it is the possibility of making intelligible a set of problems of a semantic nature, which cannot be reduced to a formal explanation nor can they be approached outside the contexts with which they form an indivisible unit.

According to Gadamer, hermeneutical understanding is not only a method, as Scheleiermacher and Dilthey had proposed, but it designates the way of being of humans (Gadamer, 1994). Understanding is not a method for the knowledge of a chosen object, but a process that is presupposed to be within the happening of a tradition.

Understanding is a possible way to reach the understanding of those objects that have constituted themselves before any theoretical intervention, that is, objects that are symbolically structured, that embody structures of a pre-theoretical knowledge, elements of the "world of life" that are generated through language and action (Habermas & Redondo, 1987). The foregoing is consistent with Granda's statement according to which "in public health we need to interpret the actions generated by the structures, which in turn enable or limit their development. For this reason, we not only need to explain the structures, but we must also interpret the actions" (Ugalde, 2008). The recognition of a symbolic structuring of health as an object of study for the social sciences highlights the subjective aspects of significance — inaccessible directly through observation or experimental control— (Habermas & Redondo, 1987) that constitute the support of beliefs, behaviors and representations around phenomena related to what is assumed to be "health" (the relationship with the body as a symbolic construction, hygiene, the relationship with institutions, upbringing guidelines, eating habits, etc.). From this perspective, health is not a "fact", but a symbolic construction, only accessible through language, which escapes analytical reduction in favor of a contextual reading that recognizes historical, social and cultural particularities of the scenarios in which subjects are born, live, interact, build their projects, "get sick" and die. In this sense, Schütz affirms that the scientific constructions of the social sciences are constructions on the constructions already made by the social actors and, therefore, are considered "second constructions" that must be adapted to the understanding that of the "cons- first instructions" have the social actors (Mardones, 1991). Thus, health is not understood as an object in itself

(objective), but rather the symbolic constructions of social actors on health in the life world scenario.

Health is for the social researcher a “pre-interpreted” object, already loaded with meanings attributed by social actors. This particular situation implies a double hermeneutic (Giddens, 1987), that is, an interpretation on data that have been previously interpreted by social actors. Data in the social sciences are not “aseptic”, they are not “collected” independently of the researcher; on the contrary, the researcher is a participant in the processes of understanding of social phenomena and, for this purpose, he must use the languages he finds in his objectual scope, since this is the only possible way of accessing the data (eleven).

3. Health as a language problem

The Aristotelian definition of man as “living being endowed with logos” has been maintained in the Western tradition under the idea of a rational animal; however, as Gadamer points out, the translation of ‘logos’ as “reason” or “thought” is insufficient, since the word ‘logos’ preferably means “language” (Gadamer, 1994).

From the perspective of positivist science, more specifically in the context of the Vienna Circle, a new logic of language was proposed that had the purpose of founding a language for science that was transparent, objective, and strictly grounded in empirical reality. However, this claim to reduce language to a series of technical precepts increases the gap between science and everyday life and paradoxically dismisses as “nonsensical” those problems related to meaning, that is, semantic constructions that do not have an empirical correspondence, but a symbolic relationship with reality. In this regard, he affirms

Heissenberg (1974): “On the other hand, the logical analysis of language brings with it the danger of an oversimplification and a certain unilateralism in the appreciation of the possibilities of language. Although logic creates the precondition for a scientific language, within which the uniqueness of meaning and precision of the arguments are reached, it does not, however, offer, on the other hand, the descriptive capacity of colloquial language, which it has much richer means of expression”.

From a comprehensive perspective, everything human is human because it is crossed by the linguistic; language is not a medium or a tool; It is the sine qua non condition of possibility of every process of human understanding: “Every inter-human process of understanding is a linguistic process, just as the process of understanding itself is a linguistic fact, even when it refers to something extra-linguistic”

Language makes it possible for man to communicate his thoughts and build common concepts that make coexistence, social life, economic life, politics (Gadamer, 1994) and, of course, science itself possible (it cannot be forgotten that epidemiological data, in the particular case of public health, are also a form of language, susceptible to interpretation).

Moving towards comprehensive public health requires a genuine dialogue between stakeholders in the State, researchers and social actors, which allows the understanding of the constructions of meaning and the semantic frames of reference from which people, leaders and researchers think and act that they share with social actors the world of life.

Many of the actions and research that are being carried out in public health widen the gap between government officials and scientists, on the one hand, and social actors, on the other, since the needs and problems, as well as the ways to do it, are born in the civil servants' desks or in the classrooms of the universities, but not in the genuine dialogue oriented to the understanding of the constructions of meaning that direct the action and the thought of people in relation to health.

When the health worker genuinely commits himself to dialogue, he must be willing to transform his points of view from the conversation with social actors; You must be committed to your ideas in the same way that you are committed to the ideas of your interlocutors to avoid imposing your own arguments. Only in conversation is it possible to undo the block that clinging to one's own opinions generates (Gadamer, 1994).

The power and authority attributed to the researcher by reason of his knowledge and his place as a "producer of true statements" have become the greatest obstacle to authentic dialogue with social actors. The assumption that scientific knowledge constitutes a "good" that must not only be defended, but also imposed "in favor" of people and communities is the initial presupposition of the alienation generated by an unthinking science, which tries to colonize -savage the world of life. As Gadamer puts it: "This same esteem constantly limits the critical freedom that is so much admired in the researcher, invoking the authority of science when it is actually about political struggles for power" (Gadamer, 1994).

Another aspect that has distanced science from authentic dialogue is the overwhelming enthusiasm generated by scientific "evidence". Evidence has become the supreme criterion for political, academic and professional decision-making; It is the new face of the truth that bases many of the programs, projects and public policies in health, "exempting" the researcher or professional from coming into contact with social actors for the definition of needs and problems and for the agreement of the ways to approach them. According to Hernández, "evidence-based public health is the execution and evaluation of the effectiveness of interventions, plans, programs, projects and policies in public health through the application of scientific reasoning principles, including the systematic use of data and information systems" (Hernandez, 2003). The evidence constitutes what is "already said", which is not said by anyone, since in the evidence there are no concrete, historically situated researchers, nor concrete, historically situated subjects. It is a kind of oracle that is consulted and from whom an answer is received, but in the absence of any form of authentic dialogue. The uncritical attitude towards the evidence is the antonym of dialogue and the death sentence to understanding, because in the face of "unquestionable" evidence, social actors (and on many occasions researchers and

public officials) have no other option than It is not to be silent and submissively follow the indications of the "oracle".

Health theories only inhabit the minds of academics and in their books and magazines, just as public policies inhabit the minds of rulers and the documents that contain them, but the experience of health is built on the daily life of particular men and women, and is often split from such theories and policies. It is necessary to reconcile the language of science and everyday language to overcome the legendary unintelligibility of science [10], to generate constructive and performative dialogues between popular knowledge and scientific knowledge, without the interests of domination of one over others.

4. Public health and practical rationality

The generation of theoretical knowledge that makes it possible to explain phenomena related to health and disease has been one of the tasks that public health has dealt with as an episteme; that is, as a domain of scientificity. These theories attempt, from an instrumental rationality, to reduce the phenomena of public health to abstract formulations that give rise to an articulated, formalized and communicable knowledge, which is the one that circulates in scientific journals and in universities and academic events.

Gadamer takes up the Aristotelian distinction between theoretical rationality (science) and practical rationality (phronesis) to point out the relationship of the sciences of the spirit with ethics and politics, based on the concept of application. For Aristotle, theoretical knowledge is teachable, transmissible, a –knowledge of the unalterable that rests on the demonstration– (Gadamer, 1977) while practical knowledge refers to a moral knowledge, which only takes shape in action and that, therefore, cannot be transmitted in the same way as the episteme or the same *tecné*, since they are insufficient to guide human action because they do not contain in themselves a principle applicable to concrete situations. This is evident, for example, in the case of modern science, which it has managed to control with its own logical relationships, but it has not been able to control the purposes to which such knowledge is applied, as was clearly stated since Hiroshima; the reasonable application of our knowledge is only possible from our global human and political capacity (Gadamer, 1977) of a practical rationality that allows us to guide actions ethically and politically.

To affirm that public health is a –moral science–, in Gadamer's sense, does not imply a renunciation of the theoretical endeavor that he has been carrying out, but rather constitutes a call for attention to the urgency of advancing in updating these epistemic productions, based on an ethical and political commitment that makes it possible to orient the action of men and women towards more dignified health conditions, based on a better understanding between the actors committed to health care of human collectives. Together with phronesis, comprehension appears, as Aristotle points out, since we can only speak of comprehension when a shift in judgment has been achieved to the full realization of the situation in which the other

acts: phronesis and comprehension cannot be understood as a general knowledge, but as something concrete and temporary (Gadamer, 1977).

The ethical and political commitment of public health cannot be reduced to a paternalistic action of intervention on passive objects, carried out by officials of the State and science who give themselves the power to determine what is good and convenient for people. The health worker of the twentieth century appears as a normative technician who, under the power of the State, deploys his normative technical arsenal to control the savage functioning of nature and human behavior and to advance towards a world of health and rationality (Ugalde, 2008). Practical knowledge, on the contrary, is only constituted as ethical knowledge when it allows and promotes the development of the autonomy of people and human groups, and generates all the necessary conditions for them to assume themselves in the place of deciding, responsibly, about your own life and health.

Only in practical knowledge, in application, a communion between the world of science and the world of life is possible, and in this sense the ethical and political commitment of the public health researcher is not restricted to the generation of knowledge, but to its application, in the Gadamerian sense of updating the tradition in the current horizon of the interpreter: "The task of moral decision is to hit the right thing in a concrete situation, that is, to see what correct and do it. Also, those who act morally have to make use of something and choose the appropriate means, and their actions have to be guided as reflectively as that of the craftsman" (Gadamer, 1977).

As stated by Granda, it is necessary to change from a normative technical health worker to a health worker interpreter-caregiver and mediator, who can interpret the constructions of meaning of social actors in their daily life, develop actions aimed at promoting care of health and that strategically mediate between the scientific, political and economic powers to improve health and living conditions (Ugalde, 2008) as the final objective of any action in public health, be it investigative, political or professional.

5. From Asepsis to Asceticism: The Researcher's Horizon in Comprehensive Approaches to Public Health

Cartesianism, and with it modernity, inaugurated a tradition in which scientific knowledge became the royal way to access the truth, without the subject having to be altered or modified: "The subject acts on the truth, but the truth has stopped acting on the subject" (Foucault, 1994). The ego of the philosophy of Descartes is an impersonal ego, a thing that thinks (Descartes, 1904), a de-subjectified subject. Modern science tries to objectify tradition and also aims to systematically eliminate any influence of the interpreter's horizon on his understanding, that is, to remain independent of any subjective application for the sake of his methodology (Gadamer, 1977). If it is a question of making knowledge more objective, the exclusion of the subject is not only possible, but necessary: this suppression of the

subject and its replacement by the method has meant the passage from asceticism to asepsis.

The modern ideal of objectivity has incessantly sought to keep scientific knowledge aseptic to avoid its "contamination" with any kind of interest; However, as Habermas made clear, all knowledge is inseparably linked to an interest, and the denial of this symbiotic condition between the two is nothing more than an attempt to protect science from the risks that it entails self-reflection (Habermas, 1997). This self-reflexive practice is an ascetic practice, that is, an awareness on the part of the researcher of the cognitive interests that underlie him and also of the political, economic or social interests that, consciously or unconsciously, permeate his research.

Approaching research from an ascetic perspective thus implies a reintroduction of the researcher as a participant subject in the research, and not only as a qualified operator of the scientific method: "Understanding is not so much the correct assertion of a point of view, how much a transformation into a communion in which we do not remain as we were" (Saenz, 2001). Likewise, action in public health implies a process of construction of subjectivity for the researcher, going through a subject of life, an epistemic subject, then a public subject to reconstitute itself and, finally, as a subject of life committed to the required change (Ugalde, 2008).

In social research, the researcher cannot renounce the pre-theoretical knowledge that she possesses as a member of the world of life, that is, she cannot renounce her own world of life, since this is inherent in every process of understanding (Habermas & Redondo, 1987). Habermas proposes the rescue of a first-person position that, through an inter-subjective relationship with a second person, adopts a non-objectifying position (such as the third-person position), but a performative attitude: "The symbolically pre-structured reality constitutes a universe that it has to be incomprehensible if you only look at it with the eyes of an observer incapable of communication. The world of life is only open to a subject who makes use of his linguistic competence and his action competence" (Habermas & Redondo, 1987).

Understanding in public health is only possible if the researcher assumes himself as a participant in a horizon shared with the subjects and human groups in which the complex web of social, cultural, political and historical relationships is woven health as a semantic universe. From a comprehensive perspective, the public health researcher assumes himself as part of the observed reality and, in this same sense, necessarily adopts an interested position that must become a compromised position: the ultimate meaning of a comprehensive approach to problems of public health must be the researcher's conviction that the meanings attributed to health, disease, life, death, poverty, and other categories of interest to the discipline can be transformed (re-signified), operating from this so transformations in the ways of life and in the material conditions of existence. The subjectivity issue, which has recently been introduced in public health, has made it possible to understand the importance of this perspective for the strengthening of the subject of the action and for the

construction of an alternative symbolic power, without which progress is impossible truly emancipatory (Breilh, 2006).

D. CONCLUSION

The proposal of a comprehensive public health does not have a colonizing purpose of enrolling public health in one of the continents of the globus intellectualist, but rather has a democratizing purpose in which problems related to the world of life, to which they enter complex mates of meaning in which health emerges as a social construction can be taken into account as legitimate scientific knowledge problems, under different assumptions than those of positive science. Comprehensive public health does not constitute an antinomy of explanatory approaches, but rather advocates the recognition of the complex nature of the object of study "health", which becomes unattainable from a single perspective; However, for this purpose to be fulfilled, it is necessary to generate strategies that make possible the convergence of said perspectives and not simply the sum of methods that perpetuate the fragmentation of the problems. In the first place, a new ethical commitment by researchers is necessary to make it possible to recognize and legitimize diverse approaches to knowledge and to establish constructive dialogues around public health problems. It is not possible to continue conceiving the population and nature as objects, but it is necessary to understand them as subjects, and to generate new dialogue scenarios (Ugalde, 2008).

The introduction of a comprehensive perspective to address public health problems not only implies a methodological shift and the introduction of new logics for understanding the research process, but also introduces a new form of relationship between researchers and stakeholders based on authentic dialogue, on the recognition of the active role of social actors in the construction of meanings around health and on the reflective and practical attitude of the researcher who assumes himself as a partner in the world of health life of the social actors and who, therefore, presents himself as a committed actor. From this point of view, expertise does not constitute a private property of the researcher or health worker, who based on their knowledge has the power to define what is good, fair and appropriate, but rather that expertise is an emergent condition of the relationship between dialoguing subjects who can share and transform the meanings attributed to their individual and collective experiences in the scenario of inter-subjectivity.

This comprehensive perspective brings with it new demands for the training of professionals and researchers in public health. It is not enough then with an instrumental training that endows the health worker with a technical arsenal, but rather the "formation of an attitude" is necessary for authentic dialogue, empathic listening and sensitivity that allows that fusion of horizons that is the possible scenario of all understanding. This formation is only possible through a permanent process of reflection and criticism aimed at transforming our mode of cognitive relationship with the world, usually traversed by early and generally intense exposure to the inherited tradition of science (Guba & Lincoln, 2002).

Faced with the worrying health conditions of human populations, an ethical and political commitment by academics and public health professionals with practical knowledge, a knowledge that is specified in the possibility of generating transformations in human action, is urgent that promotes the autonomy of people, that gives voice to social actors, that denounces the social contradictions that affect health and that turns knowledge into an instrument of social transformation.

It is worth mentioning the lack of understanding of the professionals themselves about the concept of social and family matrixing described in the documents. It is not problematized, only attributed as the centrality of the family in the Social Assistance Policy.

It is important to consider that the principles that aim at Socio-familiar Matriciality enable the understanding of the subjects' reality and the knowledge of the ways to resist and face the expressions of the social issue that are inserted.

It is worth noting that an instrument that must be used to implement the Social Assistance Policy is the articulation and integration between sectoral policies, performing in an articulated and integrated manner, contributing to the exchange of knowledge and providing a solution when considering the totality of the problems of the users, that is, that their problems are not treated in a fragmented way through disjointed actions that hinder their social inclusion, breaking with a culture present in national politics, marked by assistentialist, clientelist and paternalistic actions. The sectors must dialogue with each other, know and build ways of working together to allow improvements in the living conditions of families, especially those in situations of vulnerability and social risk, access to benefits, services, programs and projects that are part of SUAS.

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