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Health Education as a Transformative Experience: Meanings and Practices Among Older Adults Participating in Community Programs in Bogota

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ABSTRACT

Introduction: Health education is often conceptualized from biomedical approaches focused on disease prevention. However, in community settings, alternative meanings emerge that link education with personal transformation, autonomy, well-being, and a sense of purpose. This study explores the conceptions that older adults construct about health education within community-based health promotion programs in Bogotá.

Methods: A qualitative, critical–hermeneutic study was conducted using semi-structured interviews and focus groups in diverse community settings (day centers, hospitals, and district programs).
A thematic analysis was performed, grounded in Freire's popular education framework and humanizing pedagogy.

Results: Four macro-themes emerged from the data: (1) *Education as knowledge and updating*, connected to "keeping up to date," "moving forward," understanding the body, and recognizing healthy habits; (2) *Education as transformation*, understood as changes in attitudes, awareness, and lifestyle reorientation ("education occurs when information transforms you"); (3) *Health education as practices for good living*, associated with nutrition, physical activity, self-care, and emotional regulation; and (4) *The encounter with others as an educational space*, where guided physical activity, group therapies, workshops, and everyday interactions become meaningful learning processes.

Conclusions: For older adults, health education goes beyond information transmission and becomes a humanizing, dialogical, and community-based experience that enhances autonomy, self-esteem, and the construction of meaning. These findings highlight the need to rethink health education programs through participatory and transformative approaches that integrate the cultural and lived experience of older adults.

Keywords: Health Education; Aged; Community Health Services; Health Promotion; Physical Activity; Social Participation; Qualitative Research

Introduction

Traditionally, health education has been conceived from preventive approaches focused on risk control, individual hygiene, and the modification of behaviors deemed inappropriate for public health purposes [1,2]. This model—an heir to the biomedical and hygienist rationality of the twentieth century—has prioritized the transmission of technical information, surveillance of the body, and the shaping of obedient subjects[3,4]. Within this framework, educating for health meant correcting practices, preventing disease, and ensuring normative behaviors, thus reinforcing vertical relationships between professionals and the community[5].

Health promotion, beginning with the Ottawa Charter[6] and its subsequent development in international conferences, expanded this conception by recognizing health as a social process involving participation, empowerment, and intersectoral action[7]. *These global developments positioned health education as a transformative component of public health systems, emphasizing not only behavioral change but also the strengthening of individual and collective capabilities.* In Latin America, these transformations resonate with popular education approaches, where educating is understood as a humanizing, dialogical, and emancipatory act oriented toward critical consciousness and contextual transformation[8,9]. From this perspective, health education moves beyond content transmission and becomes a situated process with cultural and political significance.

Nevertheless, tensions persist between technocratic, prescriptive approaches and those that are participatory and humanizing. Among older adults, health practices are shaped by sociocultural conditions, life trajectories, accumulated inequalities, and community ties that cannot be reduced to individual behaviors[10,11]. Despite the relevance of the issue, there is limited qualitative evidence exploring how older adults understand, re-signify, and experience health education within their everyday contexts. *This gap is particularly relevant in rapidly aging regions such as Latin America, where community-based initiatives have become central strategies for promoting well-being and autonomy among older populations.* Most studies have focused on biomedical adherence, clinical indicators, or institutional evaluations, overlooking the voices and meanings of the participants themselves.

Analyzing the narratives of older adults allows for a broader understanding of health education by integrating dimensions such as social encounter, recognition of others, self-care, self-esteem, community, and sense of purpose[12,13,14]. It also enables the identification of humanizing forms of resistance to educational models that tend to homogenize aging and disregard its cultural and historical diversity. *Situating these narratives within contemporary debates on aging and well-being enriches the understanding of how health education becomes a lived, relational, and meaningful experience.* This study seeks to address this gap by examining the meanings attributed to health education by older adults participating in community programs in Bogotá, and by understanding how these meanings shape their daily practices and experiences of well-being.

Methods

STUDY DESIGN

A qualitative study with a critical–hermeneutic approach was conducted to understand the meanings that older adults attribute to health education within the community programs they attend. This approach enabled the interpretation of experiences from the participants' subjectivities, considering the sociocultural contexts in which their narratives emerge, as well as the tensions, forms of resistance, and meanings associated with the health–illness–care process. Critical hermeneutics was appropriate due to its emphasis on situated interpretation, reflexivity, and the analysis of human phenomena from the participants' historical, social, and cultural perspectives [15,16].

CONTEXT AND PARTICIPANTS

Participants were older adults residing in Bogotá who attended diverse health education and promotion settings, including:

- Local government day centers,
- Physical activity programs offered by district agencies and universities,
- Educational workshops and chronic disease clubs at public hospitals,
- Community spaces such as communal halls, parks, and volunteer groups.

Sampling followed an intentional and theoretical strategy to ensure diversity in age, sex, educational level, prior experience in community programs, motivations, and trajectories of participation. Inclusion criteria required regular attendance at program activities and willingness to share educational experiences. The study drew upon interviews and focus groups previously systematized in the doctoral research project (identified as P2, P3, P4, P5, P7, P8, P9, P11, P12, P15, P24, among others), ensuring depth and richness of narratives.

DATA COLLECTION TECHNIQUES

1. Semi-structured interviews

Interviews enabled in-depth exploration of individual conceptions regarding education, health, self-care, personal transformation, community participation, and life meaning. A flexible interview guide addressed:

- Significant educational experiences,
- Perceptions of health education,
- Daily practices derived from program participation,
- Relationships with peers and professionals,
- Subjective changes and perceived transformations.

Interviews lasted between 45 and 75 minutes.

2. Focus groups

Focus groups allowed exploration of the collective dimension of learning, peer interactions, and the construction of shared meanings. They facilitated the identification of common understandings, tensions, agreements, and collective interpretations of health education.

3. Field notes
During physical activity sessions, educational workshops, and community gatherings, observations were recorded regarding interactions, behaviors, and pedagogical elements present in practice. These notes contextualized and triangulated participants' narratives.

Analytical procedure. Analysis began with the complete transcription of all interviews and focus groups, followed by exploratory readings to achieve familiarity with the textual corpus. Units of meaning were then identified, leading to an initial (open) coding stage that generated labels linked to emerging meanings.
Codes were grouped semantically into provisional categories and subsequently reorganized through axial coding, allowing relationships to be established among central categories such as education, transformation, practices for good living, social encounters, and sense of purpose. These analytical steps informed the development of interpretive macro-themes.
The process incorporated triangulation across actors (older adults, instructors, and professionals) and across sources (interviews, focus groups, and observations), strengthening the credibility of the analysis. Theoretical saturation was reached when new narratives no longer contributed substantial changes to the existing categories. The analysis was grounded in Freire's framework of liberating education, humanizing pedagogy, sociocultural perspectives on the health–illness–care process, and contemporary literature on health education [8,9,15–18].

RIGOR CRITERIA. METHODOLOGICAL RIGOR WAS ENSURED THROUGH:

- **Credibility:** data triangulation and comparison of individual and collective narratives.
- **Dependability:** detailed documentation of analytical procedures and methodological decisions.
- **Confirmability:** use of verbatim excerpts to support interpretations.
- **Transferability:** comprehensive contextual description to facilitate applicability in similar urban community settings.

Ethical Considerations. The study adhered to principles of respect, voluntary participation, and confidentiality. All participants provided informed consent. Identities were protected using alphanumeric codes (e.g., P2, P3). Data were used exclusively for academic purposes in accordance with national ethical standards for research involving human subjects.

Result

The critical–hermeneutic analysis yielded four macro-themes that illustrate how older adults understand and experience health education within community programs. These themes reveal that health education is a complex experience that integrates knowledge, personal transformation, practices for good living, and community building. Within each macro-theme, several sub-themes emerged that reflect how meanings are constructed, negotiated, and embodied in daily life. Representative excerpts are included to illustrate these interpretive findings.

1. HEALTH EDUCATION AS MEANINGFUL ACCESS TO KNOWLEDGE AND CONTINUOUS UPDATING
For older adults, learning about health involves accessing information that enables them to better understand their bodies, their illnesses, and appropriate ways to care for themselves. This education is not perceived as the accumulation of data but as a form of "updating" that allows them to feel current, informed, and capable of making decisions.

Two sub-themes stood out:
a. Knowledge as a bridge to contemporary life
Education is described as a gateway to a rapidly changing world, shaped by scientific and technological developments that older adults feel compelled to understand to avoid exclusion.
"Education is being aware of advances in technology and science… staying updated" (P10).
"It is being up to date with knowledge…" (P4).

b. Knowledge as personal affirmation
Participants highlighted that knowing more strengthens their sense of dignity, autonomy, and agency, countering cultural narratives that frame aging as decline.
"When one learns, one feels useful again" (P7).
"Learning gives you confidence, like saying 'I can still do things'" (P3).
Thus, knowledge acquires symbolic value: it sustains identity and reinforces their sense of being capable and active citizens.

2. HEALTH EDUCATION AS A PROCESS OF PERSONAL TRANSFORMATION AND LIFESTYLE RECONFIGURATION
Beyond knowledge, participants understand health education as a process that transforms attitudes, habits, and ways of relating to themselves. Education is conceived as a path toward critical reflection on everyday life, consistent with humanizing pedagogical approaches.
"Education happens when information transforms you…" (P25).
"It is about respecting your body, eating well, exercising, sleeping peacefully…" (P11).

a. Emotional and behavioral transformation
Older adults describe gradual changes in their daily routines and emotional regulation:
"I have learned not to let stress dominate me…" (P14).
"I used to be very grumpy… now I try to breathe, think, and not explode" (P8).

b. Reconfiguration of daily rhythms
Participants associate education with learning to manage time, organize responsibilities, and prioritize self-care.
"Now I make time to walk, to sleep better, to cook healthier… that is education for me" (P19).

c. Rediscovery of the body
The body becomes a reflective territory: older adults reinterpret sensations, limitations, and capacities in light of what they learn.
"I didn't know why my knees hurt… now I understand how to care for them" (P6).

Transformation is lived as an integrative journey—physical, emotional, and relational—that reshapes their sense of who they are and how they want to live.

3. HEALTH EDUCATION AS EVERYDAY PRACTICES FOR GOOD LIVING

Health education materializes in concrete practices that sustain well-being, functionality, and independence. Participants describe learning as doing, anchoring education in daily actions related to nutrition, physical activity, sleep, medication adherence, safe mobility, and emotional regulation.

"Health education is following guidelines… understanding those aspects that, due to ignorance, can affect your life…" (P5).

"Taking your medication responsibly, just as the doctor says…" (P8).

"Health education is what they give you to maintain a better lifestyle…" (P12).

a. Embodied learning through physical activity

Guided physical activity is not perceived only as exercise, but as a pedagogical space:

"The exercises they teach us, all the techniques…" (P4).

"Physical activity is both physical and mental" (P24).

Participants explain that they learn to listen to their bodies, pace themselves, reduce fear of movement, and increase confidence in their physical abilities.

b. Micro-practices of self-care

Education appears woven into simple, daily acts:

"I've learned to check the sugar in food, to walk slower, to breathe better…" (P9).

c. Continuity between learning and living

Older adults emphasize that education does not remain in the classroom—it becomes routine, habit, and lifestyle.

"It becomes normal… you just do it without thinking" (P13).

4. ENCOUNTERING OTHERS AS A PEDAGOGICAL SPACE AND SOURCE OF COMMUNITY BUILDING

A central finding is that older adults link health education to interaction with others—peers, instructors, professionals, and neighbors. The social and emotional dimensions emerge as essential pedagogical spaces.

a. Learning through shared experience

Group activities create environments of reciprocity, solidarity, and emotional expression:

"Just waking up early and taking the bus is already an education…" (P2).

"We learn a lot…" (P21).

"It is physical exercise, but also mental…" (P24).

b. Community as a space of affective pedagogy

Participants describe learning to coexist, negotiate emotions, and cultivate empathy:

"You learn… not to be bad-tempered, not to mistreat others… to change" (P8).

"One learns to be patient, to listen, to understand the other person's sadness" (P22).

c. Collective meaning-making

Older adults explain that community spaces help them reframe life difficulties, overcome loneliness, and strengthen their sense of belonging.

"When I am here, I don't feel alone… I feel accompanied and that teaches me too" (P16).

Thus, health education emerges as a collective experience where caring for oneself is intertwined with caring for others.

SYNTHESIS

Taken together, the results show that health education for older adults:

- Transcends the transmission of biomedical content.
- Integrates cognitive, emotional, physical, and social dimensions.
- Is experienced as a transformative and humanizing process.
- Operates through embodied daily practices and micro-routines.
- Finds meaning in community encounters and shared emotional experiences.
- Strengthens sense of purpose, autonomy, and self-esteem.

This expanded interpretive framework provides a richer understanding of how older adults construct meanings around health education and how these meanings shape their ways of living, caring, and being in old age.

Discussion

The findings of this study show that the health education experienced by older adults in community programs in Bogotá goes beyond traditional approaches centered on information transmission and behavioral correction—approaches that have historically predominated in health education [16,10]. In contrast, participants construct an understanding of health education as a relational, experiential, and transformative process, aligning with research that advocates for participatory, culturally situated, and socially responsive educational models [17,3]. This shift reflects broader global debates in health promotion that increasingly recognize the limitations of didactic, risk-centered interventions and call for pedagogies rooted in empowerment, agency, and contextual meaning-making.

This conception is consistent with the principles of Latin American popular education and the ideas of Paulo Freire, who proposes that education must be a dialogical, emancipatory act oriented toward critical consciousness [12,13]. In this sense, older adults' narratives demonstrate that learning about health does not entail repeating biomedical instructions, but rather integrating knowledge with lived experience, re-signifying self-care practices, and understanding the body as an object of reflection. These perspectives resonate with contemporary discussions on humanizing pedagogies in health, which argue that educational processes must honor lived experience, dignity, and autonomy—especially in populations historically positioned as passive recipients of care, such as older adults. Studies in aging education similarly show that dialogic approaches strengthen self-esteem, perceived competence, and emotional well-being [15,23,7,14].'

The results also show that health education is expressed through everyday practices that support buen vivir, such as guided physical activity, mindful eating, or emotional regulation. This is consistent with research indicating that meaningful health learning is sustained by concrete, culturally embedded activities linked to daily life [29,26]. Additionally, recent studies have demonstrated that physical activity constitutes both an educational and cultural practice that contributes to emotional, physical, and social well-being among older adults [20,30]. By highlighting the centrality of everyday practices, this study reinforces the idea that health education does not occur in isolated instructional moments but is woven into embodied routines, micro-decisions, and shared social experiences.

A key contribution of this study is the identification of interpersonal encounters as a pedagogical core. Group activities—particularly guided physical activity—emerge as educational spaces where participants build relationships, develop socioemotional skills, and strengthen their sense of community. This finding aligns with research recognizing the central role of social support networks in active and healthy aging [5,19]. Similarly, current evidence confirms that social participation is a fundamental determinant of well-being in later life [1,27,31]. These findings foreground the relational dimension of learning, suggesting that health education for older adults operates not only through cognitive means but through affective exchanges, reciprocity, and the construction of collective meaning.

Across all themes, the active agency of older adults emerges as a central element in the construction of health-related meaning. This challenges educational models based solely on professional expertise and supports perspectives that promote empowerment and autonomy as essential dimensions of health education [21,11]. These results also echo health promotion frameworks that emphasize social participation as a core component [24,8]. Importantly, the narratives analyzed here counter deficit-based discourses that portray older adults as dependent or resistant to change; instead, they reveal reflective, adaptive subjects capable of transforming their practices and negotiating their well-being.

Finally, the findings confirm that health education in older adulthood is inseparable from its sociocultural context. Participants' narratives illustrate that educational practices are shaped by life trajectories, structural conditions, and community relationships. This coincides with studies demonstrating that social inequalities, territorial contexts, and community dynamics influence health practices and educational processes [2,4,28]. Recognizing this contextual embeddedness is crucial for designing interventions that avoid homogenizing aging and instead acknowledge heterogeneity, accumulated experience, and the symbolic dimensions of learning. In doing so, health education can move toward models that align with the principles of healthy aging advocated in international frameworks, including the WHO Decade of Healthy Ageing [25].

Taken together, these findings contribute evidence to advance person-centered health education models that recognize autonomy, relational ties, and transformative capacity. They also offer practical insights for designing interventions that better align with the real needs of this population, in accordance with international guidelines on healthy aging [25]. By situating older adults as active producers of meaning, this study expands the conceptual understanding of health education and offers a foundation for policies and programs that are more inclusive, humanizing, and responsive to the lived realities of aging.

These findings have significant implications for public policy on healthy aging and community-based health education. First, recognizing older adults as active producers of meaning—rather than passive recipients—calls for policies that ensure their sustained participation in the design, implementation, and evaluation of educational programs. This aligns with international frameworks that emphasize autonomy, empowerment, and social participation as core determinants of healthy aging.

Second, the centrality of community encounters, social support, and shared learning in older adults' narratives suggests that health education policies must move beyond individual behavior change models and instead strengthen community infrastructures. This includes ensuring stable funding for neighborhood centers, community instructors, intergenerational programs, and locally adapted educational strategies.

Third, the emphasis on everyday practices and embodied learning indicates that policy interventions should integrate health education with broader social policies—nutrition, mobility, housing, and access to safe public spaces—recognizing that self-care is inseparable from structural conditions. Strengthening intersectoral collaboration (health, culture, sports, social protection, and education) becomes essential to support the holistic well-being of older adults.

Furthermore, policies must acknowledge the sociocultural diversity of aging in Latin America, incorporating pedagogical models that value life histories, cultural knowledge, and collective memory. This requires shifting from standardized, biomedicalized curricula toward flexible, humanizing, and context-sensitive educational approaches.

Finally, the evidence presented here supports the need for public policies that institutionalize health education as a continuous, relational, and participatory process, recognizing it as a right rather than a complementary service. Such an approach would allow countries in the region to advance toward the goals of the WHO Decade of Healthy Ageing, promoting environments that enhance autonomy, social connection, and meaningful participation throughout older adulthood.

Conclusions

The findings of this study show that health education for older adults in community programs in Bogotá is experienced as an integral and humanizing process that transcends the transmission of biomedical information.

Older adults understand education as a relational and transformative practice that integrates knowledge, emotions, bodily awareness, and social interactions. Through this process, they re-signify their experiences, modify everyday practices, strengthen self-esteem, and develop capacities for self-care and informed decision-making. Guided physical activity, daily conversations, and group encounters function as pedagogical spaces where learning becomes embodied, meaningful, and connected to buen vivir.

These results highlight the need for health education models and public policies that recognize older adults as active agents who contribute knowledge, life experience, and collective meaning to educational processes. Incorporating dialogic, participatory, and culturally situated approaches can strengthen autonomy, social connectedness, and well-being in later life. By acknowledging the diversity of aging and the importance of community ties, this study provides conceptual and empirical foundations for designing more humanizing and context-sensitive programs that respond to the real needs of older adults and promote healthy aging.

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