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CONCEPTS OF HEALTH AND ILLNESS AND RELATED BEHAVIORS  
AMONG FAMILIES LIVING IN A BRAZILIAN FISHING VILLAGE

by

Ingrid Elsen

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF NURSING SCIENCE

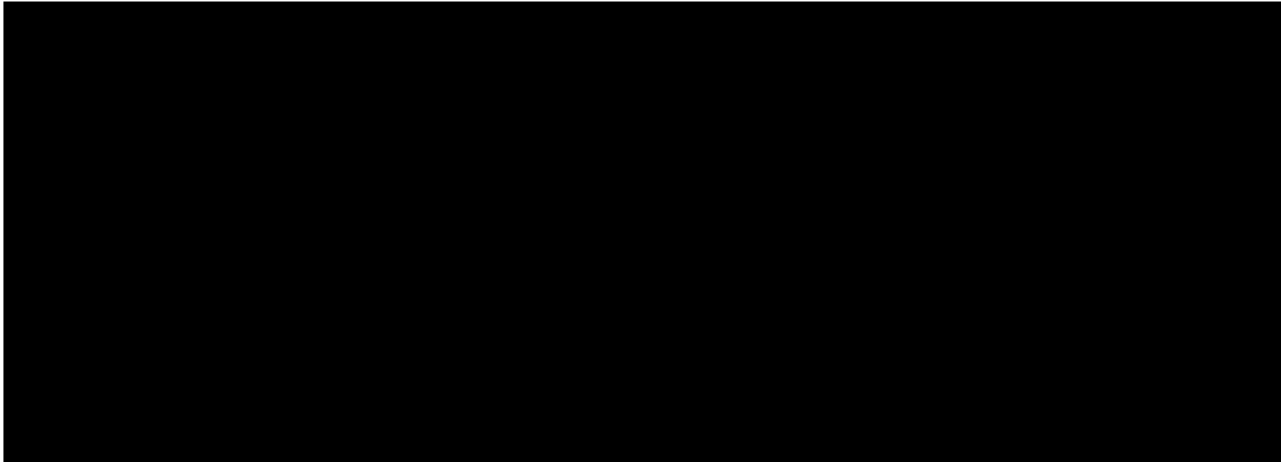
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University of California, San Francisco

School of Nursing

ABSTRACT

CONCEPTS OF HEALTH AND ILLNESS AND RELATED BEHAVIORS  
AMONG FAMILIES LIVING IN A BRAZILIAN FISHING VILLAGE

This exploratory field study investigated concepts of health and illness and related behaviors among families living in a Brazilian fishing village. The primary purpose was to delineate patterns of family care in a cultural context. The investigator lived in the village approximately six months collecting data by participant observation and in-depth case studies. The sample comprised twenty-two families at the school-age stage, who were followed for 1½ to 3½ months.

The results indicate that families have models, rooted in their culture, that guide them in assessing the health status of their members, selecting preventive behaviors, and deciding about the types of treatment needed. The Brazilian families' models differ from those of health professionals and are characterized by both personalistic and naturalistic theories of health and illness. Preventive and curative modalities employed by families are consistent with these conceptualizations, which utilize sources of natural and supernatural

origins. Although the families do not include principles of scientific medicine in their models, they do frequent health clinics for prevention and treatment. However, this utilization is selective and pragmatic, with earlier community and family experiences with the system being key factors in determining acceptance or not.

Ingrid Elsen  
Ingrid Elsen, Author

Marilyn Savedra  
Dr. Marilyn Savedra, Chair





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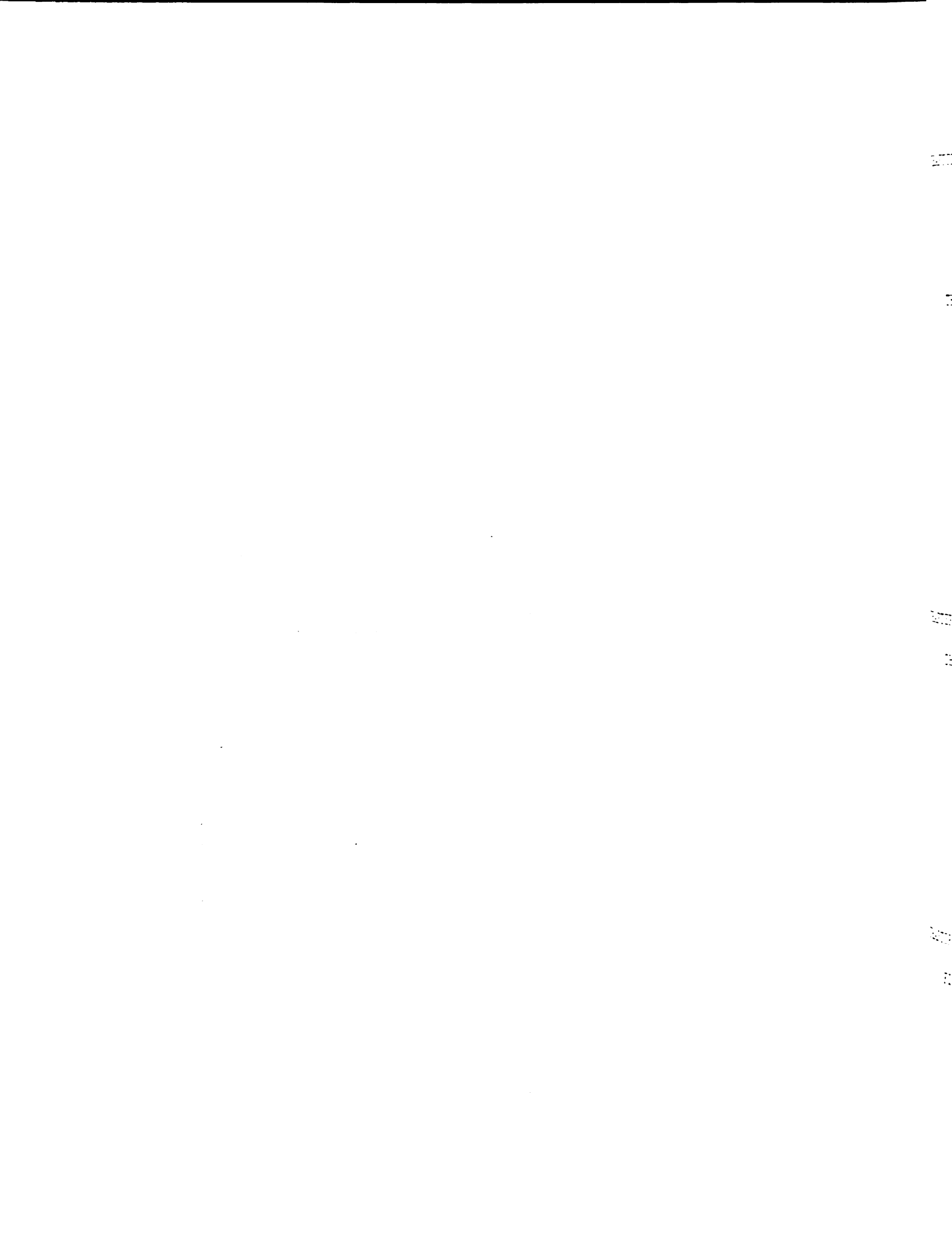
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## CHAPTER I

### INTRODUCTION AND CONCEPTUAL FRAMEWORK

This chapter describes the background of the study, statement of the problem and its purpose, the significance of the study, and the conceptual framework.

Since my early professional nursing experience in Brazil I have been struck by the ways families differed in dealing with health and illness. There were families who strictly followed the health professional's advice on procedures to promote health and prevent disease. There were also a great number of families who did not immunize their children even if the vaccine was painless and available. Some waited too long to take their dehydrated child to the hospital and others, who did see a physician, only partially followed the treatment prescribed. Many times, Brazilian nurses and physicians feel helpless when parents decide to take their very sick child from the hospital to try unconventional treatments such as blessings or the use of sympathy. What are the underlying motives for families to behave so differently from what health professionals practice and expect of them?

Although people's knowledge, attitudes, and practices are believed to have a significant impact on how they utilize the health-care system, little is known about families' conceptualizations of health and illness

and their related behaviors. What meaning does health and illness have for a family? How is health enhanced and disease prevented in the family? What are the factors that influence some families to take better care of themselves than others? How are decisions made when a member gets sick? Which measures are taken at home before a sick member looks for professional care? These questions motivated this investigator to explore in depth the families' world of health and illness according to their own explanations and from their point of view.

#### Statement of the Problem

The problem, briefly stated, was to study the concepts of health and illness and related behaviors among families living in their sociocultural environment. In more detail, this problem included the following questions:

1. How do families orient to and make sense of health and illness?
2. What are the families' explanations of causation of disease?
3. What kinds of actions do families undertake to prevent disease?
4. How do families manage common illnesses at home?

#### Purpose of the Study

This research had three main purposes. First of all was to delineate patterns of family care toward health and illness in a Brazilian fishing village. In addition, the investigator expected that

this study will help nurses and health professionals to better understand the families' behaviors. Third, this study also intended to generate basic hypotheses related to family and health care, to be investigated in future research.

#### Significance of the Study

The primary reason for undertaking this study was the need for nurses and health professionals to know more about how health and illness is experienced by families in their daily life. As the review of the literature demonstrates, there are few research studies that have focused on the family as the unit of study in health and illness situations. Most of them have looked at individuals or at group definitions and have left unanswered the question of the family and whether it, considering its special nature, conceptualizes health and illness differently from individual members of the community.

Secondly, an intensive study on the family and health care will give nurses an opportunity to learn more about families' own perspectives on matters of health and illness. Indeed, there has been increased acknowledgment in the health literature that professionals and clients do have different cognitive appraisals of health and illness (Mechanic, 1976; Twaddle, 1966). The need for nurses to bridge this gap and take into consideration the patient's point of view in planning and implementing nursing care has been stressed by nursing scholars (Brink, 1976; Henderson, 1966; Steiger & Lipson, 1985).

Third, this study also will add a cultural dimension to nursing care. There is a growing movement in the nursing profession for a

holistic perspective on nursing care. For Leininger (1978), a nurse and anthropologist, a full consideration of the cultural aspects of health and illness not only provides more comprehensive nursing care to patients, families, and communities, but also greatly enhances health care services. By investigating families in Brazil, this study will expand knowledge on the beliefs, perceptions, values, and practices of this specific cultural group and as such will offer nurses the opportunity to add this component when caring for their patients.

Fourth, the results of this study can be used to improve the quality of health care delivery to individuals and families. Health statistics in Brazil indicate that mortality and morbidity rates in the maternal-child group are very high and that the major causes of illness can be prevented (Dourado & Coelho, 1980). A clear picture of the rationale and strategies used by families in dealing with health and illness will increase the competence of health professionals in planning and delivering more effective health care to the population.

Finally, this research also intended to offer a contribution to the field of family health and illness theory. Identification of the ways the family as a unit conceptualizes health and illness, makes daily decisions on these matters, and the factors that affect its actions will expand knowledge on the family as provider of health care and, hopefully, will provide an incentive for the development of family theory.



## CONCEPTUAL FRAMEWORK

Symbolic interaction was the framework selected to guide this study. It was used here in the sense that human interaction is mediated by a process of interpretation in which the actors ascertain the meaning of one another's actions (Blumer, 1962). As a consequence, human response is not directed to the actions of another but to the meanings that are attached to such actions. The emphasis of symbolic interaction on the discovery of the meanings and values that precede people's overt behaviors and its potential for exploring meanings that are culturally shared provided both the formulation of a model for conceptualizing family, health, and illness and the direction for the methodological procedures.

The theoretical formulations underlying the model used in this study were based on the works of Blumer (1962, 1969), Burgess (1968), Mead (1934), Rose (1962), Shibutani (1962), and Thomas (1967). In its organization, three basic principles were followed. First, the concepts and assumptions should explore the inner or phenomenological aspects of the family facing health and illness situations. Second, the family should be viewed in a community context so that physical and sociocultural characteristics can be identified. And finally, the model should 'sensitize' the investigator to the problem instead of prematurely structuring the empirical world (Turner, 1978).

Based on these premises, concepts dealing with the family, society, culture, and definition of the situation were identified and adapted to a context of health and illness. The processes linking these concepts are mainly communication, interaction, role-taking, interpretation, and

socialization. The assumptions supporting the model were derived directly from conceptualizations of Rose (1962) and Blumer (1962).

### Concepts

Four main concepts - definition of the situation, family, society, and culture - were selected from symbolic interactionist approach as central to the development of this study. They are first presented separately and later they are integrated with the model used to guide this research.

Definition of the situation. For Thomas (1967), preliminary to any self-determined act or behavior there is always a stage of examination and deliberation, which he called the "definition of the situation". In their analysis, Burr and colleagues (1979) identified at least three dimensions related to this concept. The first one takes into account the fact that definitions can change under some circumstances. For example, the same event can be interpreted differently by different cultural groups. Spradley (1979b) exemplified this in his description of a situation where a group of policemen trying to save an old woman who had a heart attack on the street were accused of abusing her by a group of people who were on the scene. These individuals, who ignored the life-saving techniques, reacted to the situation based on what appeared to be a case of abuse of the elderly. Furthermore, definitions can vary even from the same person facing a situation for the second time. The effect of the first experience on people's perceptions is another element responsible for changing their interpretations. Thus, meanings of the phenomenon can vary from

situation to situation and are subject to historical time and cultural background (Burr et al., 1979).

A second important dimension of this concept relates to the value people give to different situations. For human beings, some phenomena are more worthy than others. Consequently, the way they define a situation that involves high values will probably differ from one that is less meaningful to them (Thomas, 1967).

The third component, as described by Burr and colleagues (1979), refers to the element of truth or reality that people inject into their definitions of a situation. Thomas (1967) described it very well when he stated, "If men define situations as real, they are real in their consequences." People's interpretations do not emerge in a vacuum. They are dependent on different factors such as acquisition of the language, perceptions of significant others, and generalized others, and the nature of the social institutions in which a person lives (Burr et al., 1979).

According to Thomas (1967), the family is the smallest social unit and the primary defining agency for the individual. As soon as the process of socialization begins, the parents begin to define situations for the child. In the area of health and illness, this can be exemplified by phrases such as "chew your food well", "wash your hands before eating", "don't eat food that is on the floor", and so on. This process, initiated at home, is continued through interactions with playmates, school teachers, and health professionals, among others.

After the family, the community is the next largest agency responsible for defining situations for the individual members. In traditional societies, this process occurs more intensely than in modern

ones where people have to face many different and new situations for which there is no previous interpretation. Among the techniques community members use to teach its members these common meanings, Thomas (1967) identified gossiping, signs of approval or disapproval, and rejection.

Stebbins (1972) described three classes of definition of situations: cultural, habitual personal, and unique personal. The cultural, also called collective, representations refer to the standard meanings of events embedded in the community as a whole or in some subparts of it. These cultural definitions are consensually shared to the extent that those who are members of a particular group are aware that others in it recognize and utilize that definition in the same way. The habitual personal definitions differ from the cultural ones in that people share the same meanings but are not aware of it. Finally, unique personal definitions occur when people face events that are unique for them or are rarely encountered in the community and for which there is no previous definition.

According to symbolic interaction, it is the capacity of mind and self that makes possible human beings' interpretations of situations. In other words, it is the ability to think or symbolically find alternative courses of action, weighing them in relation to the values, and selecting one for action, added to the ability to derive self-images or to picture oneself as an object, that make it possible for human beings to define situations (Turner, 1978). The way an individual behaves rests largely upon this definition of the situation (Thomas, 1967). Shibutani (1955) expanded this idea by asserting that the manner in which human beings consistently define a succession of situations

depends upon their perspective. For Shibutani, a perspective is an organized view of one's world, incorporating what one takes for granted about attributes of objects, events, and human nature. Moreover, a perspective is often shared by others in the community because of common channels of communication. In this way, a common perspective can also be considered as an element in a group's culture.

Family. According to symbolic interactionists, the family is viewed as a unity of interacting personalities (Burgess, 1968). The emphasis is on interpreting family phenomena in terms of internal dynamics such as communication, role-taking, socialization, and decision-making rather than in terms of the family's formal functions as they relate to society. Family interaction is the main mechanism that keeps the family alive, growing, and changing. For Burgess, the family dies only when communication between its members ceases.

Within the family each member occupies one or more positions to which a series of roles are determined, and norms or role expectations are yielded accordingly (Schvaneveldt, 1981). For instance, a mother with a sick child plays the role of health provider which involves such behaviors as taking care of the diet, medication, and physical and emotional comfort of the sick member. Furthermore, family members assume that, in this case, the mother has the knowledge and the skills to recognize symptoms, to perform home treatments, and to decide when the sick member requires help from a physician (Litman, 1979). Roles have meaning only in relation to other roles, and every role presumes some counter-role (Bell, 1971). Thus the mother in the health-provider role requires at least one of the family members performing the sick role.

It is in the realm of the family that roles are first learned. From infancy, the child is taught which behaviors are considered appropriate for a particular position. He learns not only the expected behaviors for his specific position but also the ones related to other positions in the family. The major mechanism underlying role-learning is role-taking. This process begins in childhood with the infant observing and imitating other role models (usually parents and siblings). It evolves until the child has the capacity for mentally anticipating the actions of others and adjusting his behavior based on such anticipations. The acquisition depends upon the development of mind and self (Mead, 1934).

Family interactions proceed through the use of symbols that have a common meaning for all individual members. According to Maurin (1983), one of the first tasks a husband and wife face when creating a new family is to develop a universe of shared meanings. This common understanding includes things that family members agree upon as well as matters where there is no agreement at all and that even cause family fights. This universe of shared meanings, also known as "family perspective", includes norms and values of how the family life should be, the roles and expectations for each of its members, what is recommended as good or healthy for the family's growth and development, and causes of strain in the relationships. This perspective is created through the interactive processes occurring within the family and is expanded over the years. The human infant is born into this ongoing interaction and gradually learns the meanings, values, and beliefs family members have attached to objects, situations, and events. As a

result, after some time the child begins to share the same perspective as other members in the family.

Family life is considered to have a time dimension. It has a history which begins with marriage (Waller, 1938) and goes through different stages of development; it ends when interaction between the members breaks. As a consequence, the family is a dynamic unit with needs and problems that vary according to specific stages of life cycles family members are going through.

The family is also believed to exist in interaction with the larger society of which the family and its members are a component (Mowrer & Mowrer, 1957). Members of a society share common meanings, perspectives, and behaviors. In other words, they share a culture. The family, as a system mediating between the individual and society, is also responsible for teaching the child the ways of the culture and society. It is through socialization, the special type of interaction that occurs more intensively in childhood but expands through all stages of human life (Rose, 1962), that the child learns his/her culture. As such, the main purpose of socialization is to allow the family member to acquire the meanings, values, and concepts shared by community members in order to achieve self-development, interpersonal competence, and conformity (Heiss, 1976).

Society. Society, or community, represents the organized and patterned interactions among diverse individuals (Mead, 1934). This organization is viewed as being affected by mind and self. It is the capacity of the mind for role-taking and imaginatively rehearsing different lines of action and the special capacity of the self for

reflection and evaluating the self from the perspective of the "generalized other" that construct and maintain society.

Mead made a clear distinction between infrahuman and human society. Cooperative behavior for the first group is physiologically determined, while in human associations cooperation can be brought about only by symbolic processes where each individual ascertains the intentions of the acts of others and then makes his own response on the basis of that intention (Meltzer, 1967).

Two major characteristics are implied in the concept of society. First, individuals comprising a community have selves (Blumer, 1962). To have a self means that human beings have the capacity for thinking about their own actions and thereby draw conclusions about "Me", the author of the action (Mead, 1934). This capacity to derive images of oneself as an object of examination is dependent upon the processes of the mind (Turner, 1978). The self is essentially a social process within the individual and involves two different facets: the "I" and the "Me". The "I" is considered the impulsive tendency of the individual. Because it is the spontaneous and unorganized aspect of human experience, it offers the potential for new and creative activity. On the other hand, "Me" represents the "incorporated others" within the individual and comprises the organized set of attitudes, definitions, understanding, and expectations common to the group. Usually every human act begins in the form of an "I" and is followed by "Me". In other words, the "I" gives propulsion to the act while the "Me" gives direction. Being so, the act is a result of the interplay between "I" and "Me" (Manis & Meltzer, 1967).



Second, human society consists of acting people, and the life of a society is to be seen as consisting of their actions. The acting units may be separate individuals, families, or collectivities whose members are acting together on a common quest (Blumer, 1962). Human acts occur under two main conditions; one is related to the context in which the action takes place, and the other is the way the actions are formed. People's behaviors do not take place in a vacuum; they always happen in and with regard to a situation. Moreover, individuals' responses to an event are constructed or formed based on the way they have interpreted the situation. This is to say, between the stimuli and the answer people add an interpretative process (Blumer, 1962).

For interactionists, the community is a dynamic process. Turner (1978) stated that society is a constructed phenomenon that arises out of the adjustive interactions among individuals. As such it can be altered or reconstructed through the mechanisms of self, role-taking, and imaginative rehearsal.

Culture. Community members who define or interpret situations in the same way and share common perspectives have a culture (Blumer, 1962). This is possible because, through previous interactions, individuals develop and acquire common meanings, values, or definitions of how to act in different situations. According to Rynkiewich and Spradley (1976), culture is the framework within which people see the world around them, interpret events and behaviors, and react to their perceived reality (p. 7). There are at least three characteristics in this definition of culture significant to this study. First, culture is seen as learned and not as innate characteristics of the individual. As such, cultural knowledge is coded in complex systems of symbols. It

involves the "definition of the situation" that must be learned by each generation (Spradley & McCurdy, 1972). Children in every society are taught to "see" the world in a particular way. This process of learning to recognize and identify some objects while ignoring others starts at the level of the family, through socialization, where children are taught a "tacit theory of the world" (Kay, 1970, p. 20).

Culture also implies, to a certain degree, a shared knowledge. Thus members of the same society come to have the same customs and agree on the basic characteristics of reality as well (Rynkiewich & Spradley, 1976). From a symbolic interaction approach, the fact that people have common meanings and definitions does not mean that there is no process of interpretation between a person's perception of the situation and his behavior. Having cultural definitions just makes people put less effort into the interpretation because of the ready-made definitions (Blumer, 1962).

Third, cultural knowledge, seen as knowledge that is learned through communication and interaction, also affects the type of methodology to be used in studying the culture of families. It requires the investigator to make a systematic attempt to discover the knowledge a group of people have learned and are using to organize their behavior instead of just describing their actions. In other words, as Spradley and McCurdy (1972) stated, the investigator, instead of asking "What do I see these people doing?" will ask "What do these people see themselves doing?" (p. 9). This point of view on methodology is also consistent with the symbolic interactionist approach, which emphasizes the need to "see" the family's world from the perspective of its members (Blumer, 1969).

### The Model

A model, as depicted in Figure 1, was organized to guide this study. Its concepts and assumptions were derived directly from symbolic interaction and adapted to a situation of health and illness.

#### Components of the Model

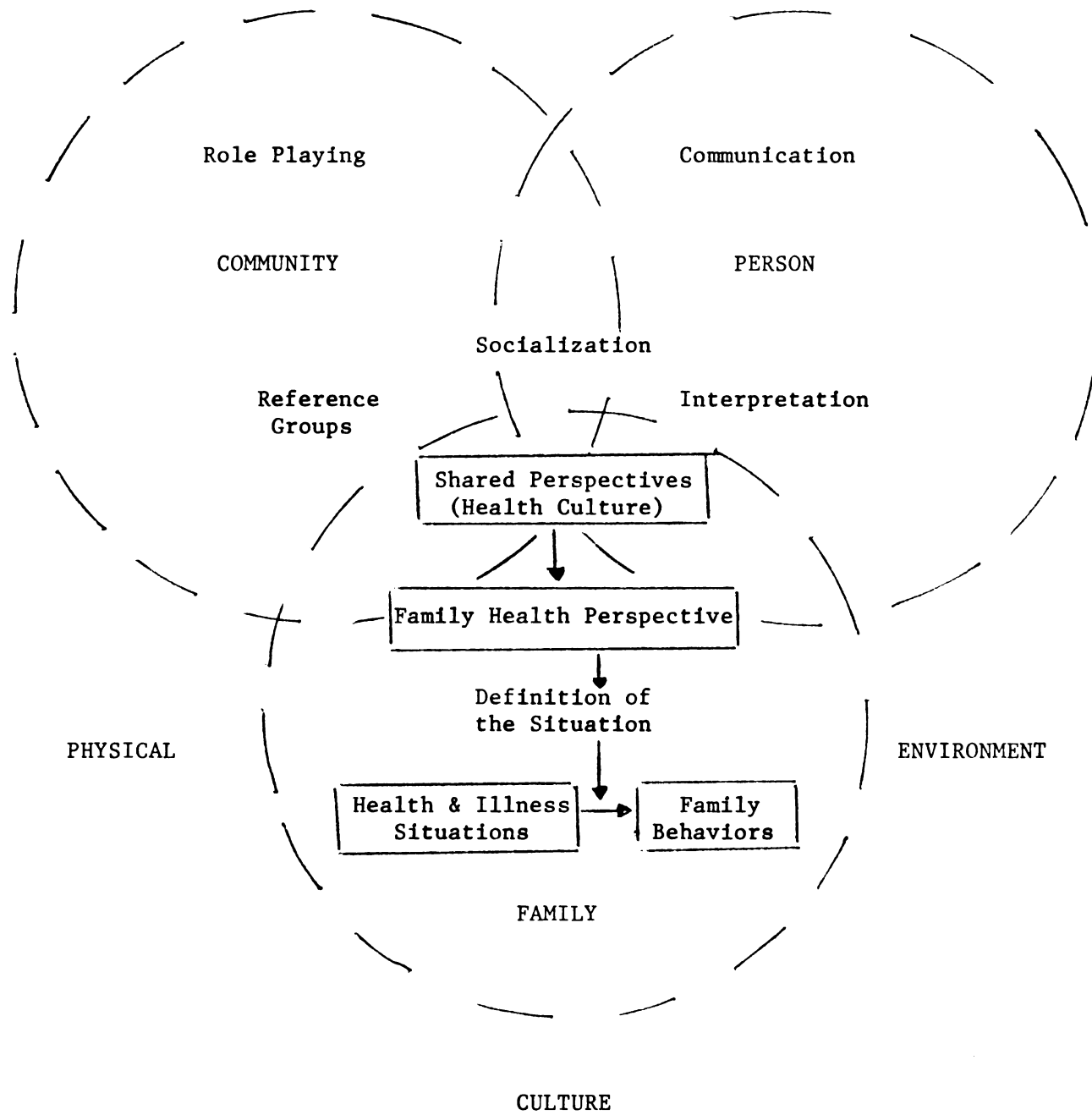
The main components of this model are the community, the individual, and his/her family. The family occupies the central circle because it is the focus of this study. The units do not stand by themselves; they are assumed to share the same physical, symbolic, and cultural environment.

The community. For this model the society, as defined by interactionists, is represented by the word "community" and consists of a network of individuals, groups, and families who live in a specific geographic area and share to more or less the same degree language, ideals, values, knowledge, and artifacts that make their culture. The part of this general perspective that deals with health, sickness, modes of preventing disease, and the management of health problems is called "health culture".

Within the community, certain groups can affect the individual's or family's ways of dealing with health and illness situations more directly than others. Those groups that are ranked as significant and whose perspectives or health cultures are adopted by the family in their definitions are considered a "reference group" (Shibutani, 1955).

The fact that people in this community share the same symbols, values, and meanings makes it possible for them to define many health and illness situations in the same way and perform actions that are

SYMBOLIC ENVIRONMENT



The Family, Health and Illness Definitions  
and Behaviors According to Symbolic Interactionism  
(Adapted to This Study)

FIGURE 1

similar. In other words, they are expected cultural definitions of situations. But because groups and individuals face new events, situations change, and special characteristics of the self appear, there is always room for habitual and unique definitions of events.

The person. The person in this framework corresponds to each one of the members who compose the family and the community as well. It is the individual member who has a self that makes him have an inner experience or mental life, to direct and control his actions, and to be an agent of change for himself (Manis & Meltzer, 1967). Furthermore, this same individual has a mind that makes him understand conventional gestures, to take the role of the other or others, and imaginatively rehearse lines of action (Mead, 1934). Therefore it is the development of both mind and self that is responsible for the symbolic interactions occurring between individuals and groups. They are so-called because they are based on mutual interpretation of the meanings of each other's actions and also have a continuous mental representation.

It is the individual member who first faces a health situation such as vaccination, check-up, diet, exercise, or illness symptom, interprets them according to his perspective, and makes a decision on what measures he intends to take to promote health, prevent illness occurrences, or seek treatment. But individuals do not live alone; they are born as members of a family. It is in the realm of the family that one first learns behaviors to promote health and the norms that govern the sick role. It is through the process of socialization that one acquires most of the meanings, values, and concepts that make up the family health perspective or family health culture and their related definitions.

Later on, in interaction with other community members, a person will expand his perspectives and definitions and will be engaged in different groups as acting units.

The family. The family is depicted in the central circle because it is the unit of study. It is viewed as mediating between the individual member and the community and is responsible for providing health care for its members.

Families are assumed to have a universe of shared meanings that are in part resultant of their interactions with community members but also as a product of its internal relations. The part of the family universe of shared meanings in regard to health promotion, disease prevention, and modes of treatment is called, for the purpose of this study, family health perspective. This frame of reference guides the family in making decisions related to health and illness. In addition, the family perspective and definitions are transmitted to the children through the process of socialization.

In health and illness situations at home, family members perform roles such as health educator, health-care provider, decision maker, and the sick member, among others. Concomitantly, family members hold expectations about these roles. As such, a healthy member is expected to act in a different way than when he is sick. In the same way, when sick, the family member is assumed to have certain prerogatives that are exclusive to this role.

### Assumptions

The basic assumptions underlying the model are described below.

1. Families live in a symbolic, physical, and cultural environment and, as such, can be stimulated to act by both symbols and physical stimuli (Rose, 1962).

The first implication of this assumption for the study is that health and illness can be symbols that have a learned meaning which can vary for different people. For instance, for some families health may be viewed simply as an absence of symptoms while for others it can mean physical and emotional well-being. In the same way, illness can be considered as God's will, bad luck, or caused by a chemical or biological agent.

As symbols, health and illness also have an intrinsic value attached to them. In the significance continuum, families differ in the way they rank each of these symbols. There are families who value health highly and, as a consequence, health behaviors have priority over other activities, while in others, actions to promote health have to compete with other family values. Families act toward health and illness according to the meanings and values these concepts have for them. Therefore a family who defines health as physical and emotional well-being and considers it as valuable is expected to engage in a series of behaviors that will differ considerably from those families to whom health means absence of disease and has lower priority to their members.

Health and illness meanings and values are learned by family members through interaction (Rose, 1962). Thus a child, while interacting first with his parents and later with relatives, neighbors,

friends, and health professionals, develops a perspective about health and illness that serves as a guide to his actions. This perspective is, therefore, partly shared with other members of the community, but it also has its own dimensions that result from his unique experiences as a person and as a member of his family.

2. Family behaviors toward health and illness are constructed by its members through symbolic processes rather than by being simply acts of release (Rose, 1962).

This means that before families engage in actual health or illness behaviors there is a stage where knowledge, beliefs, values, and meanings are examined and weighed (family definition of the situation). Thus, when facing any health and illness situations, for example a free vaccination program for children to be developed in their own community, families will first define this event, not only according to the cost, accessibility, and facility of the program, but mostly to the meaning it (i.e. the vaccination) has for them along with the value put on it.

This assumption offers at least three implications for the methodology: 1) The study of families' definitions and actions has necessarily to look at the covert mental activities if a full understanding of the matter is desired; 2) The investigator has to see the family's world from the point of view of its members. This, translated to a symbolic interaction language, is achieved by taking the role of the other or, as Lindesmith and Strauss (1968) emphasized, "to imaginatively assume the position or point of view of another person" (p. 282); 3) It requires the use of naturalistic and unstructured techniques of data gathering in order to allow the investigator to get close to the family's world of everyday experiences and to be free to



observe their daily activities and to ask questions on the spot (Blumer, 1969).

3. Families live in a community that existed prior to their arrival (Blumer, 1962) and whose members have in common a culture that is taught from one generation to the next.

Individuals and families are born as members of a community. As such, they live in the same physical and cultural environment, interact frequently with other families and members of the community, and share some of the same meanings, beliefs, and values. In other words, they share a common culture or perspective that guides and helps them to define most of the situations they face in their everyday life. This applies to the area of health and illness as well.

According to Foster and Anderson (1978), people as cultural beings have developed social institutions, etiological theories, and therapeutic techniques to help them cope with health and illness situations. This intellectual construct, called disease theory by the authors, is represented in the present model by the concept of "shared perspective" or health culture. This knowledge about health and its nature and explanations of causation of disease is assumed to be shared by the families living in a fishing village in southern Brazil.

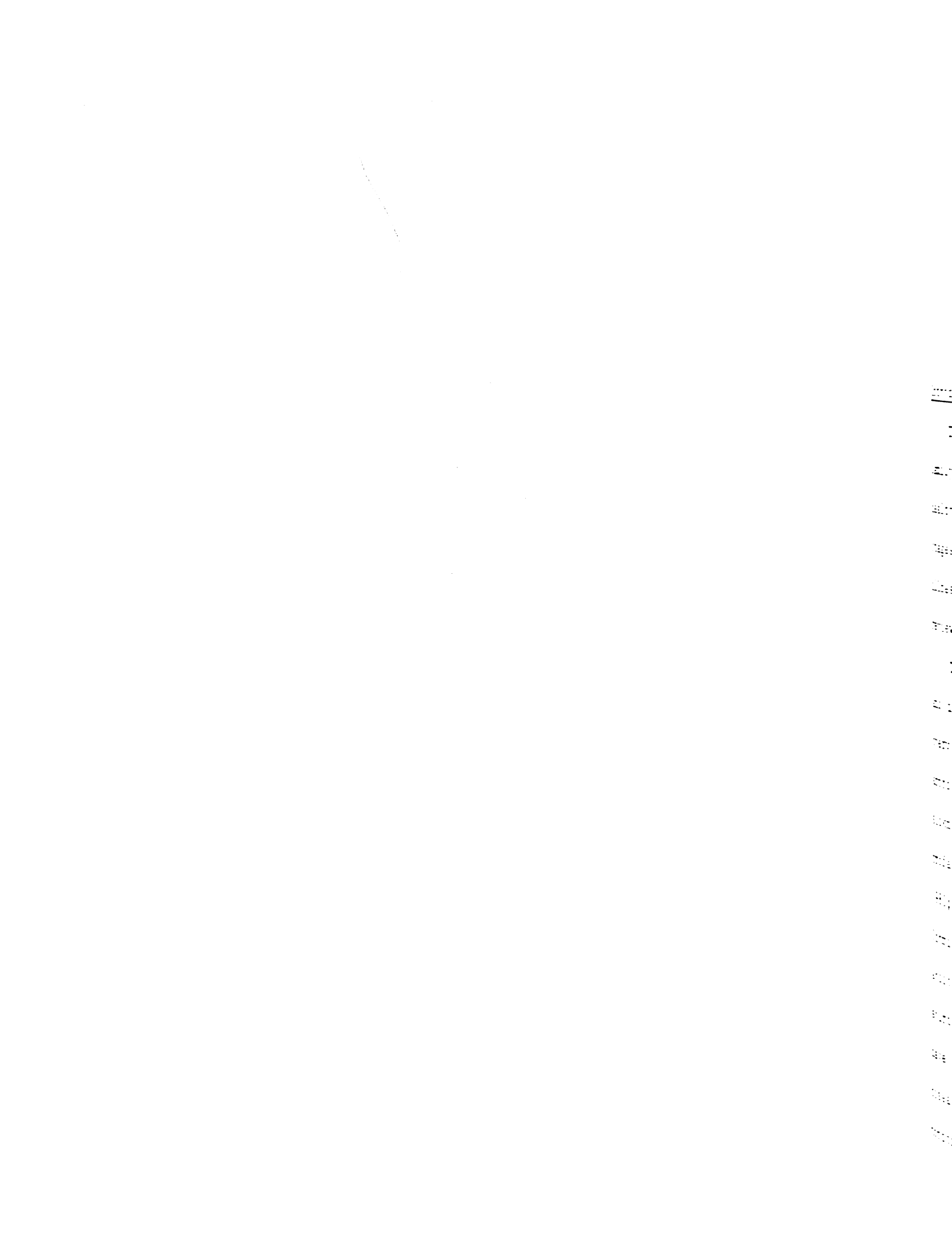
Individual members are very soon socialized into the ways of living, thinking, and valuing of the community, including theories of health and illness. This occurs in stages, first at home when, through interaction with close relatives, one learns the family health culture, and later, when this body of knowledge is reinforced and expanded through interactions outside the family environment.



### Functioning

Each unit - individual, family, and community - is represented by one circle to demonstrate the uniqueness of the interactions within each system. However, the circles are interlinked, which means that close relationships are going on between the units as well. Processes of interaction that maintain the coordination of the three units are role-taking, communication, interpretation, negotiation, and socialization. Each component is perceived as growing, living, and changing units and, for this reason, the circles are depicted by interrupted lines. This means that each circle can be expanded or contracted as a consequence of the interactions that occur within and between the units.

The form of a circle was chosen to describe the dynamics present in each of the units. Individuals in the three circles are conceived as able to interpret and construct reality, and their actions are the product of symbolic processes rather than a result of external forces. The overlapping area between the three units shows the common or shared knowledge, meanings, and values. In the present study, it corresponds to the perceptions of health and illness that individual family members, families, and the community have in common. The three units are located in space and time and in a cultural context. For this study, they represent families and their members living in a fishing village in southern Brazil who have the same cultural background and are going through the stage of school-age children.



## CHAPTER II

### REVIEW OF THE LITERATURE

#### Introduction

This chapter presents the literature and research related to family, health, and illness. It approaches the family as a unit of health and illness conceptualizations and related practices in the stages of health promotion, disease prevention, and treatment of common illnesses at home. Although research on different cultural groups is reviewed, the major focus is on Latin American studies.

There has been a growing interest in the area of family, health, and illness in the last 40 years (Litman, 1979; Vincent, 1963). An overview of the literature shows that authors have applied different approaches to the study of the family as it relates to health and sickness. The first approach looks at the family as the focus of professional care; this is stressed by nurses (Clements & Roberts, 1983; Ford, 1973) as well as physicians (Curry, 1977; Geyman, 1977; Schmidt, 1978). Another way of looking at the family is through a socioepidemiological perspective which emphasizes the family as the source of causation and transmission of diseases. Studies in this area have looked at issues ranging from genetic problems, communicable diseases (Dingle, Badger, & Jordan, 1964; Meyer & Haggerty, 1962), and noncontagious diseases (Medalie & Gouldbourt, 1976; Nesor, 1975) to

psychological and psychiatric disorders (Bowlby, 1970; Spitz & Wolf, 1946). A third approach to family studies is to examine the health status of the family and its ability to function as a unit. In this context, a healthy family is defined according to its strengths and capacity to attend to the needs of its members (McEwan, 1974; Napier & Whitaker, 1975; Otto, 1973; Pratt, 1976).

The perspective adopted in this review looks at the family from yet another point of view, one which emphasizes the family as a unit of care in health and illness situations. As such, interest lies in studies about families' explanatory models of health and illness, actions taken within the family to promote health and prevent disease, and how families manage their common illnesses at home.

#### The Family as a Unit of Care in Health and Illness Situations

In general, the family can be considered the first and most natural provider of health care for its members. As simple as it may seem, this aspect of family functioning has been overlooked for many years in the literature on families. Treatises in this area do not usually include health care among the family's relevant and universal functions (Murdock, 1968; Reiss, 1965). However, a few indications of the role of the family in maintaining health and caring for the sick can be inferred from them. For example, when Parsons (1970) described the family as an essential agency for meeting the biological needs of its members and Gough (1971) stated that the role of caring for and bringing up children involves an obligation for food, adequate clothing, and hygiene, they were talking about the basic requirements for health as well. Moreover, Murdock's (1968) reference to the injured or sick being nursed and



brought back to health by another family member can easily be interpreted as being one of the roles of the family.

A clearer statement on the responsibility of the family for providing health care was made by Turner (1970) who included individual care as one of the continuing functions of the family. In addition, he stated that

The intimate familiarity with routines, moods, and subtle gestures enables the family members to detect illness or preoccupation on the basis of the minor changes in the appearance or disposition unnoticed and inaccessible by others. (p. 220)

Further, Bell and Vogel (1968) listed the care of dependents, such as the sick and the aged, as an internal family activity. Caplow and colleagues (1982) found that child care is among the roles that fathers and mothers rate as being theirs.

Recently there has been an increasing acknowledgment of the role the family plays in all stages of the health/illness continuum. For Litman (1979), the health maintenance of its members and home care are among the essential tasks performed by the family. He also observed that families tend to be more and more involved in the decision-making and therapeutic process at every stage of a member's illness, from diagnosis to treatment and recuperation (p. 77). In addition, Schmidt (1978) stressed the importance of the family's role in preventing diseases, restoring the health of its members, and helping them to adjust to serious or chronic diseases.

There are some references in the literature to the family as a unit of health care per se. Litman (1979) asserted that

The family constitutes perhaps the most important social context within which illness occurs and is resolved. It consequently serves as the primary unit in health and medical care. (p. 495)



Moreover, Pratt (1976) regarded the family as a personal health care system, since the health of its members is its central concern and major responsibility. And finally, going further, Mauksch (1974) theorized about a family "health estate". According to this author, every family has its own health estate which is

. . . the syncratic product of all the forces family members contribute within the context of their culture, their awareness of health-relevant knowledge, and their unique ways of introducing these factors into the emerging family. (p. 524)

This family "health estate" is an integral part of all family life and includes not only knowledge, beliefs, and attitudes but also role and task allocation within the family system.

However, the ability of the family to manage health and illness interactions has been challenged in the literature. Parsons and Fox (1968) were among the first to question the family's resources to deal with disease at home. According to these authors, urban American families, because of their structure and isolation, are not able to treat their sick members at home and, as a consequence, have accepted and stressed the use of medical facilities and hospitalization. Further, McEwan (1974) also referred to changes in families' roles over time, with the reduction of some of the services supported by families. Included among these are medical care, religious instruction, and recreation. These services, from his point of view, are being placed more and more in the hands of specialized agencies (p. 491).

#### Models of Health and Illness

There have been different approaches to defining health and illness, medical science being one of the first areas interested in this

subject in western civilization. As far back as 400 B.C., Hippocrates developed a holistic view of health and illness where man was seen in his relationship to both the internal and external environment. As such, health resulted from equilibrium among the body's four humors (blood, phlegm, black bile, and yellow bile) and from the harmony among the body, environment, and the person's living habits. For Hippocrates, there were three main causes of disease: 1) those that resulted from meteorologic, climatic, and geographic conditions, 2) those caused by digestive disorders, and 3) those that developed from changes in body fluids. Other causes were also acknowledged such as trauma, animal bites, and parasitic infestations, among others (Mettler, 1947, p. 324). This global approach to health changed drastically, however, after the Cartesian revolution in the 17th century, when mind and body were considered two separate identities; the body was considered as an intricate machine and disease a breakdown of this machine (Engel, 1963). This focus was reinforced later on with the discovery of germ theory and concomitant advances in immunology, pathology, and surgical techniques (Ahmed & Coelho, 1979). Thus a new and so-called biomedical model was generated, and a clear-cut dichotomy between health and illness became apparent. From this perspective, health became the opposite of illness or, as Wilson (1970) stated, an uninteresting residual category. The concept of health as merely the absence of disease has been challenged in the last few years because of its negative and narrow aspects and its limited usefulness (Engel, 1977).

An important step toward a broader definition of health was given by the World Health Organization (1958) when it defined health as a "state of complete physical, mental, and social well-being and not

merely the absence of disease". This definition, although criticized by many as an ideal and as such impossible to achieve, has the advantage of offering a positive approach to health and suggests at least four new dimensions to be explored in this concept - physical, emotional, social, and the absence of disease.

A second approach to health and illness has been developed in the area of sociology. First delineated by Parsons (1951) and later revised by him (1972, 1975), the sociocultural perspective calls attention to the social significance of health and emphasizes the individual's ability to function well and perform social roles. According to Parsons (1972, p. 107), "health is the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized". Illness, on the other hand, is conceptualized as an inferred reduction in the individual's capacity to perform the tasks or roles expected of him or her. There are at least four major assumptions underlying this model (Wolinsky, 1980): 1) social performance is emphasized, 2) health and illness must be defined in relation to the individual's status and participation in the social system, 3) illness is seen as a deviant behavior in an American society which values performance of social tasks, and 4) the sick role is an accepted one. Although some of these assumptions have been subject to criticism and have not been supported by research, this sociocultural model of health and illness has contributed to the expansion of views on health and illness other than the biomedical model and has generated studies on different areas of knowledge.

The psychological approach to health and illness presupposes that each individual is constantly and subjectively evaluating his/her own

health status. According to Wolinsky (1980), a psychological concept of health and illness has at least three dimensions: 1) negative affect, which involves feelings of unpleasantness such as boredom, unhappiness, loneliness, restlessness, and criticism from others, 2) pleasurable involvement, which includes pleasure from accomplishments and being excited or interested in one's daily activities, and 3) long-term satisfaction, which is translated as happiness of a more enduring sort.

The above models - biomedical, sociocultural, and psychological - are all characterized by being unidimensional. All of them emphasize only one component of the lives of human beings - their biological, social, or psychological facets - instead of looking at man as a whole.

Finally, there is a cultural approach to health and illness, which has been stressed mostly by anthropologists. From this perspective, each cultural group develops its own medical system in order to deal with problems related to health and illness (Fabrega, 1975). The term "medical system" is used by Foster and Anderson (1978) and encompasses at least two major categories: a disease theory and a health care system. A disease theory system involves beliefs about the nature of health, the cause of illnesses, and remedies and other curing techniques. The health care system is concerned with the ways in which societies organize themselves to take care of the sick and to utilize knowledge of diseases to aid the patient. Actually, the ways different cultures think about disease has assumed such relevance that a new area of knowledge, ethnomedicine, has developed (Fabrega, 1975).

It is within the cultural approach that this review of the literature is primarily based. The relevance of getting families' views

on health and illness can be inferred from the assertion of Steiger and Lipson (1985) that

It does not matter how professionals define health and illness if they do not consider an individual's own personal definitions, which have their roots in his family and culture.  
(p. 6)

### Lay Definitions of Health

One of the first authors to study this matter was Bauman (1961) who compared definitions of health of American patients with chronic disease with those of young medical students and found that people describe health in one or more of the following orientations or dimensions: 1) feeling of well-being, 2) absence of general or specified symptoms, and 3) ability to perform daily activities. The type of orientation varies according to the level of education. People with more education included "freedom from symptoms" more often, while responses oriented to "the feeling state" decreased with education. For Bauman, the emphasis on a particular dimension thus appeared to be affected by factors such as age, education, social class, religious affiliation, and current physical condition.

The relevance of task performance, one of Bauman's dimensions, was also expressed by low-income Americans of age 65 or older (Di Cicco & Apple, 1958), younger groups from 20 to 50 years of age (Apple, 1960), and Spanish-speaking villagers in New Mexico and Colorado (Schulman & Smith, 1963). In contrast, MacDonald (1981), studying the health beliefs and practices of north-coast Peruvians, asserted that, for them, interpretations of health and illness are based on what is perceived through the five senses. If a person looks good, feels well, and can perform daily work, that person is considered healthy. Also, references

to physical signs of body functioning such as sleeping soundly, "sangre forte" (strong blood), a well-fleshed body, good skin tone and color, and a rosy complexion were frequent among the Spanish-speaking population of New Mexico and Colorado (Schulman & Smith, 1963).

In one of the few studies that have looked at concepts of health from a family perspective, Ailinger (1974), in her research on the illness referral system of Latin American immigrant families in the United States, also identified three dimensions of health: physical characteristics, emotional disposition, and behavioral traits (pp. 70-71).

There is some indication in the literature that definitions of health can vary according to the stage of the life cycle. Thus Anchor (1978), studying Mexican-American families in Texas, found that a baby's plumpness is an indicator of good health for mothers. In contrast, aches, pains, and some physical limitations were found as characteristic of old people (Di Cicco & Apple, 1958; Schulman & Smith, 1963). Maloof's (1979) study on Arab-Americans' definitions of health reported similar findings. According to those families, a healthy child has a good color, is happy, and is active. One-third of her sample thought that a healthy child should also have a good appetite. It was generally accepted that a somewhat chubby child is healthy while being "too fat" was not considered a sign of health. In addition, a healthy adult was defined as the one having good skin color and tone, bright eyes, a cheerful, happy disposition, and being active. It was also stated that a healthy adult felt well and strong, sociable, did not complain a lot, was able to carry out his/her daily tasks without feeling tired or weak, slept well, and ate well (p. 114).

To be considered healthy does not always mean to be free from symptoms. For instance, Dunnell and Cartwright (1972) in Britain found that only 9 percent of the adults interviewed and 37 percent of the children indicated that they had had no symptoms in the previous two weeks. The average number of reported symptoms was 3.9. Those who described their health as excellent reported an average of 2.5 symptoms. Only 4 percent of all adults had no symptoms and were in excellent health.

Health as a state of being for Spanish-Americans is one of the most important values that appears with regularity in all institutional contexts and pervades the culture. Samora (1961) stated that even the conventional greeting "How are you?" has a real health meaning; the response is likely to be an account of the respondent's state of being as well as the state of being of those close to him (p. 66).

There are norms, although not stated, that govern people's thinking about health (Miles, 1978). They are usually based on the frequency of the occurrence of a condition. For instance, Sedgwick (1973) reported that hookworm was considered normal in parts of North Africa while spots on the skin are normal in South American Indians (Dubos, 1965). However, standards of normal health and people's expectations can change over time. According to Miles (1978), in western societies health expectations have increased following improvement in the standards of living. Thus it is no longer considered normal for women to die during childbirth, for people to get contagious diseases such as diphtheria or scarlet fever, or even to look at infant mortality as "God's will". In the same way that populations have higher expectations about housing and working conditions, they also desire better health.

In summary, from this brief review of the literature on health, some points become apparent. First, there is a paucity of studies that focus on lay definitions of health and still fewer on families' perspectives. Most of them show that health is translated into more than the component of absence/presence of disease and symptoms. It usually includes physical characteristics and emotional status as well as social performance. Ethnic background has a great impact on the way people define health. There are cultural norms that specify who is normal and who should be considered sick. Although cross-cultural variations exist in the way people define health, differences in the same culture have also been found according to age, socioeconomic status, and level of education. Finally, methods for collecting data on health have ranged from surveys to extensive ethnographies. However, with few exceptions (Ailinger, 1974; Maloof, 1979), they have focused on perceptions of individuals rather than on the family as a unit.

#### Definitions of Illness and Theories of Causation

Authors have made a distinction between illness and disease. At first disease was described "on the basis of deviations of the chemical and physiologic systems of the body" (Fabrega, 1975, p. 971). This concept underlies the biomedical model, and its study and treatment have been traditionally the focus of scientific medicine (Ahmed & Coelho, 1979; Helman, 1978). In contrast, illness designates the socioculturally structured behaviors and interpretations, which are a person's response to the body's events and processes (Mechanic, 1962). While disease has a biological connotation, illness is a psychosociocultural concept (Twaddle & Hessler, 1977) or, as in



Eisenberg's (1977) phrase, "patients suffer illnesses; physicians diagnose and treat diseases" (p. 11). In addition, the literature shows that a disease may occur in the absence of an illness. As an example, Eisenberg cites the case of a person with hypertension in an asymptomatic stage whose doctor becomes alarmed with his high blood pressure. The person, because he does not feel anything abnormal, remains unconcerned and later on may even stop taking the prescribed medication because it makes him "ill", even though he was told the medicine will mitigate his disease.

Illness conceived primarily in terms of "not feeling well" is described as a common explanation among Spanish-speaking people in Peru and the U.S. (MacDonald, 1981; Saunders, 1954). Saunders added that conditions not accompanied by subjective feelings or discomfort are not generally classified as illness; hence, there is no obligation to do anything about them. Furthermore, Larrick and colleagues (1979) found that Waorani Indians of eastern Ecuador allow illness to progress to a state which makes them dysfunctional before they attempt to halt its progress. This same attitude of waiting until a condition is incapacitating before going to the doctor is described by Clark (1970) about Mexican-Americans.

This relationship between illness and performance of daily tasks was also noted by Gordon (1966) who reported that working-class Americans emphasized more than did middle-class Americans the importance of symptoms that interfered with their usual activities. Especially for poor, manual laborers, someone was sick when he could not work.

Maloolf (1979) found that Arab-Americans described illness according to three categories: physical characteristics, emotional disposition,

and behavioral traits. Thus, a sick child is weak, pale, tired, possibly has a fever, is quiet or at least not as active as usual, fussy or crying for no reason, and requires more attention than usual. In the same way, an ill adult is pale, tired, and not too active, besides complaining about pain, vomiting, and dizziness, among other things (p. 115). Freidson (1973), on the other hand, found differences in people's ways of expressing their symptoms. An American working-class person has a very concrete and literal approach to his health, which is based on how he "feels", and the description of symptoms and possible illness tends to arise directly from sensations of pain, discomfort, or incapacity. In contrast, middle-class Americans have a more detached, abstract objectivity to their health problems. They more often define significant symptoms independently of discomfort or even incapacity (p. 288).

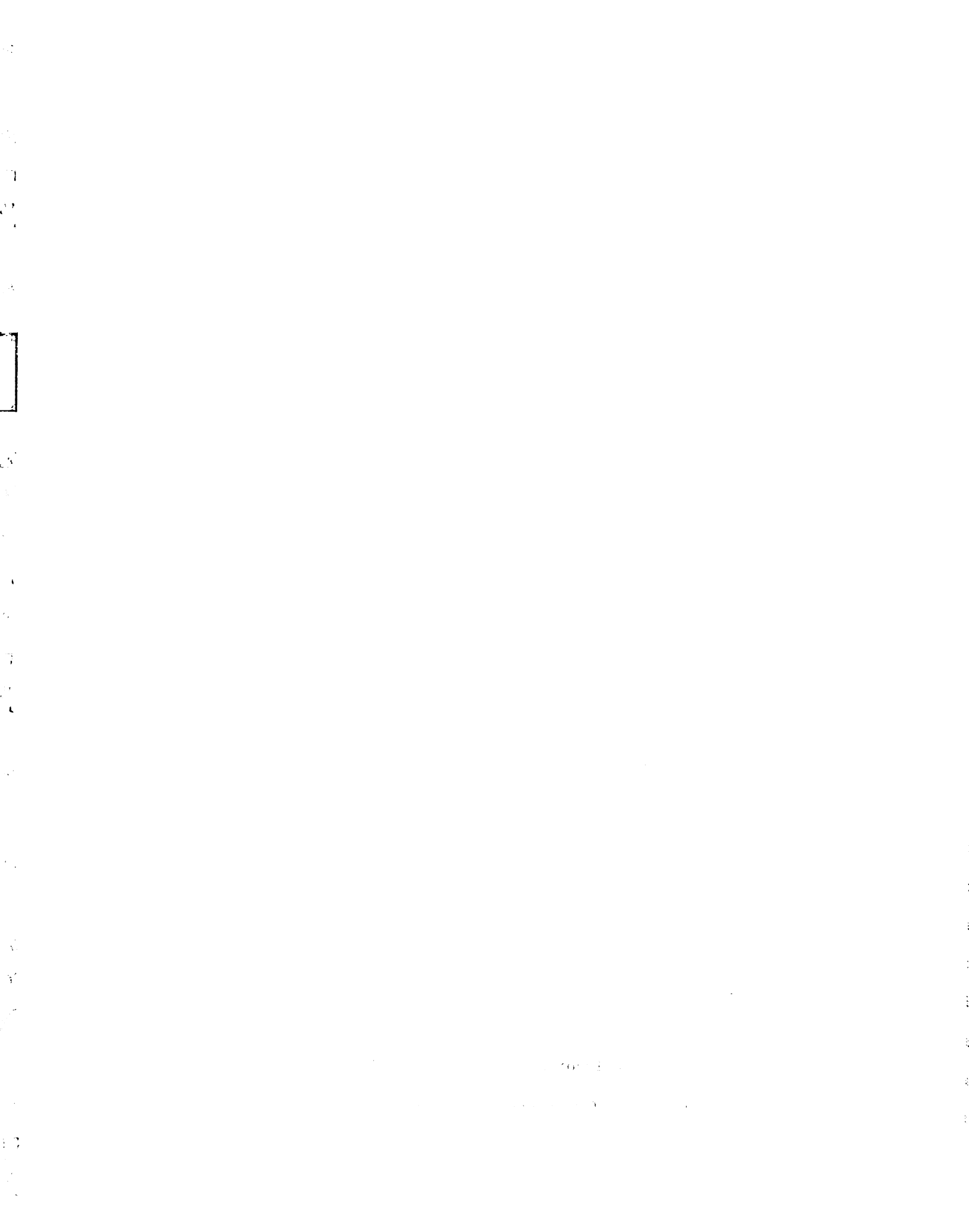
Cassell (1976), after examining over 2,000 tapes of American patients interacting with their physicians, found that people viewed disease as an intrusive object rather than as part of themselves. Diseases and even symptoms were signified by the impersonal "the" or "it" rather than by the personal "my" or "I". Cassell related this with the two major theories of disease: the first is from the perspective of physiologists who follow Hippocrates and believe that disease is resultant from the imbalance between man and his inner and outer environment; the other is from the perspective of ontologists who see disease as an object or thing that invades the body.

Blaxter (1983) reported that Scottish middle-aged women from the lower social class had a puritanical and, at the same time, fatalistic

view of the occurrence of illness. For them, to be ill is a weakness, being functionally unfit, "giving in" to disease (p. 60).

People vary in the way they explain causation of disease. Saunders (1954) identified three etiological factors as causative of disease among Spanish-speaking Americans. First, there are empirical or natural diseases, in which a known external factor operates directly on the organism to produce the illness (exposure to bad air, invasion by microorganisms, eating improper foods). Then there are the magical factors, which are outside the realm of empirical knowledge and cannot be verified (evil eye). And finally there are psychological factors in which a strong emotional experience causes the appearance of symptoms (frights). A similar model was found among north-coast Peruvians by MacDonald (1981). Clark (1970), in her study of Mexican-Americans, expanded this model by adding other causes of disease such as diseases of hot and cold imbalance, diseases caused by dislocation of internal organs, other folk diseases (latido, empacho), and standard scientific diseases, although the cause can be quite different from that identified by health professionals.

Cosminsky (1977) used both survey and case study methods to obtain information about illness concepts and behaviors in a Mayan community in Guatemala. She found that villagers' concepts of illness causation could be divided into 1) conditions that increase an individual's susceptibility and 2) external conditions or forces that act upon this susceptibility. Among the first group the author described 1) the individual's psychological state, which includes work, carelessness, diet, lack of cleanliness, ignorance, pregnancy and giving birth, weak blood, and emotional experiences and 2) social ritual conduct, which



refers to moral and spiritual transgressions such as not praying to God, not honoring ancestors, not fulfilling a promise to a saint or spirit, and having bad thoughts or intentions. External conditions that precipitate illness included 1) exposure to rain, cold, wind, and the seasons, 2) the action of supernatural agents (God, saints, evil spirits), and 3) witchcraft or sorcery. Underlying these two general conditions, Cosminsky found two major principles, strength/ weakness and hot/cold, guiding people's perspectives.

The existence of a hot/cold theory underlying health and illness conceptions and behaviors among Latin American societies is largely recognized in the literature (Foster & Anderson, 1978; Messer, 1981; Rubel, 1960). Hot and cold are not considered in relation to actual temperature but rather to the constitutional essence or innate character of a given item or to a personal state of being. Thus natural objects, foods, and illnesses possess these symbolic qualities and can alter the health of an individual through contact, consumption, or contagion (Logan, 1977, p. 489).

Studies done in Europe also show cultural variations in people's views on causation. Helman's (1978) sample from an English suburban community near London described a folk model of illness that is translated by the aphorism, "feed a cold, starve a fever". For this author, people perceive diseases according to perceived changes in the temperature, as being either hotter than normal or colder than normal. However, these feelings of abnormal temperature change are purely subjective. The conditions where the patients feel "hot" are classified as "fevers" while those in which they feel "cold" are classified either as chills or colds. He also found that there are two principles

underlying this folk model: 1) the relation of man with nature (i.e. natural environment) is present in colds and chills and 2) the relation of man to man (which exists in human society) is present in fevers.

In his sample of middle-aged Scottish women, Blaxter (1983) found the most common causes of disease were infection, hereditary or familial tendency, agents in the external environment such as "specific poisons", working conditions, climate, and dampness. At the bottom of the list came categories of neglect, the sufferer's own behavior, aging, and natural deterioration. In Blaxter's opinion, this model of causation was derived from the women's experiences as they saw them.

Maloof (1979), in her study on Arab-American families, stated that although families were aware of the germ theory of disease and of contagion, as well as the physiological basis of disease, they still held other ideas about the causes of illness. Among these she cited supernatural causes, evil eye, weather and air, emotions, and fright (p. 118).

The nature of health and illness is another aspect of the problem that has been studied by some authors. Saunders (1954), in the study of Spanish-speaking Americans in the southwest United States, found that health is looked upon as a matter of chance and it is felt that there is very little that a person can do to keep it. This point of view is also shared by low-class Blacks in the south of the United States. According to Snow (1974), southern Blacks consider good health as a kind of good luck, in the same way that success, money, or a good job is. Still other authors have made reference to illness being perceived as a matter of fate (Baca, 1973) or as God's punishment (Maloof, 1979; Martinez, 1978; Samora, 1978).

Summary. Briefly, studies on people's definitions of illness and theories of causation share almost the same characteristics as studies on health. First, they are predominantly ethnographies of cultural groups and as such have been directed more toward identifying how people from different cultures have defined illness than looking at how the family as a unit perceives illness. The literature also shows that the Hippocratic theory of disease pervades most of the groups' definitions, not just the Latin-Americans'. However, there are great variations in the ways people use these principles and the significance given to them as causes of disease. It is important to note that the samples in most of these studies were comprised of low-income informants. Koos (1954), in his study of 500 American families, was one of the few who have systematically analyzed the influence of socioeconomic levels on people's perceptions and actions toward health and illness. According to Koos, several forces besides culture operate concurrently and in an integrated fashion to shape families' perceptions; some of these are psychological factors, acceptance by the group, and level of education. In addition, he found that each of the three family groups studied (divided by socioeconomic criteria) constituted a subculture per se.

#### Behaviors to Promote Health and Prevent Disease

The literature on families' behaviors regarding health promotion and prevention is not very extensive (Levin & Idler, 1981; Litman, 1971). Litman is one of the few authors who has looked at the family as a unit and at its beliefs, values, and attitudes toward health. In a three-generational study, he found great variation between the generations and their prescriptions for good health. Among the measures

to keep family members healthy were exercise, diet, fresh air, food and nutrition, and rest. The maintenance of balance between the principles of hot/cold was stressed by Logan (1977) and Saunders (1954). The latter author also referred to periodic purging of the stomach and intestinal tract among the actions recommended by Spanish-speaking Americans.

For Arab-Americans (Maloof, 1979), to enhance health includes both a good emotional outlook or a positive attitude toward oneself and taking care of one's physical well-being. This last includes, in order of importance, good eating habits, cleanliness (personal and environmental), getting enough rest (balance between rest and activity), exercising or keeping active, and attending to health problems when they arise (p. 143). When asked about the importance of annual checkups, dental examinations, immunizations, smoking, drug and sexual education, and circumcision, most (+80%) of the informants recommended these measures with some variations according to age and sex.

The notion of prevention as it is recognized in modern medicine is little understood by Spanish-speaking Americans, according to Samora (1978).

How can one prevent an event, an activity, or a situation from arising when such a phenomenon is a "natural" occurrence, or perhaps of supernatural origin, much like rain, lightening, thunder and, as such, beyond the control of human forces? (p. 68)

Measures, of course, are taken, but they are just perceived as precautionary and not as actions of prevention. Some of these actions include prayers for good health and taking care through acts of omission or commission related to eating, drinking, work conditions, recreation, and even taking shots (i.e. being immunized).



Although prevention, as defined by health professionals, is more frequent among Americans, studies show that this is not the norm for all. In Glasser's (1958) research concerning the use of the Salk vaccine, a significant number of persons in the target group were unprotected. The failure to make use of the vaccine was traced to procrastination or feelings that they were not susceptible to the disease. In addition, those unvaccinated were more likely to be of low income status, with less than high school education, and less likely to belong to a voluntary association. Further, Moody and Gray (1972), studying mothers of children under five years of age and the polio vaccination, found that "social integration" as measured by social participation and alienation was an important antecedent of the willingness of subjects to receive oral polio vaccine.

The use of the annual medical checkup, another type of preventive measure, has also been analyzed, and no great change in behavior and attitude was observed. For instance, half of Koos' (1954) sample could not remember if they had had a health examination in previous months. The families who did remember having a checkup were more likely to be in the highest socioeconomic level. Borsky and Sagen (1959), using a national sample of adult urban population, found that nonwhites, younger people, middle-aged veterans, and lower-income groups were more willing to cooperate on a free health examination. In addition, Hulka (1967) identified that women responded to the suggestion of a friend or neighbor to participate in a cervical cancer program with more enthusiasm than they did to recommendations from others. Finally, in Litman's (1971) sample were found variations between the three generations about the use of annual checkups; the younger families were

the ones who had more health examinations when compared to their parents and grandparents.

Behaviors and attitudes related to prevention and working conditions are a different kind of measure investigated by Suchman (1967) among Puerto Rican sugar-cane cutters. This author used an epidemiological model to study the receptivity of an accident prevention program among the workers. The ones who adopted the use of gloves shared some characteristics: they were married, they were younger than 50 years of age, their parents were in the same occupation, and they had higher income and more education than those who refused to participate in the program. They also believed that an accident could happen to them. Among the environmental influences that affected their acceptance of the measure were more exposure to formal media of communication, higher social participation, and discussion about the program with family members.

A similar finding that authors referred to in most of these studies was the low level of knowledge presented by the subjects on health-related matters (Glasser, 1958; Koos, 1954; Litman, 1971). In addition, the ability of the family as a unit to enhance health and prevent disease among its members was challenged by Litman (1971). According to him, the findings from his three-generational study on families partially supported Parsons and Fox's pessimistic views of the role of the family in health care (p. 67).

Based on a series of studies on health behaviors, Rosenstock (1966) presented a model to account for personal health decisions to be made in the absence of clear-cut symptoms. According to this author, a decision to obtain a preventive or detection test was made only under the

following conditions: 1) a psychological readiness to take action, which depends both on feeling susceptible to the condition and the threat of it having serious consequences, 2) the belief that the action is feasible and appropriate to the person to use, and 3) a cue or stimulus that occurs to trigger the response.

Summary. From this brief review of the literature, some conclusions can be made. First, behaviors to promote health and prevent disease from a family perspective is an area still in need of more study. Peripheral data come from anthropological studies that have explored cultural variations in beliefs and practices about disease and modes of treatment. Furthermore, findings on prevention, as discussed above, show variations on behaviors among cultural groups but also within the same group. The main factors responsible for variations in health and illness definitions are related to preventive actions according to age, level of education, and socioeconomic status. However, there are some other factors such as social integration, feelings of being susceptible to threat, and exposure to formal communication media that emerge only in the literature about prevention.

#### Families' Management of Illness

One of the first aspects to receive attention in the literature about individual's or families' management of illness is the number of health problems or symptoms reported by persons who otherwise are considered healthy. Thus Alpert, Kosa, and Haggerty (1967b) in their analysis of the health diaries of 78 families reported that family life was frequently interrupted by the occurrence of symptoms and actions taken for their relief. The majority of these problems took place

within the family circle, with only a few of them being referred to medical professionals. The literature shows that people perceive symptoms in different ways. For instance, Koos (1954) found that families, when given a list of symptoms, reacted to them according to their social class. As such, families who rank higher in socioeconomic conditions defined more problems needing medical attention than those in the middle or lowest classes. According to Koos, the latter group of families showed a marked indifference to most of the symptoms presented. Mechanic (1964) identified mothers' stress, level of education, and age of the child among the variables influencing families' reactions to symptoms. Mothers under stress tended to report symptoms for themselves and for their children. They also tended to be more concerned with their children's health than with their own. In addition, he reported that mothers with lower levels of education tended to be less concerned about detecting illnesses in their children and taking due precautions.

In a five-year study on health insurance to devise a scale to measure symptom sensitivity, Hetherington and Hopkins (1969) reported that age and religion were also related to symptom recognition. Middle-aged females, those formerly married, and those with a high occupation level were often most sensitive to symptoms. In addition, they observed that increasing formality of religion and higher income were related to highest sensitivity as well.

The decision as to whether an individual is sick or not often occurs within the family context. For Robinson (1971), families use differential assessments, both for what might be termed a symptom of illness and what actions should be taken in response to symptoms. According to this author, certain problems are recognized as illnesses

by some family members while not by others, depending on their social positions. For instance, a sore throat for a singer can be an illness, while for others it is a problem without great significance.

A second type of decision families have to make is the kind of treatment a member has to follow when a symptom or illness is recognized. Authors have shown that, again, a series of factors can influence families' or individuals' decisions. Alpert, Kosa, and Haggerty (1967a) found that different kinds of symptoms determine different kinds of responses (maternal [home] or medical care). This last option was used by families in a very selective way. For Koos' (1954) families, the decision to look for medical care had to compete with other priorities in their lives. As an example he cited one of his informants:

I wish I could get it fixed up, but we've just got some other things that are more important. First, our car's a wreck, and we are going to get another one. We need a radio, too . . . but it's got to wait for now. There's always something more important. (p. 37)

This need to make decisions on health and illness in the light of competing priorities was also reported by Robinson (1971) in his study of families in South Wales.

Families' allocations of resources to health and illness is also related to the level of priority given to these matters. Weeks, Davis, and Freeman (1958) when studying two different socioeconomic groups found that health care was neglected in favor of obtaining other benefits; this tendency was the same in the highest and lowest groups. In contrast, Coreil (1983) described families in Haiti who allocated great amounts of resources for family members with diseases with a poor prognosis. However, they did not do so when the chance of survival was

absent, such as in the case of neonatal tetanus. In addition, families invested more in diseases of older children than for newborns, demonstrating that cost/benefit factors operate with respect to age-specific chances for survival.

The decision to look for treatment can be individual or in a group. Uinga (1983) when comparing migrant urban households and nonmigrant rural households in Nigeria observed that in rural areas, group rather than individual decision-making is the norm. The elders or compound heads have the final say on issues of health care as well as in other issues. In the same way, the active participation of the family unit in decisions about health in Spanish-speaking populations in North America was stressed by Saunders (1954) and Clark (1970).

Besides the recognition of symptoms, family management of illness includes the whole area of decisions about treatment and home remedies. Health and healing practices among five different ethnic groups in Miami were studied by Scott (1978). This study was a comparative research among Cubans, Haitians, Puerto Ricans, Bahamians, and southern U.S. Blacks. Data were collected through different methods: questionnaires, health calendars, participant observation, and interviews. The pilot study showed that each group tended to use the health system somewhat differently. The author also observed that these groups were not moving resolutely away from traditional health beliefs and practices toward scientific medicine. Rather, they combined the two systems - the western and the traditional.

Bahamians' health calendars showed chronic poor health. Apparently the western system was used only for crises. Traditional health practices included the use of herbs and concoctions. The Obeah men

(local curers) were first consulted in case of illness. Bahamians sometimes used the services of southern Black root doctors and spiritual doctors as well as southern Black faith healers.

Cubans used the emergency room less than the other groups, probably because they have Cuban private clinics. Their calendars indicated they experienced less illness than the other groups. They also made full use of the medical resources available to them.

Haitians constituted the most recent group to arrive in Miami. They tended to first treat their health problems with herbs and home remedies. When they moved into the orthodox system, they usually made frequent use of the emergency room.

Puerto Ricans were the group that used the orthodox health care system least of all. They relied heavily on herbs and folk remedies, and their health calendars showed they were less likely than any of the other groups except the Haitians to take action in response to a symptom.

Southern Blacks showed a greater range of variation in their traditional healing system than the Haitians or Puerto Ricans. Home remedies included vinegar and rubbing alcohol more than herbs. The people also used faith healers, spiritualists, and root doctors. In their use of the western care system, Blacks appeared to have numerous but superficial contacts. Half of the sample had attended public clinics during the previous year and 23 percent were seen in an emergency room.

Mothers' and children's utilization of medical services in rural Greece was analyzed by Tzoumaka-Bakoula and Lovel (1983) who found patterns of help-seeking related to socioeconomic levels. According to

these authors, only half of the women had received postnatal care, while 37 percent of the children never had been taken to the doctor in their first year of life and only 31 percent had completed the immunizations for their age. Further, the poorer the family a child belonged to, the older the child was likely to be when he/she would be taken to the clinic. In another study on mothers, Mechanic (1964) described that the decision to seek medical care for children is related to the mother's own pattern of help-seeking. As such, mothers with high inclination to use medical facilities for themselves follow the same pattern for their children.

The whole matter of people's reactions to symptoms and their decisions about treatment was an area of study for Kasl and Cobb (1966), Mechanic (1972b), Mechanic and Volkart (1961), Stoeckle, Zola, and Davidson (1963), and Suchman (1972). Among the factors pointed out by these authors as having an influence on people's decisions about looking for treatment are: 1) the perceived threat of the disease, 2) the perceived value of the action to be taken, 3) pain, discomfort, and disability resulting from the symptom, 4) the commonality of the symptom, 5) its predictability, 6) the cultural background of the person, 7) the availability of medical knowledge, and 8) the person's own tendency to look for health care.

The selection of home remedies as a form of treatment is acknowledged in the literature. Saunders (1954) and Clark (1970) referred to the use of family remedies among Spanish-speaking populations, such as herbs, massages, ointments, foods, types of bathing, prayers, and ritualistic practices. Levin and Idler (1981) classified the family as a system of self-care, with numerous home



remedies used for minor injuries such as cuts, scrapes, bruises, and burns. They also referred to a series of treatments such as vaporizers and bed rest for colds and flu, ointments, compresses, and astringents for skin problems, home surgery for blisters and splinters, kisses and Band-Aids for imaginary "boo-boos", massage and hot-tubs for sore muscles, chicken noodle soup and a "nice hot cup of tea" for anything, hot water bottles and heating pads for menstrual cramps, ice packs for swellings, vinegar douches and yogurt for vaginal infections, and salt-water gargles within the context of self-care.

There is a growing interest in studying the individual or the family as providers of self-medication (Pratt, 1973). Ames and colleagues (1982), after interviewing parents about the use of over-the-counter medicines for their children, reported that 79 percent of the parents would independently medicate their febrile child and pointed out at least ten different types of medications. The knowledge about these medications, however, was not always accurate, with more errors found among parents in the low categories for education, income, and occupation.

The roles individuals play during illness in the family is another area beginning to be assessed. As such, the mother emerges as the most frequent caregiver in illness situations at home. Alpert, Kosa, and Haggerty (1967a) described the mother as being the one who generally decides what symptoms should be brought before a physician, makes all the arrangements for a medical appointment, and also accompanies the sick member to the clinic or hospital. Robinson (1971) added that the mother's role does not stop at that point. She also acts as a home nurse after the consultation because of her responsibility for following

medical orders and prescriptions as well as observing the progress of the patient at home.

Finally, healing, curing, and caring practices of families have not been free from debate and criticism (Parsons & Fox, 1968). For Levin and Idler (1981), family functions in health and illness are dominated by two major themes. First, there is a concern with the efficacy of family practices, which are defended by some and criticized by others. Second, also dependent on the issue of efficacy, is the concern about the safety of families' measures, which raises the whole question about who should actually administer care for the sick members of a family.

In summary, studies on families' behaviors in every-day health and illness situations do not seem to have achieved the same stage of development as those dedicated to families facing serious physical, mental, or chronic diseases. In contrast, these studies are sparse and knowledge is still fragmented. However, from the existent literature it can be inferred that families do face a significant number of health problems at home that require a series of decisions and actions. Data on this area are derived from various methods such as ethnographies, health calendars, questionnaires, and prolonged interviews. Most of the studies have been developed within a conceptual framework that in some way guided the questions to be answered. With the exception of ethnographies, which usually focus on cultural groups instead of on families, only a few studies have tried to identify the family's own perspective on their function as health care providers. It seems reasonable to assume that if health professionals and social scientists discuss the efficacy and efficiency of the family as a unit of health care, the families' own views on the subject must be revealed first. As

such, intensive studies on the families' world of health and illness as have been conducted by authors in different areas (Henry, 1965; Hess & Handel, 1974; Kantor & Lehrer, 1975; Lewis, 1967) are needed before a position can be made or projects for changes in families' health and illness behaviors can be introduced.

### CHAPTER III

#### METHODOLOGY

This chapter is divided in two main sections. The first describes the research design, the sampling process including the procedures for acquiring the families' informed consent, research methods and roles, recording field notes, as well as the methods used for coding and analyzing the data. The second part reports the field experience of this investigator from the time she reached the village and made the first contacts, the problems and questions that arose during her work, until the time she left the field. It ends with a brief evaluation of her role while being a participant observer.

#### RESEARCH DESIGN

An exploratory field study (Festinger & Katz, 1953) was the design selected to approach health and illness conceptualizations and practices of Brazilian families. This design was chosen because the actual knowledge of cultural factors affecting family health care in Brazil is an area that has yet to be systematically researched. Therefore a design which emphasizes discovery of ideas, enhances new insights, and allows the study of different aspects of the phenomenon (Selitz et al.,

1976) should be recommended. It was also my intention to get the information directly from families in their own environment. A field study was the most favorable design to achieve this goal because it allows the researcher to be present in the setting where families' behaviors naturally occur, that is, at home (Blumer, 1969; Polit & Hungler, 1983; Schatzman & Strauss, 1973). Also, a field study design would enable me to capture the meanings which health and illness have for Brazilian families. This aim of getting the insider's views or, as stated by Malinowski (1922, p. 25), "to grasp the native's point of view, his relation to life, to realize his vision of his world" would be best maximized by using this kind of design.

#### Selection of the Sample

The process of sampling involved both the selection of the community where the study would be developed and the families who would participate as informants.

Selecting a village. Since the beginning of my graduate studies I had decided to do my research with Brazilian families living in the state of Santa Catarina, in southern Brazil. As such, during summer vacation of 1981 I went to Brazil to talk with faculty members from different departments of the Federal University of Santa Catarina about my interest in looking at cultural factors affecting health and illness. They all advised me to choose one of the villages on the island of Santa Catarina for two major reasons. First, because of their proximity to the university campus, I could get any help I might need. Secondly, the results of my study could be used by the university to plan future programs for the community. These aspects, added to the short period of

time I had in which to collect the data, made me accept their suggestion.

Having made the decision to study one of the forty-two villages that form the island of Santa Catarina, I had three options from which to choose: 1) a very traditional fishing or agricultural village where the access is so difficult that I could only get there by boat or horse, 2) a village which is still traditional but where the effect of modernization is beginning to affect people's life styles, or 3) a modern village near Florianopolis, the capital of the state. This third kind of village has changed dramatically over the last twenty years. Most of them have elegant houses where rich people spend their summer vacations and where fishing as an economic activity has lost its significance. I opted for the second alternative because of my interest in studying a community whose economic base was still relatively untouched by changes in technology. Also, its easy communication with a larger center would guarantee the protection of my personal health.

After visiting some of the districts included in this second type, my final choice was Solemar (Sun and Sea), a comparatively homogeneous community of 2,463 people (IBGE, 1980). This village, unlike others, has a clear-cut division between the area used by beachgoers (Areias beach) and the fishing village itself. It is linked to Florianópolis, the only city on the island, which is also the capital of the state of Santa Catarina, a few kilometers away. This fact of having easy communication to the urban center also would give me the opportunity to observe how much influence Florianopolis has had on the village and how much interaction occurred between the two.

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Selecting the families. Because an intensive study of all families would not be feasible in a period of six months, I decided to select families who were going through the same stage of the life cycle. It was expected that families in the same stage would probably present some similarities regarding health and illness situations. All families who met the following criteria were contacted:

1. Nuclear families whose members were all living in the same household.
2. Families whose oldest child (ages 6-11) was in school. This upper age limit was dictated by two factors: one, the researcher's intention of not including teenagers, who may elicit some specific problems related to this stage in life, and two, the interest in interviewing at least one child in each family.
3. Families where both parents were at least a third-generation Brazilian and who had been living in this village for at least four years. This criterion followed from the investigator's aim of studying families who shared the same environment.
4. Families who were free of any disease condition in the form of either chronic or other impairments that would require special medical treatment.

Access to the families. Initially, I planned to select the families by following the traditional way of first getting well acquainted with a few of them who would in turn introduce me to other families. However, I realized after two months that this process, which was very time consuming, would never uncover in four months the number of families I needed.



Then I decided to change the technique and asked the school principal for a list of all children between the ages of six and eleven enrolled in the school. With the help of the principal, teachers, and students, a list of the parents whose oldest child was within this limit was finally compiled. Included in this list were 30 families whose children were eleven years old and were studying either in Solemar or other villages. This was possible because the principal knew all the families and had a record of previous students. Only one of these families was obtained by referral.

After completing the list, the second step was to locate the families, which was a difficult job because the village has many small streets without names or numbers. This locating, which was not a problem for the villagers because they had known each other since childhood, took me almost eight weeks. Again, with the help of the children, friends, neighbors, and people from the local school, I finally located all the families.

My next goal was to visit each family to check the study criteria: type of family, age of the children, years living in the village, ethnic background, and absence of chronic disease. Of the families contacted, five had to be dismissed from the study because they had been living in Solemar for less than four years. One family was not included because of the husband's serious drinking problem which prevented some home visits. Of the twenty-four families left, only two rejected participation in the study. The first one, the only non-Catholic family, did not explain their reasons; the second one claimed that the mother, who worked downtown, had no time at her disposal. At the end of this stage I had twenty-two families who agreed to be my informants.

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During the months I visited the families, none of them withdrew their consent. On the contrary, most of them were waiting eagerly for the scheduled weekly visits, creating a friendly atmosphere in which to conduct interviews. However, I did face some problems, mainly with two families. Although our relationship was good, I had to rearrange my scheme of working. With the first family I had to change the time, place, and subject of the interview according to their needs. For example, most of the interviews occurred either in the backyard while the mother was washing clothes or on the bus when we were going downtown. The second family, despite always treating me very well, often changed the agreed-upon schedule of visits. I could have adjusted easily to the problem had the family lived near the village. However, I had to walk fifteen minutes just to arrive at their place and would find no one home. This would eventually make me waste more than half an hour at least three times a week, sometimes under rain, south winds, and high tides.

Confidentiality and protection of human rights of the families.

During the entire period of field work I was conscious that ethical questions could appear at any point of the field work (Rynkiewich & Spradley, 1976). In order to prevent some of them, some measures were taken. First, I introduced myself in my actual role as a nurse, a faculty member of the university, and a student at the University of California, San Francisco and explained to the villagers the purpose of my study. Second, the families when first contacted were not pressured to participate in the study and were told they could withdraw at any time if they so wished. I explained to the families that the home visits would occur only during the day at a previously agreed-upon time.

They were told that they could ask me to leave the house any time they considered my presence to be intrusive. They were also assured that I would maintain all the information in secrecy and would preserve the anonymity of the families at all stages of the study.

Furthermore, an informed consent written in Portuguese was read aloud by me to all the families. After this they were asked to read it again carefully and the father, mother, and oldest child were asked to sign it (Appendix A).

The problem of informed consent in a community unaccustomed to it and where only one's word is enough to secure agreement became clear in my study. I had no difficulty explaining how I would protect their rights and guarantee the confidentiality of the information: rather, my problem was to clarify why I had to take all these measures, including the written informed consent. From all the explanations I gave about their rights, the one accepted the best was that this was a requirement of the American university.

### Methods

Information was gathered from three main areas: the village, the medical system, and the families. The methods used to generate information were participant observation, photography, and in-depth case studies.

Participant observation was the methodology considered best to meet the study requirements. According to Denzin (1970), participant observation is a commitment to adopt the perspective of those being studied by sharing in their day-to-day experiences (p. 185). The unique characteristic of this method of combining a variety of data-gathering

techniques such as direct participation, observation, informal interviews, and document analysis, among others, contributes to the adequacy of participant observation as a research methodology for the study of the present problem.

As such, I observed people's behaviors while going to the local school or health-care facility, visiting the families, or just walking on the beach and watching fishermen at work. I asked informal questions about the villagers' lives and common events of whomever wanted to talk with me. Thus I talked with retired fishermen at the restaurant or at the "venda" (a mix of grocery and bar), with old women at their windows or on the church steps, and with children and teenagers who were playing with, or just teasing, others. I also conducted more structured interviews with the local authorities, curers, and health workers.

Participant observation, besides being used as a method for collecting data, was also employed as a role or set of behaviors in which this investigator was involved (Pearsall, 1965). According to Gans (1962), the investigator can assume three different types of role: 1) observer, where the investigator just observes the event, 2) participant observer, where the investigator participates in the event as a researcher, or 3) participant, where the investigator abdicates his role and becomes a "real" participant, and only when the event has ended the researcher goes back and analyzes his/her own actions.

At the initial stages of the field work, my position was clearly the one of an observer. This role, I believe, was dictated by my lack of knowledge of villagers' habits and customs and my desire to be socialized into their ways of living. Another factor that made me

consider being an observer rather than a participant was my not living in the village. The daily commuting to and from the city always made me feel like an outsider studying the village.

Moving to Solemar was the main event that changed my role from just being an observer to being a participant observer. At that time I began to be involved in religious festivities by taking part in such activities as cleaning the church (as all women and teenagers did), selling things at the booth, and eating "churrasco" (a traditional kind of meat) with the villagers and their guests. But at the same time I was taking pictures of the ceremonies and all events going on, asking people to explain their meaning. I was also active in the organization of school parties, helping the teachers, talking with parents, and having fun with the children's plays. During the mullet season, I accompanied women, old people, and children to the beach to observe the fishermen catching fish and rejoicing with them when the net was full. But I also had to follow a daily routine like other women, such as cleaning the house, killing cockroaches, catching rats, washing clothes and hoping they would dry before the weather changed, going to the grocery, or just wasting time at the local "venda" waiting to be served.

In most of the activities I was conscious of my role and my research purpose, and people were aware of my intentions. Many times I was invited to go with them to learn how everything was done at the village, and if anyone asked who I was, they would reply, "She is the faculty member who is studying our village to write her dissertation."

On the other hand, there were times I almost forgot my role and freely participated in the villager's life. This occurred mostly when I was invited to go to Canoas, a nearby village, to pick fruit or go to



someone's house to eat fried bananas and drink coffee, or while sitting on the steps of my house talking with Da Osvaldina (my neighbor) about our children. It was only later on, when I was describing my day in the daily report, that I would look back on our conversations and analyze them as a researcher.

Going native was one of my concerns, mostly because I was a Brazilian, too. In order to prevent this, I took some measures. The first one was to introduce myself in my actual role of investigator and to make clear the purpose of my stay in the community. In addition, I went away some weekends to visit my family and to have a few meetings downtown with faculty members from my university. I think that most of the time this scheme worked out well. However, I could not prevent my feeling close to the villagers. This could be clearly identified in my angry reaction when someone on the bus going to or returning from downtown would criticize the village or its inhabitants.

Besides participant observation, I also made use of photography. At the beginning of my study I just used photography as a tourist would to document the physical and environmental characteristics of the village. Later on, as I got used to the camera and as people knew me better, I began to take pictures in a more systematic way to record fishing activities, children at play and at school, religious festivities, or just people at work. People accepted my taking pictures of them. I always asked their permission before I took them and explained that they could get a copy if they wished.

To study the families, the investigator used the method of case studies. For Polit and Hungler (1983), case studies are intensive investigations of an individual, group, institution, or other social



unit (p. 200). This method was selected because it is less structured, more informal, and allowed a more holistic and in-depth view of the families over a period of time. Thus the family's past health history, their daily activities, and their experiences through the weeks were better explored through this technique. In addition, it offered the opportunity to ask the same questions in different contexts so that some indication of consistency was also obtained.

### Collecting the Data

Village. According to Brownlee (1978), if someone intends to gain understanding of a community, he/she has to learn the visible parts of the culture such as types of housing, food, and dress as well as the cultural values, attitudes, and traditions which are not always so obvious. Based on Brownlee's work, an outline was developed to direct the collection of data related to the physical, sociodemographic, historical, and cultural elements of the village. This guide, with the dimensions to be researched as well as the techniques employed, is presented in Appendix B.

While the concept of health and illness was not the main focus of this part of the study, the information collected here was fundamental for understanding the physical, socioeconomic, and cultural environment where they naturally occur.

Medical system of the village. According to Foster and Anderson (1978), each culture has its own medical system that embraces all beliefs, actions, knowledge, and skills pertaining to health promotion, disease prevention, and treatment. This system involves at least a disease theory and a health-care system. In collecting data about the

medical system, the investigator observed and interviewed both health practitioners and local healers as well as lay people. She also visited the health facilities, consulted statistics about morbidity, identified the different programs offered, and observed the daily activities of the clinic. The outlines used to guide this part of the study are described in Appendices C and D.

The families. The families were visited at home at least once a week. There was a variation in the number of months each family was interviewed and observed at home. The first families contacted were followed for almost three and one-half months while the last families contacted were only followed for one and one-half month.

At some point in the study I became interested in knowing if there were differences between parents' and grandparents' views of health and illness. This idea occurred to me after perceiving the closeness between these two generations. My interviews were very well-accepted by the older generation; however, I did not have enough time to do all the interviews I wished. I talked with only ten grandparents, usually widowed grandmothers. Among them I had an extensive interview with the only first-generation non-Catholics who, besides being grandparents of one of the children from my study, were also parents of one of the families who refused to work with me. Table 1 presents the main dimensions investigated during the home visits as well as the different techniques used to get this information.

#### Recording the Data

Since the beginning of my observations at the local school, I started to write my notes on the spot. I did so for three reasons: I

TABLE 1

Outline for Studying the Families

Dimensions	Description	Techniques
Sociodemographic information	Family members by age, birthplace, level of education, occupation, ethnicity, religious orientation	Interview, based on Bott, 1971 and Friedman, 1981 (Appendix E)
Family health history	Information on grandparents' health, age, occupation, marital status, birthplace, abortions, number of children, and their health status	Interview using a genogram, based on Jolly, Froom, & Rosen, 1980 (Appendix F)
Family structure and functioning as related to health practices	Division of labor, distribution of power, communication patterns, rituals, taboos and symbols, values, with emphasis on health and illness situations	Direct observation and informal interviews, based on Clemen et al., 1981 (Appendix G)
Family health and illness definitions	Health: Definition of a healthy person, things families recommend to maintain health and prevent disease Illness: Definition of a sick person, causes of diseases, health problems the family face	Semi-structured interviews (Appendix H)
Management of common health problems	A list of common health problems was discussed with the families in relation to causes, treatments, sources of help	An initial list, based on Spector, 1979, Schatzman & Olesen, 1982, was presented to the families who asked to add other health problems (Appendix I)

TABLE 1 (continued)

Dimensions	Description	Techniques
Family health practices	A description of the health status of each member at the time of the visit, with an explanation of the cause for each problem, treatment sought, and sources of help if asked or given	This information was asked every time a family was visited (Appendix J)
Housing conditions	Type of building, heating and lighting conditions, number of rooms, kitchen and bathroom facilities, water supply, presence of specific health hazards	Observation, informal interviews (Appendix K)
Food patterns	A description of all food and drink taken in one full day for each family member	Informal interviews
Leisure activities	A report on which leisure activities the family performs as a group and which are done individually	Observation, informal interviews
Women's daily activities	Each mother was asked to describe the activities she performed on a typical day	Informal interviews
Intergenerational views on health and illness	Grandparents and children were interviewed on health and illness subjects to find out how they viewed health and illness.	Informal interviews

had the time, nobody seemed very concerned about me, and I was tremendously afraid of forgetting something very important. So, I wrote when seated on the wooden benches at the schoolyard, in the restaurant while waiting for the food, or on the steps of the church while waiting for the bus. After doing this for two months, I think people got used to seeing me with the notebook and pen, and I was accepted like this. When I was interviewing a family, they would look at me to check if I were really writing while they were talking. In cases where they did not want the information to be part of the study, they would just say, "Don't write this down; this is only between us."

I was happy that people accepted me writing on the spot for two reasons: first, later in the study when I had many families to visit each day, I did not have the time to make notes after each visit; also, I would not have been able to recall all the conversations later in the evening.

If I did not have any problems with writing in front of them, my tape recorder was a problem. When I asked them if I could tape our conversation some would say it was okay but were still uneasy, and others would say they did not like to listen to their recorded voices. After a few trials, I soon gave up and used it only to tape public ceremonies and traditional songs.

### Types of Field Notes

From the beginning of the study I described in a daily report all my activities, people I met, thoughts, reactions, problems, and decisions I had during the day. I usually began it in the morning and ended it at night at home when I had finished all my other notes. I did

not follow any special plan in doing it; I just tried to be faithful to myself and to my study. I first wrote in a book-like notebook, but later I just wrote each day on a different loose page. This was easier because it occupied less space, there was less danger of losing it, and I could write at any time and place.

Besides this, I had for each family an envelope in which I kept their name and a code number plus, in chronological sequence, all the visits made. Each interview had a small section at the end called "Observation" where I wrote what I saw during the interview, the scene and interactions between family members, informants, and researcher, and my own reactions and impressions. This was done just before I left the house or, sometimes when this was not possible, I wrote some basic points of reference and finished at night at home.

Information related to the health-care system and to school functions was also maintained in separate envelopes so that each new bit of information could easily be added at any time. I wrote the notes on different pieces of paper according to the subject I was observing or studying. I found this method the easiest way of organizing the data and keeping my writing up to date. All my field notes were handwritten because most of them were done on the spot. I did not have time to type all of them at night, which I sincerely regretted when it came time for coding and analyzing the material.

The notes, initially written in Portuguese, soon were translated into English. After some weeks I just wrote directly in English, maintaining the native language only in cases I thought were important or when I just could not find the right meaning in English. I did this for two main reasons. First, it was taking me too long to translate,

but most of all because the children were very curious about my notes, and I was afraid they would come to my home and read them. Thus, doing the field notes directly in English would prevent any disclosure of information.

#### Assuring Reliability and Validity of the Data

Reliability refers to the extent to which a specified procedure yields consistent observation of the same facts, from one time to another and from one situation to another (Seaman & Verhonick, 1982). The measures taken in this study to control for its reliability included:

- the use of multiple techniques for eliciting families' information such as observations, interviews, photographs, and genograms (Langness & Frank, 1981);
- weekly visits to the families over a period of time to minimize the risk of informants assuming a false position (Lewis, 1967);
- collecting the data from different members of the family - the husband, wife, and at least one child - in order to get a sense of the family;
- checking and rechecking the families' positions on different issues over time to watch for inconsistencies (Denzin, 1970).

In contrast, validity is a judgment of the extent to which a component of research - the method, scale, instrument, or measure - reflects the theory, concept, or variable the researcher intends it should (Seaman & Verhonick, 1982). According to Denzin (1970), the different factors that can jeopardize the internal validity of a study are subject bias, subject mortality, reactive effects of the observer,

changes in the observer, and secular aspects of the situations in the study. In order to minimize the reactive effect of her presence, this investigator tried to develop a relationship of trust with the families. She was also conscious as much as possible of the existence of her own reactions and, because of these, she kept a diary and notes regarding her participation in, reactions to, and feelings about each event under study. In addition, she used some techniques for not "going native". Her introduction as a researcher and faculty member of the Federal University of Santa Catarina was one of them. Further, contacts with her peers at the university and occasional visits to her family also helped to prevent this problem.

To have some control over the situation itself, the investigator always kept notes not only on what was happening, but also information about the setting, the number of participants in the situation, and their interactions. On the other hand, control over changes in the informants, because of maturation or other effects difficult to identify, was made through observation of families' behaviors and reactions during the interviews, which were systematically recorded in the field notes.

For verification of external validity, the investigator first selected as many families as possible within the criteria established for sampling. She also looked for variations in the sample, such as using families from all socioeconomic levels, differences between generations, families who were more inclined to use the scientific medical system, and those who preferred folk treatments.

Last, the investigator was also aware of the issue of establishing the credibility of her study (Glaser & Strauss, 1967; Schatzman &



Strauss, 1973). Thus the categories and themes labeled during the process of collecting and analyzing the data (see the following section) were checked to see that they were derived from the original field experiences and represented the families' points of view accurately.

#### Analysis of Data

In analyzing the findings, this investigator used a thematic approach based on the work of Clark and Anderson (1967) and Spradley (1979a). The concept of cultural themes was first introduced by Opler (1945), who found it useful as a way to understand the general pattern of a culture. Spradley (1979a) defined a theme as "a cognitive principle, tacit or explicit, recurrent in a number of domains and serving as a relationship among subsystems of cultural meaning" (p. 186). Themes are considered to have a high degree of generality, being applicable to numerous situations and being easily accepted as true by informants. According to Spradley, people do not express themselves easily, even though they know the cultural principle and use it to organize their behavior and interpret experiences (p. 188).

In order to identify the themes, this investigator used the following strategies.

Immersion in the data to look for recurring patterns. This strategy was initiated during the process of data gathering and continued for some months after. It consisted of listening carefully to families' descriptions, asking questions, participating in the cultural scene, and reading the field notes. At this point, the transcriptions of families' responses were read and examined for folk terms that recurred with some frequency. These regularities, representing

patterns, were sorted into preliminary categories. Spradley (1979a) defined a category as being "an array of distinct things that are treated as if they were equivalent". For instance, informants' references to winds, coldness, rains, and sun as causing diseases were all included under the category of weather and climate conditions. In the same way, eating too much, eating heavy foods, and mixing certain types of food were classified under the category of food and eating patterns. This process of categorizing the data was repeated for the four main areas of research: families' definitions of health and illness, causation of disease, preventive measures, and management of illness situations. At this point, the investigator worked back and forth between the data and the classification system to verify the meaningfulness and accuracy of the initial categories and the placement of data in these categories.

Making a cultural inventory. This stage included at least four different activities. First, the preliminary categories were reassessed and then grouped into broader categories, also called domains. For Spradley (1979a), a domain is any symbolic category that includes other categories. As such, all the members of a domain share at least one feature in common. In the process of discovering a domain, the emphasis was given to similarities among folk terms. For instance, in the present study, the categories of weather and climate and food and eating patterns were coded under the domain of natural causes of disease, while others, such as evil eye and souls of the dead, were included in the domain of supernatural causes.

Secondly, this investigator made a list of all domains, some including a large number of categories and others with just a few, for

each of the four research areas in an initial attempt to find relationships among the domains. At this point, some similarities and consistencies began to appear between domains in some of the four areas. For instance, the presence of natural, supernatural, and scientific sources appeared to a greater or lesser degree in the causation of diseases and preventive measures, as well as in the families' management of illness situations.

Besides the list of domains, the investigator reviewed maps of the village, location of the houses, the sketches on the health histories of the families, and photographs. Further, she began to make diagrams representing the steps families followed to make decisions about treatments, the mothers' daily activities, eating patterns of the families, and the ways in which the families dealt with health and illness at home. This gave an opportunity for some initial insights on the internal processes occurring within the families.

A final activity at this stage was the selection of examples. According to Spradley (1979a), an example always gives details and specific facts of the situation (p. 193). In selecting examples, this investigator had in mind to show the similarities as well as the differences between families' reports. She also tried to include at least one example from each family in the research report. A concern for depicting perceptions and actions of all the informants led to the inclusion of tables where reports from all 22 families are represented at least once for each major question. At the end of this stage, some initial themes began to emerge from the data and were added to each area.

Making a schematic diagram of the cultural scene. Once categories and domains as well as emerging themes were identified, the researcher searched for relationships between the domains and the emerging themes. The use of schematic diagrams was very helpful at this stage. Thus four different kinds of diagrams were developed. The first was intended to answer the question, "What are the families' perceptions and actions regarding health and illness?" Within this context, a second diagram explored the relationships between the families' definitions of health, theories of causation, and preventive and curative actions in an attempt to identify linkages and inclusiveness. A third diagram looked at the families' ways of dealing with health and illness at home. The purpose of this was to find the internal processes within the families when they faced health and illness situations and how they were interrelated. The intent of the last schematic diagram was to depict the family in its relationships with the outside world. At this point, all the possible connections the families had with other systems such as school, jobs, reference groups inside or outside the community, and health care were analyzed as well as their impact on the families. As a result of this process, the themes that initially emerged independently at the end of each question were consolidated into fewer and broader family themes.

## THE FIELD EXPERIENCE

This is a brief description of the main steps followed by the investigator in her field work. They are presented here to show some of the joys and difficulties of participant observation in a natural environment.

### Preparation to Enter the Field

The first arrangements for me to enter the village were made months before I left California at the end of November 1982. I contacted two friends on the faculty of my department at the university in Florianopolis to arrange for an informal visit to Solemar to meet and explain to the principal of the local school, the physician, the priest, and the mayor my intentions of studying families' views on health and illness for six months. I also asked them to look for someone who was interested in helping me find a place to stay. Da Ana, the school principal, offered to look for a house and asked for my family's address and telephone number to contact in case she found something. At that time, July 1982, there was no house available, and the principal said it was going to get more and more difficult as the summer vacation approached. Usually, families that would normally have a room to rent had their relatives coming to visit during the summer.

Accustomed to living in cities where it is easy to find a place to stay, I did not fully realize that this could be - and was - a real problem for someone doing field research. I was sure that I could find a place, at least a room, in which to live. Only later did I see that

the houses were not only very small but also lacked privacy and, in some cases, bathroom facilities.

I spent my first week in Brazil meeting faculty members of my university who gave me information on the village and on the best way to begin my study. Through the Public Health Department I became acquainted with a study on immunization done by students in Solemar two years earlier. The Nursing Department was developing a health education program for teachers at the local school as part of one project that involved the Federal University of Santa Catarina, the Ministry of Education and Culture, the Public Health Department of Florianopolis, and the local Secretary of Education. This project, according to the nurses I contacted, had the main purpose of improving the health of the children through preventive programs at the local school and health clinic.

I met twice with the nurses working on this project. First they explained the project and the activities in which they were engaged: a study on herbal treatments and the training of school teachers on health and illness matters. Since they were curious about my research and how it could overlap with their own work, I told them the objectives and methodology I intended to use as well as the sample I wanted to study. I also explained my role and intention of working independently of the health and education systems.

#### In the Field: Arrival and First Contacts

Once the purpose of my study and my future activities were clear, we began to work on the best way of researching the community and the problems I should be prepared to face. In the nurses' opinion, I should

begin my contacts with the local principal and the physician, who were best suited to introduce me to the village. Among the problems they anticipated I would probably face was the great number of people working with the community who were also asking questions. Such people included a group from the government (comandos sociais) who worked with the elderly to learn their needs, public health professionals doing a survey on nutrition, health, and illness practices, and a group interested in identifying elements of the culture that are beginning to disappear. However, the most serious difficulty they thought I would encounter would come from my not offering any practical services. At this point I was asking myself if it would be a good idea to move to another village. But I knew that both problems would also be found in another community. At the end of our discussion, feeling a little bit afraid, I decided that the next day I would go with the nurses to their meeting with the local teachers in the village.

The morning was beautiful and hot when we came to Solemar. The trip by car made me sleepy, but as the nurse announced our proximity to the village, my eyes became wide and alert. As we got closer, I identified the tower of the church, some houses scattered in the valley, a few people taking care of the cattle, and the high evergreen mountains surrounding the village on three sides. To me, the sight of the blue skies in contrast with the green of the vegetation and the almost deserted village gave me the impression of being in a quiet, beautiful countryside. I could even feel the fresh, pure air, so different from the pollution downtown.

As we approached the center of the village I saw a few beachgoers dressed in bikinis going toward the beach. A barefoot fisherman, with

his pants rolled up to his knees and wearing an old coat, was coming back from the sea with some fish. Another man in his fifties was sweeping the street. He wore shorts and Hawaiian sandals, with a big hat to protect his head against the hot sun.

The architecture of the small village called my attention to its cultural and economic differences. The old church was clearly constructed in the last century, as were the small houses to its right, with their windows still made of wood. To the left sat a new, out of place, two-story building - the parochial house, said the nurse. Across the street a yellow new school was being constructed, with part of its fence material already fallen down. Again, the nurse informed me it was the bus driver who did this a long time ago when he was turning the bus around, and nobody had rebuilt it yet. At the back of the school was the health clinic and the "prefeitura" (city hall), both sharing the same building near a nice modern pink house. I could see a little bit in the distance, but still in the main street I saw a new, big, two-story white house and, just in front of it, an old dilapidated house in the same Portuguese style of the two buildings near the church.

I was a rather impressed by the contrast between the high mountains near the valley and the flat scene, the smooth green pasture and the crystal white sand dunes of the beach, the countryside and the ocean, and the modern and old architecture. However, the serenity lying over the whole place made me feel at ease and curious. The first thought that came to my mind was "I will like living in this village" (daily report, December 1982).

We went directly to the school where the nurses introduced me to Da Ana, the principal. She took me to one of the classrooms because her



office was full of people waiting for the weekly meeting. Da Ana, a short, dark-skinned lady, received me with a smile, saying she was happy to finally meet me in person. At the same moment I felt very comfortable and explained in a few words my study, its purpose, and basic methodology. It was a very noisy place because the children were playing and singing near our door. In addition, we were interrupted many times by teachers who wanted to know about the meeting, by the maid who asked about lunch, and by curious children who came just to look at us. After studying three years in the United States, where appointments are considered private business affairs, I felt some difficulty in maintaining the conversation while all those things were going on. But this was not the case with the principal. She answered all questions, solved the problem with the maid, sent the children away, and told me she liked my study and wanted to help me. However, she foresaw a problem in finding a place for me to stay.

While we were talking about my plans, the nurse returned with a young, blond, and beautiful woman, Da Marta, the local physician. I asked the principal for permission to describe briefly my study and its goals to the physician so we could discuss it together. Da Ana agreed, saying that she would leave us for a few minutes to complete some job and would join us again later on. So she did. At the end of our meeting, they both agreed that if I wanted to know more about the village I should live there. They also recognized, however, that it would be difficult to find a place because the summer season was just starting. Anyway, both told me they would talk to friends and acquaintances to see if something were available. Regarding my work,

they advised me to begin with the school or the health clinic because they were the best places to meet prospective families.

During our conversation the physician explained to me about the questionnaire on home treatments (herbal teas) which two nurses, a nutritionist, and herself recently gave to the villagers for the project on culture and health education. They asked for my help in writing the report. I said I would gladly do it because this was one way of getting more information on local modes of treatment.

It was almost noon when the physician, who works in the afternoon at the nearby village of Pedras, took me for a visit to the health clinic. She introduced me to the nursing aides and told them I was coming to observe the clinic functioning and that I would have access to the charts, statistics, and daily reports as well as any room I wanted in which to write my notes. The way I was treated, without any formality or bureaucracy, and their trust made me feel as good as I did at home. At the end of the morning I was sure I had met two people who were interested in helping me, at least during the first stage of my study. But this help continued for the whole six months I lived in the village.

I made my decision to begin my observation at the local school for two reasons. First, the classes were going to end in three weeks and I was interested in meeting children and some families before the summer vacation (almost three months). Second, I wanted to maintain my identity separate from the local health professionals. By choosing the school, I expected villagers would see me first as a nurse coming from outside and doing an activity different from what they normally saw nursing aides perform.

Entering the Field (December 10, 1982 to February 10, 1983)

During this period, I went every morning by bus to Solemar and returned at the end of the day. Initially I was living with a couple of friends, but I soon realized that I needed to stay alone in the evenings to write, think, and plan my activities for the next day. I also felt I should not be distracted with things or people who would take my mind away from my study. Thus these same friends offered me a small, one bedroom apartment where I lived until I moved to the village.

The first three weeks I spent my mornings at the school, observing teacher/children interactions, parent/school communications, children at play and at lunch, teachers at work, and the maids' activities of preparing the meals and maintaining cleanliness at the school. In addition, I always had some time just to chat with the principal and her son (he was working as her secretary), to drink coffee, and listen to the children telling me their stories.

When the classes ended at the end of the month, I went to the health clinic to observe its functions. I asked the clients about their health problems, watched their behavior, and listened to their conversations. I also observed health professionals' activities and their interactions with their patients.

At noon, when everybody went home, I went to a restaurant to have lunch. After a first experience with a restaurant near the beach, with modern Brazilian music and filled with beachgoers drinking and eating, I chose the only remaining restaurant, not so close to the beach but far more useful for my study. There, while waiting for the meal, I could write my notes, observe the interaction between the few beachgoers and the waiters, watch the street, and talk with the fishermen who stopped

there to have a drink before going home. Sometimes I would just look at the beautiful view of the green ocean with its three islands, the colorful boats, and the blue sky. Only a few people would take a chance and walk in the sun between noon and 2:00 pm. When I was well-known in the restaurant, whose owner was related to one of the village families (I discovered this after some time), they gave me a special price because I was a frequent customer. They would also prepare special foods they knew I would like to eat or would just share their meal with me, which was usually better and more varied than the menu.

After I became acquainted with some families, they began to invite me to eat with them at their homes. These were my best meals, not only because I began to feel accepted, but also because they knew how to prepare fish a thousand different ways.

In the afternoons I had different activities. First I went to the school until vacation began. Then I began to visit the local clinic, which was very calm without the physician and dentist. Clients would come in, a few at a time, asking only for curatives, for treatments of infections, for inhalations, or just for information. I spent my time observing the nursing aides at work, writing my field notes, and participating in people's conversations. There was always one of the health worker's friends or relatives who stopped by to gossip about the latest events. We also had the bus stop in front of the clinic, which usually became a good center for conversation.

On the days I knew something different was going on at the local library, I would go there. Thus I took sewing classes with Da Joseana, a recent widow and a religious leader in the village, and met some of the women who later became my informants. I also went to the old

people's meetings with the "comandos sociais" and talked to them about my research, and they told me what it was like to get old in a fishing village.

Another choice for my long afternoons was to explore and photograph main points of interest. I always had someone interested in showing the beautiful places surrounding us, such as the nearby mountains, the waterfall, the fountain where women once washed their clothes, the rocks near the ocean, and the beaches. This was a difficult task for me because my young scouts were full of energy, wore appropriate clothes and shoes, and never got tired. I had to face the mosquitoes, the hot weather, my fear of snakes which I knew were there, and my lack of experience in walking on rocks or through forests. Considering all these factors, I think I did a good job because I did not let down my small friends and always remained until the end of our excursions through the village.

Usually I returned to Florianopolis on the 5 pm bus, a daily adventure in itself. The bus leaves Solemar almost empty. Only a few villagers who work downtown on night shifts take the bus at that time of the day. But five minutes later, in Pedras, all the beachgoers who came in the morning to spend the day at the beach were ready to go home, too. Different from the morning, they were wet, their bodies covered with sand, and some of them were drunk. There were a lot of them, small children with their mothers and old people, but most of them were teenagers. They nearly fought while waiting for the bus because they did not stand in line and everybody wanted to be the first one to board the bus and find a seat. The bus collector observed the men and shouted loudly that they must wear their T-shirts (not a word was mentioned

about having dripping clothes, being barefooted, or being drunk). When all the people packed inside the bus - double its capacity - the driver began the journey downtown at an incredible speed. His radio was turned on and all the passengers had to listen to the program because of its volume. People began to joke about everything, the driver, the music, even themselves and others. There was always an argument with the money collector, who never had change. Passengers got mad at him because, they said, he purposely did not bring enough money so that he could keep their change. Finally, after a harrowing hour's drive, we arrived alive in Florianópolis. When I got home I felt exhausted, wishing only for a warm shower and some rest, knowing that tomorrow it would begin all over again.

#### Moving to the Village (February 10 to April 1983)

Finding a house was difficult. One day in December, while talking to the principal, I told her about the problems I was enduring from not having a place to stay. She offered that I stay in her house but I knew it would be impossible because that would make, with the addition of me, four people in a house with only two small bedrooms. Then she decided to explain my situation to the students, asking for their help. Next morning a boy came in and told Da Ana that his family was going to move to another place and his mother wanted to rent the house. Not believing how easy it was, I wanted to talk with his mother right away. Lourdes, one of the school aides, went with me to show me the house.

The house, which was only a few minutes from the school, was the fourth in a row of five. The lady, very young but nonetheless a mother of four, told me that her husband, a policeman, had been transferred to

Guaraiba, a city far from Florianópolis (about three hours by bus). They wanted to move there, and their house was almost ready. She told me she could not make any decision about renting the house, that I must wait for her husband who would come only on the weekend. I said it was all right. I was feeling happy, and I liked the location.

The house seemed ideal for me. I wanted some privacy, but at the same time I did not want total isolation. I saw some children playing around, teenagers working, and old people everywhere. And the house was almost new, with three bedrooms, dining and living rooms, a nice bathroom, and a large kitchen.

When I returned on the weekend to talk with her husband, the situation was not as good as I had expected. Their new house was not ready yet and probably would not be ready until March. Feeling a little frustrated, I said it was all right. Meanwhile I would try other places. If I found something else I would give up this house, but he should still talk to me before he rented it to someone else. In the end I waited more than two months to move into the house. Another alternative, which I turned down, was to stay in a friend's house in Areias beach. Besides being too far from the village, I would not have the opportunity to share in the villagers' daily life. I could also rent an apartment at the parochial house owned by the local Catholic church, but villagers did not think it safe for a "woman who lives alone". Finally, on February 5, I moved to my new home in the village.

In order to give a sense of how daily life on the first day really was, I will transcribe directly from my daily report.

February 7, 1983 - I woke up at 7:30. I had a good night's sleep, although I was a little bit afraid of staying alone in this

big house. Today I decided to stay at home to clean it, and besides I had to wait for my bed from downtown. There is no way of finding furniture here; I have to buy everything downtown.

I was beginning to put some order to my things when two children came to see the pictures I took of them at school. We talked for a while and then they left. Later on, Da Ana came to tell me how much she and Da Joseana made on the last church feast. It was approximately \$210, and to her that is a large amount of money. She also told me her brother, wife, and the oldest child went downtown today for a blood test for syphilis, The physician required the test when the last baby was born with this disease. Da Osvaldina, the lady who lives in front of my house and mother of the policeman who rented me the house, came also, and we began to talk about the Sunday procession. For her, the procession on the beach with the boats would have been more beautiful if it had not rained.

Around 10:30 a.m. I went to talk with the man who cleans the street to find out what days the truck collects the garbage. He explained that it comes Monday, Wednesday, and Friday, but I had to bring it around 9 a.m. near the beach because the truck does not pass by this street. I forgot to ask the reason. (Later on I was told that the truck driver had a fight with one of the villagers living on my street, and since then he decided not to pass by here any more.)

I began to clean the kitchen shelves, which were full of cockroaches. Marianinha, one of Da Osvaldina's daughters, came to



help me a little bit. It seems to me everything here smells of cockroaches.

One of the things that is bothering me is the two small goats. When I am least expecting them, they come in my kitchen, over my sink, or in my living room. I am afraid they will eat my field notes. I was told these animals eat everything they see. There are also dogs and a cat around the house, but they have not tried to come in yet.

14:30 - My neighbor's grandchildren and her youngest son, who is 8 years old, are now playing near my house. I can hear them crying "the goat, the goat", and all began to run. I went to the window, but I cannot see them anymore. Then I decided to go back to the kitchen to work. Marianinha, who was with her grandparents at the back of my house, saw me cleaning and came here to help me again. We killed more than twenty cockroaches. I was nauseated, but she was firm. She knows how to do the job. I felt ashamed because she is only 15 years old. She also killed a small frog in my kitchen. When we finished we sat for awhile to rest and we talked about her life, friends, "hippies", and drugs. Marianinha is going to study downtown because only there they have high schools. I asked her opinion about the hippies, who are living near the village, and she said, "Some are good, others take drugs."

In the evening she came back to ask if I wanted to go with her mother for a walk on the beach. I knew I should go, but I said I would go next time. I was really tired from cleaning the whole day, and besides, I had just killed another small frog and a big worm I found in my bedroom. This was enough killing for one day.

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Marianinha decided to stay with me. She told me her foot was painful and red. I tried to see what was wrong with it, but in that light it was almost impossible. I told her to leave her foot for some minutes in warm water with soap to clean it, then maybe she would find something. She brought a basin with water and washed her foot in my living room while we were talking. After half an hour I saw a small thorn. She told me she would ask her sister to take it out. Finally, around 9:30, she went home.

One thing that amazes me is the way they take care of the old couple living at the back of my house. They are 76 and 78 years old. She had a stroke and cannot walk any more. Da Osvaldina's husband and sons built the small house for them to feel at home. But Da Osvaldina's daughters and sons have to do everything for them; they wash the old lady, take her to the bathroom, clean the house, wash their clothes, and cook the food. Because Da Osvaldina has many children, some married and living in different houses throughout the village, others still at home, everyone has a task in caring for the grandparents. If they are not doing any specific job, they just enter, sit on the bed, and chat with them. Today they brought one of the nursing aides to measure the lady's blood pressure and reinforce the need for maintaining the special diet the physician prescribed. [End of the daily report]

It did not take long to adjust to my new life, with my new friends and neighbors playing a significant role in helping me with this. Rapidly I learned that in the morning I had to open all the windows for fresh air and to put out the bed clothes to get the sun. This was also the best time to wash clothes if I wanted them dry by afternoon. I also

learned how to look at the moon, sea, and the trees to determine any change in the weather and which kind of wind would blow in the next hours. In addition, I found that if I wanted soft bread I had to go early in the morning to the grocery, and Friday was usually the best day to get nice fresh meat. And the garbage could not wait two days for the truck to collect it because the ants, rats, and cockroaches would eat it before then, so I had to burn it every day and bury the leftover fish. The house also had to be swept at least two times a day because of the sand and earth brought inside by the wind and by shoes.

There were other things which I did myself: boil the water for drinking, go downtown to find different vegetables and fruit, and buy powdered milk in order to always have milk in the house. Furthermore, I established a routine, which I communicated to everybody, that in the evenings I would do my paper work. I also was very careful with what I said; I always wondered at how fast news could spread throughout an entire village that had only one telephone.

By the middle of February I was very well-acquainted with my neighbors. I had more friends, but still the number of families for my study was too small. I felt I needed to do something urgently because I was running out time and I knew I was ready to begin a more focused study. After thinking about different alternatives for recruiting families, suddenly the idea came to my mind of using the school as the point of reference to get the sample. And I was sure Da Ana would help me in this process. The scheme of identifying the families through the students proved to be useful; this was the way I got almost all the families.

Thus a new stage in my field work began. Suddenly I had more things to do than hours available in the day. Besides my role as housekeeper, neighbor, and friend, I now had home visits to do. Besides visiting the families which already were part of my sample, I had to establish a good rapport with the families that were just beginning to be interviewed. In addition, I had the work of identifying and contacting all the other families from the school list to explain my study and to ask for their consent to participate. Furthermore, I had to find the best way to keep my notes in secrecy while still maintaining each family's information as separate but easy to manipulate. I was just overwhelmed with all the things I had to do.

#### Entree to the Families (March 10 to May 30)

This was the most interesting and most difficult period of the whole study. I was waking up at 7:00 am and going to sleep at almost midnight; sometimes I fell asleep over my notes. There were some factors that contributed to this busy stage. First of all, there were a great number of visits to make. I had to do forty-four visits from Monday to Friday, mostly in the afternoons. This soon proved to be impractical, so I needed to make some changes in the methodology. Furthermore, I had my old friends, neighbors, and people at the church, school, and health clinic who were always claiming that I was forgetting them and that my new acquaintances were taking me away from them. To maintain these old contacts took my time and energy, too.

One of the things that really interfered with my field work at this stage was the bad weather. Most of the days it was raining or very

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windy. This prevented me from doing some visits because of the mud and water in the streets and made other visits very difficult because of the distance and location of the houses. There was also the problem of my health. I, like all the villagers at this time of the year, had to endure colds, fevers, and sore throats, which twice sent me to the doctor.

It was also at this time that I started to interview the oldest child of each family, and I began to realize some differences between generations in relation to definitions of and behaviors in health and illness. This prompted me to add a new piece of information to the study; by interviewing some of the grandparents, I would determine their own experiences and views related to health.

Another significant event which took place during this period was the beginning of a special season for the fishermen and villagers. This was the time of catching mullet, a very tasty and desirable fish for Brazilians. Everything in the community spins around this theme. Women, children, and old people all interrupt their work to go to the beach when they hear fishermen crying out that it was time for the "lance" (catching the mullet). And I had to go with them, first, because they wanted me to see it and, second, I wanted to document this whole ritual from the catching of the fish to the counting, weighing, selling, and distribution of them among the fishermen and the villagers. This was a very special time in their lives which I could not miss. On the other hand, it also was one of the causes of my being overloaded with information and work.

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### Going Back (June 1983)

Suddenly, just when I was feeling adjusted and it seemed to me I was getting some work done with the families, it was time to return to the United States. Although I had been preparing since May to leave the village, the last two weeks were very painful for me. To say goodbye to all the friends I had made, to thank the families for sharing their lives and secrets with me, and to separate from my caring neighbors was a difficult task for me. For three days I was just going to their houses, drinking coffee, eating a piece of cake specially baked for me, or trying for the last time a piece of mullet, receiving their pictures as a memory and promising I would send a card from San Francisco. My heart was heavy with sadness. I was leaving the village and these good people, but I was also leaving my own country again!

It was a beautiful, sunny morning when I left the island. Villagers said God made it specially for me to have a nice and safe trip. When the plane circled around the whole island and I saw Solemar for the last time, my eyes were full of tears.

### Evaluation of the Field Work

#### Problems I Faced During the Field Work

Although I would say my field work went smoothly, I did face some problems during the six months I lived in Solemar. Some of them came from my inexperience in doing participant observation and not having the anthropological background most field workers have before studying a culture. Others were related to the situation itself. But the most difficult problems were those involving ethical and moral aspects.

Among the first type of problems I include my initial fears of not being accepted by the community and not finding the families for the study. I also list in this category not planning enough time to type the field notes and not developing a more systematic way of doing a preliminary analysis. A more serious situation that could have endangered the whole study was the fact of not having a duplicate copy of my field notes. I was always conscious of the risk of losing my notes and, for this reason, when returning to the United States I carried them all the way on the plane in a handbag with me. I put in the luggage only some pictures, my notes regarding the last day at the village, and the bibliography in Portuguese. To my chagrin, all my luggage was lost at the airport in Los Angeles and I never recovered it. But at least I saved my field notes.

Among the problems that interfered with my study over which I had no or very little control was the weather - which was first too hot and then heavy rains, the difficulty of finding a house, the gossip, and the invasion of my privacy. I know that gossip occurs all over the world, and I was expecting to find it in the village also. However, my fears increased when, after doing some of the family histories, I identified most of them as being related by blood or by religious ceremonies (godparents). This feeling worsened when I found that information between friends and relatives was exchanged freely after my visits. I felt just terrified by the idea that if one of the families should drop out of the study, I could lose all of them. This overreaction of fear made me watch my words for almost three weeks and made me act in such a way that I did not feel I was myself any more. Finally, tired of controlling my reactions and tired of being

artificial, I decided to be myself again and face the consequences, which in reality never happened.

I also had the problem of lack of privacy. It was not to the same extent as Bowen in Return to Laughter (1964), but I had my watchers also. First, my neighbor next door and all her children always wanted to know which family I was going to visit, the reasons for my coming home late last night, or my plans for the weekend. If I had visitors at home, they would come to be introduced and tell how they cared for me. At lunch time there was always someone to see if I had enough food or to bring a special dish for me to eat. The children of the whole village controlled my steps, too. They would come to visit me at any time of the day, walk with me when I was going to visit a family, sit with me when I was waiting for the bus and, as I later discovered, would look through the window when I didn't open the door. This problem of not feeling free initially made me very angry, and sometimes I would go downtown just for a change. Later on, maybe because I got used to it or just because I was so busy with all the families, this was not a big problem any more.

But my greatest concern was related to ethical and moral questions. Although I had read about ethical problems in the field, I think an investigator is never totally prepared because each study presents unique challenges in this area. For me, the first problem arose when I realized the socioeconomic differences between me and my informants. It was very difficult for me to see the children eating bread and drinking black coffee while I had milk, cheese, margarine, and jam at home. It was difficult for me to go to bed at night knowing that near me people were cold and getting sick for lack of blankets. I knew I could not

solve their social and economic problems, nor was this my role, but I did what my conscience told me to do. Sometimes I would bring fruit, milk, eggs, or vegetables to some of the families more in need. I brought a toy, candies, chocolate, or coke when visiting a sick child, and I gave clothes as presents for birthdays, Christmas, and Easter. Some of the smaller children I referred to the food program at school or the health clinic, or even downtown. But this was sporadic and no family at any time gave me the impression of waiting for my gifts. On the other hand, I always accepted what they offered to me: a cup of black coffee, an artificial juice, an egg, squash, or tangerines. I knew it was important for them that I should receive these in exchange for what I gave to the children. Exchanging goods is a rule in the village. I never felt as if these gifts were being offered as payment for their information, and I am sure this was true for them, too.

There was only one family who asked me to lend them some money to buy food. I did it twice, and after this I always gave food instead of money. I thought maybe they would not work with me any more, but that did not happen. They would pay my ticket at the bus or send me fresh fish, which I usually accepted.

Another difficult situation was my feeling of "using people" for my study. Despite making clear my objectives since the beginning of the field work, I think people never considered me only as an investigator. By giving information they were sharing part of their lives, which they did only to friends. I was sure about this because many times I observed their interactions with strangers, which was totally different from the way they treated me. This feeling of using people became more evident to me every time I moved to study a different aspect of the

community, which required that I make new acquaintances and leave some others. I never found the right answer to this dilemma.

#### Problems I Did Not Have

The first big problem foreseen by the nurses, which could have come from not offering any concrete kind of help, never materialized. Only a few people asked for my professional care or advice, which I always gladly gave. But I recognize that some kind of help was given, although not the type my colleagues were expecting the villagers to ask for.

My home visits to the families had in common the questions about health and illness, but my relationships with each one of them was, in my opinion, unique. There was the family who was just waiting for me to finish the usual questions to tell me the news about the children, their jobs, and the latest gossip. To another couple I was one of the few or maybe the only person with whom they could freely discuss the family's internal problems. To another I was the right person to discuss sexual education, almost a taboo subject in the village. As an outsider, I could understand the feelings of rejection felt by one of the families not born in the village. Because of my travels I could give information on other ways of living to a very curious family wishing to expand their horizons. Thus, despite not having any specific role besides being a researcher, the families and the villagers in general soon found ones for me.

Another problem I had expected to face was from my being a single mother in a small, traditional Catholic village. From the beginning I explained my marital status and answered their questions honestly. But soon this seemed not to interest them any more. They accepted my

daughter very well whenever she came to visit me at Solemar and invited her to go to their homes, to the beach, to dances, and so on. This gave me the opportunity to meet the teenagers and to learn more about their perspectives on the village. After some time I discovered their parents were more interested in knowing how I was educating my daughter than in my marital status. And if I had any doubt about my being accepted by them it disappeared when I saw them allowing me to take their adolescent children out at night to the beach, to parties, or to other villages nearby.

#### Being a Woman Doing Field Work in a Traditional Village

I am sure that being a nurse, a female, a mother, and not very young accounted for my being accepted easily by children and families and justified my presence in almost every place. However, I found some difficulties in dealing with the opposite sex in situations outside the family environment. Generally, husbands at home were very talkative and would discuss any topic with me, from politics and the socioeconomic situation of the country to drinking problems, drugs, and even their fears. But outside the home, when they were usually in male groups working at the beach, drinking at the grocery, or even on the street or at the bus, rarely would one of them talk with me unless I asked a question. In public places only boys, teenagers, or old men would come talk voluntarily with me. I observed this fact during all my study, and I think it happened not because I was a researcher or outsider but because of my sex. In this village a woman is expected to be with other females, not with males.

### Studying One's Own Culture

I was always reminding myself that I should look at everything as if it were new to me and that my purpose was to try to understand the villagers' point of view. Even though I had been living for three years in the United States and never before stayed in a fishing village, I think the simple fact of being a Brazilian led me to identify sometimes with my informants, which did have some effect on the study. Sometimes I found myself taking for granted some of the explanations instead of asking "probing questions" (Schatzman & Strauss, 1973) or "contrast questions" (Spradley, 1979b) and having to go back and ask more questions.

## CHAPTER IV

### CHARACTERISTICS OF THE SETTING

This chapter describes the village - its physical, cultural, and sociodemographic characteristics, the health care system - both ethnic and scientific, and the families' sociodemographic and housing conditions.

#### The Island of Santa Catarina

Solemar, one district of Florianópolis, is located on the island of Santa Catarina which is part of the state of the same name. The state of Santa Catarina occupies an area of 95,483 square kilometers, which corresponds to 1.3 percent of the country of Brazil, and has a population of 3,629,000, according to the census of 1980. Santa Catarina is situated in the south of Brazil (see Map 1) and shares boundaries to the north with the state of Parana, to the south with Rio Grande do Sul, and to the west with Argentina; to the east lies the Atlantic Ocean.

When Brazil was discovered in 1500 by Portugal, the state of Santa Catarina was populated by Indians (Cabral, 1950a). The few Indians still remaining in the state are concentrated in reservations such as the Xoklengs in Ibirama and the Kaigangs and Guaranis in Abelardo Luz. Today Santa Catarina, as well as other parts of the country, is known

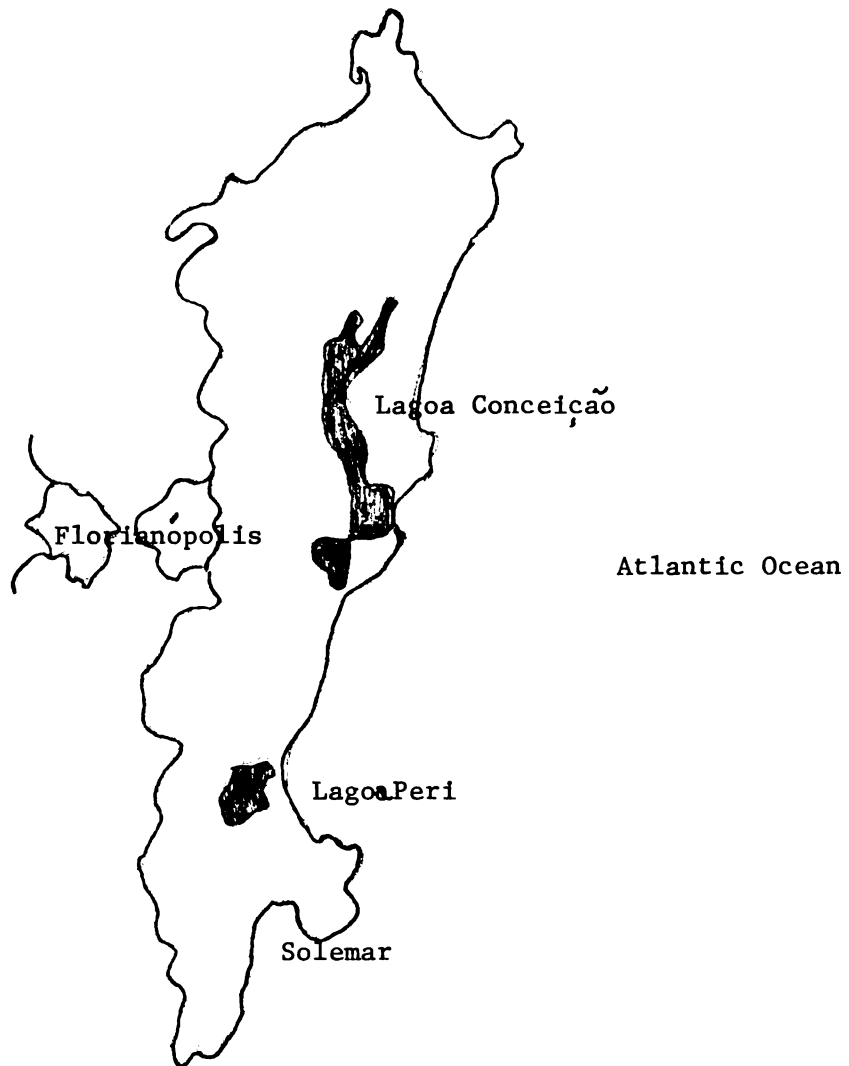




MAP 1: The States of Brazil

for its cultural and ethnic diversity (Coelho dos Santos, 1971). The north and northeast of the state, with its industries, are predominantly Germanic. The agricultural area in the south and west is marked by the Italian culture. Finally, the east coast near the Atlantic has Portuguese characteristics.

According to Cabral (1950a), the island of Santa Catarina (see Map 2) was first inhabited by Carijós indians. The first white people to arrive on the island were the "Vicentistas" (from São Paulo), who came in the 1600s. However, it was Açoriano families (from the Portuguese islands of Açores and Madeira) who actually began to colonize the island. In 1748 the first families were sent to Santa Catarina in order to populate the island. The purpose of Portugal for sending the



MAP 2: The Island of Santa Catarina

families was twofold: first, the islands of Açores and Madeira were overpopulated and people lived in very poor socioeconomic conditions. In addition, it was important for the kingdom of Portugal to make sure that the land, newly discovered, was populated by Portuguese. This was necessary because of constant attacks by Spaniards in the south of

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Brazil, who claimed the land (Piazza, 1959). Families came with specific instructions to build their houses along the roads, leaving a square in the central part of the village for the construction of the church and a plaza. The first villagers coming to the islands adhered to these main characteristics, which can still be recognized today in Santo Antonio, São Francisco Xavier, Nossa Senhora do Conceição, Nossa Senhora da Lapa, and Rio de Miguel Tavares, among others. Further, families kept to the activities they knew best, such as agriculture, fishing, and raising cattle (Coelho dos Santos, 1962-63).

Up to the present, the population of the island and most of the rural area is made up of descendants of the Portuguese. The influence of this culture is present in the architecture (Silveira de Souza, 1981), economy (Beck, 1979; Coelho dos Santos, 1971), habits, customs, music, handcrafts, and folklore (Soares, 1979).

At present, the rural area of the island is going through a series of changes. The state of the economy has not been good for the past several years. Villagers face serious problems due to the lack of resources and money and because of equipment too old-fashioned to face the challenges of new technologies required by the increasing development of the state. Furthermore, this area is going through dramatic changes. The growing movement toward urbanization of the beaches and the presence of tourists are rapidly changing the picture of the villages and the people's way of life (Beck, 1979; Halfpap, 1980).

According to Coelho dos Santos (1971), one of the cultural characteristics of the villagers is to be family rather than community oriented. Decisions are made in terms of the needs of the family. The nuclear family is considered the unit of production, and division of

labor has a definite gender connotation. Men (father and sons) are responsible for the farming and fishing activities. Women take care of the house and the yard, where they plant vegetables, fruit, and coffee (Beck, 1979). They also make lace at home, a product highly valued by tourists. This activity has an important effect on the family's budget. According to Soares (1978), this kind of craft is a female's work that has its origins in the Portuguese islands. Girls learn it from their mothers as early as the age of six.

The language spoken on the island is Portuguese, as in the rest of the country, but with a special accent. Analyzing the villagers' language, Seixas Neto (1972) asserted that they speak as fast as in Portugal but with a musical pronunciation. They use many words that have the same meaning as in the 16th century, which sometimes makes it difficult for people from other areas to understand them.

The folklore of the island has been subject to intense study in the past few years, as the villagers represent a culture that is beginning to change. The songs, dances, and religious rituals can be found in the works of Ferreira de Melo (1950), Soares (1979), and Cascaes (1981). The study of folk medicine has also attracted the attention of social scientists, but not to the same extent as other areas. References to health and illness are found in proverbs and mottos (Boiteux, 1950) and are still commonly used, such as: "to spill salt or oil brings unhappiness and/or illness", "to sleep with the feet turned to the street means death", and "to lose teeth means that a relative will die".

The language used by lay people in medical clinics was studied by Cabral (1950b) who described not only the words but their meaning in the medical world. Some examples of these are "mother of the body"

(uterus), "nature" (genitals), "busy" (pregnant), "health" (menstruation), "widower" (sty), and "constipated" (cold).

People's explanations of disease are varied. Cabral (1977) referred to "mau olhado" (evil eye), which can cause economic problems, disease, and even death. As preventive measures, people wear charms and "breves" (small cloth sacs that contain prayers, animal teeth, or images of saints). Cascaes (1981) reported cases of "encosto" (a soul of a dead person would stay in another's body) and witchcraft. It was believed that a witch (usually a woman) would suck the blood of small children (p. 135). The words "embruxar" or "empresar", according to Cascaes, mean to attack a person with something bad through the means of a witch, werewolf, or an enemy (p. 87). Among the diseases frequently found on the island in its earlier days, Cabral (1977) and Cascaes (1981) described malaria, tuberculosis, syphilis, diarrhea, snake bites, and intestinal parasites.

Traditional as well as western medicine are found side by side on the island (Cabral, 1977). According to this author, each one has its own practitioners, philosophy, and modes of healing. Among the treatments referred to by Cabral are African magical rituals, sorcery, prayers, and herbal teas. An extensive study of the types of teas, their use as treatments, and their effects is found in Soares (1978) and Cascaes (1981). Herbs and plants are used as both preventive and curative measures. Cascaes also described the treatment for "bichas" (intestinal worms), which consists of a cataplasm of peach leaves on the child's feet. This would prevent the worms from going to the child's throat. Garlic is also used, not only for treatment of many problems but also to prevent witchcraft. The authors also referred to different

types of blessings (prayers to God, the Holy Mother, and the saints) used to treat problems such as "erisipela", "sol da cabeça" (which is believed to be hypertension), and "mau geito". Coelho dos Santos (1962-63), Cabral (1977), and Cascaes (1981) mentioned folk practitioners such as "benzedeiros(os)" (one who blesses) and "curandeiros".

### Solemar

Solemar is located on the southeastern coast of the island of Santa Catarina. It is on a bay situated between two lines of hills, the Afogados and Iracema on one side and Lagoa on the other. The district is formed by four small villages: Sertão, Canoas, Areias Beach, and Solemar. According to the 1980 census (IBGE, 1980), the total population of the district was 2379 inhabitants, with 1523 living in the rural areas and 856 living in the urban area of Solemar. A breakdown of the population into age groups shows that 50 percent of them are under 19 years of age, 40 percent are between 20 and 49 years, while only 10 percent are above 50 years of age. This distribution shows that one of the demographic characteristics of the Brazilian population is its youthfulness, characterized by high birth rates (36 per 1000 population) (New Britannica, 1983) and high death rates (Dourado & Coelho, 1980).

### Economy

Solemar's economy is built around fishing. There are two main local companies that own the best-equipped boats and hire villagers to work for them during the fishing season. In addition, there are also fishermen who own their own boats or who share them with relatives, but in these cases the boats are usually smaller and lacking in modern

technology. The monthly production of around 30 tons is sold in part to the local establishments for the villagers' and tourists' consumption, but most of it is taken to downtown (Florianópolis) markets in refrigerated trucks belonging to the two companies.

To work as a fisherman involves both knowledge and skill. A fisherman's knowledge includes the types of fish, seasons in which to catch certain types of fish, types of boats, weather and climate conditions at sea ideal for each type of fishing, types of nets, techniques required for catching each type of fish, and the places to fish. Second, a fisherman has to be skilled in the different types of fishing because each season has its own characteristics and requires different methods of fishing. Fishermen also have to have good health, strength, and the courage to survive bad weather and the sudden dangers the sea offers to seamen with ill-equipped boats. A fisherman's life is made up of beach activities as well, such as cleaning, repairing, and painting boats and selecting, making, and mending the different types of nets. In addition, seamen also need to know how to do business. This includes keeping up-to-date with prices and negotiating with the local establishment and the tourists. It also means knowing when not to sell fish and just to clean and salt them until the prices go up. Finally, to be a fisherman requires a spirit of working in a group. Fishermen depend on each other for pushing the boats, helping in the fishery, and for exchanging goods in times of need.

Fishermen have their own private society where no women are allowed. Usually after lunch or on windy and rainy days, men go to the "ranchos" near the beach to rest, talk, tell stories, work, or do business. During this study, the investigator never saw a woman or girl



go **inside** the ranchos, but small boys were allowed to accompany their **fathers**. Every time she asked what they did at the rancho, she would get **answers** such as "I was sleeping", "I was repairing my boat", or "We **were** just talking". Fishermen also share a common social activity. **Most** of them, after fishing, go to the local grocery to drink "cachaça". **Some** drink moderately, just to warm up after the cold sail, while others **drink** more heavily. They usually stay in small groups near the counter, **talking** and discussing their daily life at sea.

Local commerce is very limited. Besides the three local **establishments** where the fish are sold, there are only four small "**vendas**", a type of grocery. However, prices are higher than downtown **and** there is not much selection. These groceries are usually owned by a **family** whose members work as clerks. As such, these groceries are not **sources** of jobs for villagers. Most of the local people would buy their **monthly** groceries at downtown stores and utilize the local "**vendas**" only **for** the most urgent articles. In addition, clothing, furniture, **appliances**, and even the thread for making lace and nets have to be bought **outside** the village.

There are only two restaurants in Solemar; one is open the whole **year** while the other is open just during summer vacation. They are **used** exclusively by beachgoers and tourists. Local families do not **frequent** them, unless the fishermen go there for their daily drink.

Raising cattle takes place only on a very small scale. A few **families** own three or four cows which produce milk just for the needs of **the** family, close friends, and relatives. Villagers do not own **pastureland** and do not even have adequate and sufficient space for their

cows which, at the end of the day, return to the small backyards close to the villagers' homes.

Public service is another source of employment, although not very extensive. As such, there is the street cleaner, the fishing supervisor, nursing aides in the local health center, and the teacher and school aides. Most of the jobs offered by the government are available only in the city and require the local people to commute to Florianopolis daily.

Lace making, an important woman's activity as reported in the literature, is declining nowadays. Although many women can still be seen sitting on the floor of their homes making lace, they do not consider it a significant source of family income anymore.

Villagers are turning more and more to the city to find new jobs, primarily those that require less skill, such as clerks, aides in hospitals, or in public organizations. As a local authority told this investigator, "Solemar was once self-sufficient; now it depends basically on Florianópolis."

### Education

There are three public schools in the district, two run by the county and one located in the urban area which is run by the state. They offer only the first four grades of elementary school. During the period of this study, Solemar school began to operate a kindergarten for children between the ages of five and six. Families who want their children to continue their education beyond fourth grade have to send them to Pedras or to Florianópolis. According to the principal, all children in the village go to school at the age of six or seven, and

most of them complete the four grades. In addition, statistics show that almost 80 percent of the population - both rural and urban - know at least how to read and write (IBGE, 1980).

Villagers, mostly of the younger generation, consider a high school degree as a condition for getting a better job today. Thus, families do their best to send their teenage children, both boys and girls, to public schools in Florianópolis. However, the number of young villagers who get into the university is still insignificant. Only a few apply for the competitive examination that selects students for the university. During the time of the field study, only one villager was already in the university and another one failed the exam. The most important reason for this small number seems to be the lack of resources and a lack of preparedness. Villagers claim the low level of the elementary schools their children go to as the main reason for their low achievement in high school and failure in the exams for the university.

Solemar's school operates with local teachers, some who come daily from other nearby villages and those who come from downtown. Some are called "hippies" because of their long hair, strange clothes, and manners and behavior that are not always accepted. Parents react, saying, "How can this kind of teacher teach hygiene to our children?"

Another source of discussion among local people is the new program the local school is developing in conjunction with health and cultural institutions. According to this program, principles of hygiene and basic health care are being introduced in the curriculum, as well as notions about the significance of retaining the elements of a culture that is beginning to disappear. Within this context, children are taught how to make lace and nets, and old songs and tales about Solemar

are remembered. Not all parents are happy with this new orientation. They say, "Instead of learning how to write and to read, they are wasting their time with this kind of thing. If we wanted our children to learn about fishing and making lace, we would teach them at home!"

Also, the local school offers a meal program that includes, besides the daily meal, teaching the children how to plant and take care of a vegetable garden in the backyard, as well as cooking classes for the girls. In general, the children seem to enjoy this program, and some of them talked proudly about what they had learned in these classes. Also, as a result of this joint program, medical and dental examinations are free for school children. In this way, some of the children's problems are detected early and referrals are made to specialized services, if necessary. In most cases, parents react positively to this program and try to follow the medical orientation. As such, the school plays an important role in the village's life. It not only fulfills the needs of education for the youngest generation, but also is an instrument to preserve cultural traditions.

#### Social Organization

One of the most significant characteristics of Solemar is that everybody knows each other by name, usually by their nicknames. This investigator had a difficult time identifying the informants, in part because she was using their legal names while they were mostly referred to by their nicknames. Furthermore, many villagers are related by blood or by religious ceremonies (as godparents for baptism, confirmation, and by marriage).

If, at first glance, the community seemed homogeneous in its interactions, after a while the investigator observed that not all people were treated alike. First, there is a difference between common villagers and the ones owning fishing establishments, companies, or groceries. This was usually described by informants as, "They treat us differently. At the grocery they make us wait, as if our money was not as good as the others." About the owners of companies, it was said, "They make us pay with interest for all the favors they do us." Among these favors are the cashing of checks or taking sick people in their cars to downtown hospitals.

A second element dividing groups in the village is people's political affiliation. Those who are in the government party usually get jobs and some other benefits that are refused to those in the opposition party. Although these differences are more apparent during a political campaign, they do underlie villagers' relationships.

Religion is also an important factor separating groups. Even though the majority of the population is Catholic and the village life mostly revolves around the church, this investigator found many references to religious differences. This was even found in health practices. As one Pentecostal informant told me, "We are not like the Catholics who believe in blessings as curative measures. We only believe in God's power and in physicians." In contrast, a faith healer told this investigator, when asked about the relation between his treatments and the Catholic religion, "There is nothing that the church does not accept in our blessings. The Pentecostals are the ones who do not believe in our treatments."

To be classified as a "hippie" is probably the most relevant criterion in separating community members. Although "hippies" do live in a separate village, they often go to Solemar to teach or to go to the beach or restaurants. They are usually young couples who come from Argentina, Uruguay, and other states of Brazil. They have a higher level of education and make their living selling handcrafts or working as teachers. Hippies differ from the villagers in their customs, habits, language, and basic principles. Besides being considered outsiders, they are always looked on with suspicion by the villagers who consider them as drug addicts (marijuana, cocaine). There is, however, a tendency for the younger generation to look at them with more benevolence than their elders.

Another group that is considered totally outside the community are the beachgoers. The villagers remain courteous when they are asked questions or directions, but do not show any interest in maintaining contact with them. They are looked on as just people who come to enjoy the beach, eat, and drink. As soon as they return downtown, it seems they are forgotten by the local population.

#### Social Problems

From the informants' point of view, the village faces some problems. One of the most frequently cited is the lack of local jobs and the need to commute downtown daily. However, this investigator did not find any movement to try to change this situation. It seems that "depending on Florianópolis" is a common and accepted reality.

Another problem is related to fishing activities. Independent fishermen tried to create their own cooperative to have a place where

they could store their fish and sell them to the public downtown without the interference of local companies. According to their explanations, the lack of spirit of working as a group was one of the reasons the project did not work.

Lack of "community spirit" was also a complaint found in the religious groups, at school meetings, and in parent and teacher groups. This was a common explanation for many of the problems existing in Solemar.

One of the frequent scenes in the village was to find someone drunk, mostly at the end of the day. Villagers gave this investigator different explanations for drinking: fishing activities, men's jealousy of their wives who go downtown to work, or old drunk men setting a bad example for the younger generation, while others said, "It runs in the family." The major effect of drinking in Solemar seems to be on family life. Husbands spend their already-small salaries on buying alcoholic beverages instead of food and, what is worse, they also become violent and abuse their wives and children. This investigator met many wives, mothers, and even children who lived in constant fear of the drunkenness and violence at home. There seemed to be a general sense of helplessness among women who faced drunkenness in the family. When it was identified, most villagers did not consider alcohol as a disease that could be cured. As such, no special treatment had even been tried for these cases.

More feared than drunkenness is the use of drugs. According to villagers, there is a growing number of drug addicts in Solemar. The major cause for this is thought to be the increasing number of hippies, who are the ones responsible for introducing this problem. Here, as in

the case of alcoholism, it did not appear that the community had any organized effort to prevent the spread of this problem.

### The Medical System

The scientific health system. Solemar has a local health clinic with one physician, one dentist (each of them working two hours daily), and three nursing aides (working eight hours) for five days a week. The clinic, maintained by the county, has a contract with the state and the federal government, which supplies it with a food program and medications to attend to the whole population independent of having any kind of health insurance. The people from Solemar and nearby villages frequent the local clinic. There is no distinction among age, sex, or social status in the clinic clientele. Whoever comes for treatment has the right to a medical appointment. According to the physician, the most frequent problems among the children are intestinal parasites, skin infections, and respiratory problems. Cases of diarrhea are less frequent and, in the doctor's opinion, finding the cause is difficult. Adolescents are the group that look for medical consultation less than others, their problems being most commonly psychosomatic (because of school, sex, taboos). Men usually complain of problems related to their work. For the physician, most of their problems are consequences of stress and difficulties found in their jobs. They also, as a group, do not go to the clinic as frequently. In contrast, the women are responsible for the majority of appointments. Their problems are, according to the doctor, also mostly of psychosomatic origin, with frequent complaints about anxiety (connected with school, suspected pregnancy, or problems of rearing children), headaches, and back pains.



Older women face more serious illnesses, with cardiac problems being the most frequent.

From the health professional's perspective, the most serious problems existing in the community are 1) the indiscriminant use of contraceptive pills by women without any medical follow-up, 2) alcoholism, which is considered common in all fishing villages around the island, 3) intestinal parasites, with poor hygiene habits being the main cause, 4) dental decay, 5) childrearing practices related to discipline and responsibility, and 6) problems in adjusting to the norms and rules of the school.

The clinic has, as its major purpose, to work at the primary care level, developing preventive measures, diagnosing and treating simple diseases, and referring more complicated cases to specialized clinics and hospitals downtown. However, many factors interfere with this situation, not allowing the clinic to fulfill its goals. First, there are problems related to the clinic itself, such as a lack of adequately trained personnel and not enough equipment, facilities, instruments, and even medicine. There were times during this study period when even cotton, alcohol, and other basic materials were in short supply. This was true for all medical, dental, and nursing activities. A second problem was the nonexistence of programs to attend to the most basic needs of the community, such as environmental sanitation, maternal/child health care, programs for controlling cardiac and diabetic patients, family planning, and alcoholism. The only preventive program the clinic developed was with school-age children in conjunction with the local school. And finally, the clinic policy of providing medical and dental care with an emphasis on the curative aspect reinforced the community's

views of the clinic as a place to treat health problems rather than as a potential place for promoting health and preventing disease.

On the other hand, there were also factors in Solemar's population that did not help the clinic to function as a primary care unit. The villagers themselves go through a selective process, using their own criteria for judging whether they should just go to the clinic or look for more specialized care. Among these criteria are the existence or lack of medicines at the local clinic, their evaluation of the local physician and dentist, the professional's ability to solve a more complicated case, and the clinic's equipment and technology to deal with a specific problem. Furthermore, villagers' patterns of help-seeking also influenced the clinic's activities. Although the physician was always consulting patients, the sick population who actually used the health facilities was not always the most significant sample. As identified by the health professionals, some of those most in need of medical or dental care were the one who never got to the clinic or downtown services.

The community and the clinic seemed to enjoy a good relationship. During the field work, this investigator did not find any significant difficulty between families and the health professionals. Many villagers passed by the clinic just to see the doctor or chat a bit. Information was exchanged in an informal way, and many times the physician or nursing aides would visit a patient at home, without charge. Local professionals also would encourage the use of home remedies known to be useful, and no antagonism was found between local healers and health professionals, at least during this study.

The ethnic health system. Ethnic medicine coexists side by side with the scientific health care system. The main practitioners are called "benzedeiros(os)" (women and men who bless). The village has a great number of these healers who "specialize" in blessing different types of illnesses. For example, Da Lucia and Sr Ananias are good for blessing against "zipra", Da Marcela and Sr Elcio for fractures, luxation, and other problems of bones and muscles, and Da Cora for evil eye. These healers are considered common villagers who have the special gift for curing. Usually they perform the blessing in their homes, using water, olive oil, and branches of green leaves while they say special prayers to God and the saints. They can also give advice about herbs or other treatments. According to the informants, healers are not paid for this kind of service.

For more complicated cases, such as evil eye, cobreiro, and seizures, villagers look to outside healers, who are also called "benzedeiros" but who work in a different way than the local ones. They have a special room where they work, some equipment, and they are always paid. There are some famous ones, such as the women from Ribeira and Saco Grande. Besides blessings, they can also do physical manipulation of muscles or bones and prescribe teas and medicines.

A third kind of healing, not used as frequently as the previous ones, is performed in spiritualist centers. Cases that have not been solved by common healers and which are usually considered the result of bad spirits are taken to these centers, located in different places on the island. Their philosophy and treatments, however, are different from the "benzedeiros". They also require payment, and the client often has to go to several sessions until he/she is cured. Cases of

"encosto", seizures, relapse, and witchcraft are among those reported by villagers as having been treated by this kind of healer.

Although, theoretically, there are clear indications of which cases should be treated by a physician and which by a faith healer, in practice there seems to be some blend among them. Informants would use faith healers as an initial treatment or as a last resort when scientific medicine failed.

#### Sociodemographic Characteristics of the Families

The sample for this study comprised 22 families in the stage of having their oldest child at school age.

Marital status. Most of the families (n = 18) were married according to Brazilian law and the Catholic religion. However, for four families, this was not the first marriage for one of the spouses. Most of these couples had followed the local custom of "running away" before they married in the church. According to the parents, a couple that has been dating for some time and wants to marry runs away and goes to live with the future husband's family or relatives. This saves them the expense of the ceremonies at church. After living together some time, they marry in the church and by law, without any feast. Usually when they run away, a close relative of the bride knows she is leaving and will tell the parents.

Religion. All families in the study were Catholic, as were their parents, with the exception of one family where the grandparents of the father were Pentecostals. Another two families, who referred to themselves as Catholics, frequented a spiritualist center for health treatments as well.

Being Catholic, for these families, meant to be married in the Catholic church, to baptize all their children, to go to church on Sundays and holy days of obligation, to follow the main principles of the church in their daily life, to fast during Holy Week, and to participate in church activities and associations. Mothers, more than fathers, were usually active members of at least one of the religious associations, the most common one being the "apostolado da oracao" (apostolate for prayers). Girls between the ages of 7 and 12 usually played the role of "angels" during important ceremonies and feasts. They were dressed all in white, with wings, and their function was to accompany the saints and the holy Virgin during the rituals. This investigator had the opportunity to see many of the children in this study acting as angels during the feast of Our Lady of Navegantes in February and in the feast of the coronation of the Holy Mother in May.

The families participated in all the Catholic feasts in the community, the nearby villages, and even downtown. The pervasiveness of Catholic themes in the families' lives could be found even in children's play. One could frequently see boys playing at being priests or finding in their rooms an imitation of a church where the children played the mass. The fathers' religious activities, although less intense, were also visible on certain occasions such as in the public processions, burials, ceremonies, and holy day masses. Some of the fathers were active members of the church and helped in organizing the big feasts and processions. It was also common among the families to open their houses for other members of the community to pray the rosary at certain times of the year or to receive the traditional visits of the "holy spirit".

Although families in Solemar are going through a stage of changes (living conditions, roles, education, growing dependency on the big city), there does not seem to be a significant trend in their religious affiliation or in the performance of public rituals and ceremonies. It is evident that some families were less involved in religious affairs than others, but no one was totally indifferent, against, or even thinking of changing their beliefs. It seems that continuity in religion is still one of the important values universally held by all the families.

However, differences were found regarding private practices, such as birth control measures. The use of contraceptive pills or even measures to provoke abortion, although not officially accepted by the Catholic church, are present not only among the families studied but in the community in general. With the exception of three families, all were using some kind of family planning method.

Almost half of both the fathers and mothers have always lived in the village. But it is also evident from this sample that mobility is common among both sexes. The sample number could have been increased by at least five more families if the criteria for selection had not established at least four years of residence in the community. Interestingly enough, usually families who moved to the village had at least one close relative living there already. Mobility is more common between the different villages of the island than from outside. There was at least one member in one family who came from another state. All the families referred to themselves as Brazilians and, with few exceptions, they could not remember from which country their ancestors came (see Table 2).

TABLE 2  
Ethnic Backgrounds of the Families

Ethnicity	Husband	Wife
Brazilian	15	16
Italian	1	-
Indian	1	-
Portuguese	1	1
Don't Know	4	5
Total	22	22

Birthplace. Regarding the place of birth, the majority of both parents were born at home. There were, however, a greater number of mothers who were delivered at the hospital as compared with fathers (Table 3). The explanation for this fact is that the mothers were younger than the fathers and were born at a time when the road connecting the village with downtown had been built. Another aspect that has to be taken into consideration is that among the 13 mothers who were born at home, only six were originally from Solemar and, of those, three were older than 30 years of age.

Following the trend of giving birth at the hospital, all the children from the 22 families were delivered at the downtown maternity facility. Another factor that reinforces the idea of change in the place of delivery is the absence of lay midwives in the village. After

TABLE 3  
Distribution of the Families According to the  
Parents' Birthplace and Years Living in the Village

Category	Family Number																						Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
<u>Fathers</u>																							
Birth Delivery	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	20
Home																							2
Maternity											x												
Years Living in																							
Pantano	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	12
Whole life																							1
5																							5
6 - 10																							3
11 - 15																							1
16+																							
<u>Mothers</u>																							
Birth Delivery	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	13
Home																							9
Maternity																							
Years Living in																							
Pantano	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	10
Whole life																							3
5																							6
6 - 10																							3
11 - 15																							3
16+																							0



the death of the oldest one some years ago, no one has replaced her. Besides, the easy communication with the main city, the coverage of birth expenses by the national or state health insurances, and the free clinic for the poor are some of the other factors that could have affected the change in health practices related to place of birth.

Family members ages. According to Table 4, which represents the distribution of family members by age, the majority of the fathers were between 30-39 years old while their wives' ages varied from 25 to 34 years. Wives were usually younger than their husbands by at least one class (5 years). Only in four families was the husband older than the wife by two classes (10 years), and in one family the husband was younger than the wife.

Most of the children were 6 to 10 years of age, with a range of less than 1 year to over 11 years. This upper limit was set by the sampling criteria. Although some of the families had more than one child at school age, most of them also had children between 1 and 5 years old. Only three families had children less than 1 year old.

According to this data, the families are young and in the process of development. The women were still in their fertile years, which made expansion of the family size still possible.

Size of the family. Families in this sample are not as large as those of their parents. According to their family genealogies, most parents came from families with six to eight children. The number of children per family in the present generation varied from one (four families) to five (only one family), the most common being two (nine families) or three children (five families). The distribution of children by sex shows a slightly larger number of males in the sample

TABLE 4  
Distribution of the Families' Members  
According to Age

Age	Family Number																						Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
<u>Children</u>																							
1									x			x					x						
5	x	x	x	x	x			x	x	x	x	xx				x	xx				xx		
6 - 10	xx	x	x	x	x	x	x	x	xx	x	x	xx	x	x	xxx	x	xx	x	x	xxx	x		
11 +	x					x											x	x	x				
<u>Father</u>																							
25 - 29				x							x	x		x	x								
30 - 34			x	x						x	x		x				x		x		x		
35 - 39	x				x	x	x	x									x		x	x			
40 +								x															
<u>Mother</u>																							
20 - 24										x							x						
25 - 29			x	x			x	x			x	x	x	x	x								
30 - 34	x				x			x										x	x	x	x		
35 - 39																							
Male	2	1	1	1	1	1	1	3	1	1	1	1	3	1	2	4	2	2	2	1	2	1	
Female	2	1	1	1	2		3		2	1	1	2	1		2	1	1	2	2	1	2	2	
Total	4	2	2	2	2	1	4	1	3	3	2	2	5	1	1	4	3	2	2	3	3	56	

According to the Number and Sex of the Children

(Table 4). During the study, six women were pregnant, and of this group, two had a one-child family. This reinforces the idea of considering these families as being in a stage of expansion. However, it does not seem that this present generation of families would follow their parents in the number of children. There is a consistent reduction in the size of the families when the two generations are compared, and the general use of contraceptives in the present sample is a clear indication of this.

Level of education. The majority of fathers and mothers had completed just the fourth grade; no one had a high school diploma (Table 5). It is interesting to observe that there is not an important difference between the sexes and their levels of education. Among those parents who did not complete even the first four years of school, most were born in other villages.

The children, however, present a different picture regarding their education. All the children but one who were five years of age (family 7) were registered in the kindergarten class. The father explained the reason as being "too early to pull him by the head" (in other words, to work too hard).

The second characteristic of this generation is that only one child (again family 7) completed fourth grade and then stopped studying. All others were continuing their studies in the nearby village or downtown.

Again, parents, when asked about the future of their children, expressed their intentions of sending them downtown to get more education. "In order to get better jobs they need more education" was the common explanation given by parents. For some of the parents, but not all, it was more important for the sons to get higher education than



for the daughters, who are expected to marry and be good mothers. However, they all clearly stated they would not be against their daughters studying if they so wished.

Occupation of family members. Fishing was still the most prevalent occupation among the fathers in this sample (Table 6). Most of those who worked in other occupations referred to having been fishermen in their early years. The reasons given for leaving it were always the low income and lack of modern fishing equipment. But fishing is what they most liked to do and, for those who did not do it as an occupation, they did it in their leisure time. Fishing was also the final choice for villagers when they were unemployed. There is always room for one more in the boats, and the sea is generous in giving at least food for them and their families. During the period of field work, two of the fathers who were working downtown at the beginning of the study ended up as fishermen before I left.

The second most common way of making a living was being a night guard. This role, as well as most of the others occupied by the family breadwinners in this study, does not require higher education or skills. Usually they get these jobs through a relative or a close friend. It is important to note, however, that all parents with the exception of those involved in fishing had to commute downtown daily to work. Besides showing the unpreparedness of the local community to expand opportunities for new roles, it also demonstrates the growing dependency of villagers on downtown as the source of employment. But interestingly enough, no family intended moving downtown. The city is considered a place to work, but at the end of the day they want to return to the village.

TABLE 6  
 Distribution of the Families According to the Fathers' Occupations

Occupation	Family Number																						Total	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22		
Fisherman	x									x*	x					x*		x					7	
Fishing																								1
Inspector					x																			1
Cook	x																							5
Guard				x						x			x*	x*										1
Fireman						x												x						1
Policeman																				x				1
Factory																								1
Worker							x																	1
Clerk									x															1
Radio																								1
Technician																						x		1
Police																								1
Instructor																								1
Draftsman																							x	2

\* These fathers changed their occupations at least once during the time of this study.

When the fathers' occupations are distributed according to whom they worked for, some additional information can be inferred. First of all, almost half of the sample worked in some way for the government. In addition, it also shows that even the fishermen did not work for themselves but for some private organizations. They did not have the money to buy their boats nor the necessary equipment that today's fishing requires. As such, they chose to work for others as employees, losing all the rights and advantages they could get if they would work for themselves. Only one fisherman in this sample owned his boat, while two others shared a boat with their brothers. All the others worked for one or another of the local fishing companies (Table 7).

Some of the problems fishermen face can be exemplified by this field note on Family 1, March 3, 1983:

"I work for myself. I don't want to work for the 'intermediarios' (the companies who buy their fish and sell them at higher prices downtown). We should have a cooperative so that we could sell the fish direct to the market and thus prevent selling them at low prices to the 'intermediarios'. They get six to seven times more than they pay to us. They are rich, and we who fish are poor."

When I asked why they do not form the cooperative, he explained, "Fishermen are not a unified group. Also, there is no help from Sudepe (the government institution that deals with fishing activities). They are not interested in helping the fishermen; they just want to be rich."

On the other hand, as to wives' activities, Table 8 shows a somewhat different picture. Most of the women are primarily family-oriented. Of the 22 mothers studied, 12 were only involved with housekeeping and childrearing. Another seven mothers had to do some kind of work to earn money to increase the family income; however, the activities they did, such as washing clothes for other families, making lace, selling clothes, cleaning houses, and raising chickens, were all





TABLE 7  
Distribution of the Families According to the Fathers' Employers

Employer	Family Number																						Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
Army		x		x			x			x							x			x			6
Government			x		x	x															x		4
Private							x		x			x	x	x	x			x					8
Self	x										x						x				x		4

TABLE 8  
Distribution of the Families According to the Mothers' Occupations

Occupation	Family Number																						Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
Housewife		x	x					x	x	x	x	x	x		x		x			x	x	x	12
Housewife & Working at Home				x	x	x	x						x					x					7
School Aid	x																						1
Hairstylist											x												1
Street Cleaner																					x		1

compatible with their role as mothers and wives. Even the mothers who were regularly employed tried to adjust the working hours to their family responsibilities in order not to interfere with the latter. Of the whole sample, only one mother worked downtown from Monday to Friday, from 7 am to 4 pm, leaving her children's care to her mother. It seems clear that mothers, at least at the time of the study, did not intend to get jobs in the village or downtown unless they really needed to supplement the family income.

Making lace, a traditional women's handcraft on the island, was still found among the present sample. However, this source of income is considered more and more as a leisure activity rather than a real way of earning a living. The majority of the women sold their lace at low prices to other people who would later resell it downtown to tourists at very high prices. The lace makers, because they do not have enough money to buy the thread, accept materials from these "intermediarias" who, in turn, pay very inferior wages. Essentially, this is the same thing that occurs with the fishermen and the local private companies.

The families have very different expectations for their children, however. When asked about plans for the children's future, parents were unanimous in desiring for their children - whether males or females - a better life with a good job downtown. No one expected their children to work as fishermen or lace-makers. This they could do for "sport" but not as a living.

Family 22: "We do not want Jair to be a fisherman, he can fish for sport. It is a dangerous and hard life."

Family 2: "If he wants to be a fisherman, he can be. It will be according to his desires, but I hope he will not. There are times without fish. Better to find a job downtown." For her daughter, Lea, "I do not want her to make lace or wash clothes in the fountain. To make lace does not bring money."

Children are not expected to work in this community beyond the ordinary caring for younger brothers or sisters, buying some groceries, or helping the mother in small jobs around the house. But this seems to be true only for the last two decades. The older generation, when interviewed, all referred to having a hard time working in the fields and small farms while they were children.

Family income. Family income was difficult to determine for different reasons. First of all, this is a sensitive subject for the families to talk about. In addition, fishing and most of the women's occupations vary according to the seasons and, as such, bring problems when calculating the income on a monthly basis. For this reason, families were asked to classify themselves in certain categories according to what they supposed could be their monthly income. This classification ranged from the equivalent of \$119 to \$300. The distribution of the families on this scale is presented in Table 9.

TABLE 9

Distribution of Families According to Income

Income	Families	Total
\$119	7, 10, 13, 14, 15, 17, 21	7
\$120 - \$179	1, 5, 6, 16, 19	5
\$180 - \$239	2, 4, 8, 9, 11, 12, 18, 20	8
\$240 - \$300	3, 22	2

Although families were reluctant to talk about their socioeconomic status, the difficulties the first two groups go through could be easily inferred by their conversations and ways of living. Thus their children could be seen every afternoon going to the beach to wait for the boats to get some fish that the fishermen always distribute free to the less advantaged, the old, and widowed (families 7, 10), medicines were not bought because there was no money (families 7, 10), installment payments were late (family 1), and visits to social organizations downtown to get food and clothes for the children (families 10, 13) were common. In addition, women looking for jobs (families 1, 13, 15), children picking up fruit and vegetables in Canoas (families 1, 15, 16), houses without ceilings and unfinished construction (families 5, 6), and men changing jobs (families 13, 14, 16) are the most clear examples of the hard life these families experience.

In contrast, families in the third and fourth groups have solved at least their basic daily needs of housing and food. However, they have not accepted their situation either. They want to improve their homes, to vary their meals and, most of all, they struggle for better education for their children.

Health insurance. Most of the families were covered by at least one kind of health insurance, INPS (Instituto Nacional de Previdencia Social), a federal type of coverage, being the most frequently cited, followed by IPESC (Instituto de Previdencia do Estado de Santa Catarina), a state coverage, and Colonia de Pescadores, a fishing organization (Table 10). Only one family was not covered by any insurance. The three types of insurance do not offer the same kind of services. INPS and IPESC, the federal and state insurances, are the



TABLE 10

Distribution of the Families According to Health Insurance

	Family Number																						
Health Insurance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Total
INPS (National)	x		x		x	x	x		x		x	x	x		x			x		x	x	x	13
IPESC (State)		x		x				x			x							x		x			6
Colonia Pescadores	x														x	x	x				x		5
None										x													1

ones that cover ambulatory and hospital expenses. "Colonia de Pescadores" is very limited in the kind of services it offers and does not cover hospital expenses.

It is important to note, however, that all the families have the right to frequent the local health clinic as well as the downtown Public Health Department for immunizations, medical examinations, and to get medications without any charge. In addition, delivery and hospitalization is also possible even without any insurance, although the system is very rigid and families have to prove their inability to pay.

The expansion of health insurance for almost everyone in the country was achieved approximately fifteen years ago. Thus even the oldest generation in this study has benefited from this governmental measure in their later years.

#### Housing Conditions

Physical characteristics. The first aspect to call attention to in Table 11 is the location of the houses. More than half of the families built their houses in the same yard or just across the street from their parents (14 families) or near a relative (3 families). There is no clear predominance of in which parent's yard the house is located; some are near the wife's family and others are near the husband's family. Of the five families who live separate from relatives, one is building a house in front of the wife's family, two do not have parents living in the village (families 7, 21), one does not get along well with the wife's family, and the last one has a grandmother who is a widow and lives with a daughter. This physical proximity between generations has

TABLE 11

Housing Conditions - Physical

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Total
Location																							
Parents' backyard	x	x	x	x				x	x	x	x	x		x		x		x	x			x	14
Close to relative					x									x			x						3
Isolated						x	x						x							x	x		5
Ownership																							
Own	x	x	x	x	x	x		x	x	x	x	x		x		x		x				x	17
Rent							x						x						x	x	x		5
Construction																							
Brick			x			x		x				x										x	6
Wood/brick	x	x		x	x			x	x		x		x				x	x		x			10
Wood							x			x				x		x			x		x		6
Condition of Building																							
Poor					x				x				x										5
Fair	x			x		x	x							x							x		8
Adequate			x	x				x	x		x	x			x					x		x	9
Status of Building																							
Finished			x									x		x							x		7
Under construction						x		x												x			2
Remodeling	x			x	x					x													4
Plan to remodel		x							x														2
Unfinished						x				x			x								x	x	7



TABLE 11 (continued)

Housing Conditions - Physical

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Total	
<b>Number of Rooms</b>																								
1 - 3									x				x						x					4
4 - 5	x	x		x	x	x	x	x	x		x	x			x	x	x	x		x	x			16
6 +			x																			x		2
<b>Number of Bedrooms</b>																								
1									x															2
2		x	x		x	x	x	x	x		x		x		x	x	x	x	x					15
3	x			x							x										x	x		5
<b>Bathroom</b>																								
Inside toilet		x	x	x				x	x		x	x					x	x	x	x	x	x		13
Outside toilet	x				x	x	x			x			x			x								9
Shower - yes		x	x	x				x	x		x	x					x	x	x	x	x	x		13
Shower - no	x				x	x	x			x			x			x								9
<b>Furniture</b>																								
Insufficient									x				x											2
Just enough				x	x	x	x									x	x		x		x			8
Sufficient	x	x						x	x		x			x	x				x					9
Luxurious			x									x										x		3

implications for the family's daily life as well as for the way they deal with health and illness.

Ownership. Tendency toward ownership is a second characteristic of this sample; 17 of the 22 families owned their homes. To build their own home seems to be one of the first priorities for a couple when they get married. One of the families who paid rent (family 20) was building their house during the time of this study, and another two (families 17, 19) frequently mentioned their desire to have their own house. The land, in all cases, was given by their parents, and the couple's savings were used to acquire the materials necessary for the construction. Usually the husband, with the help of relatives and under the guidance of a more skilled villager, constructs the home himself. The material most frequently used in the construction of the older houses was wood, while the more recent buildings are made of all brick or part wood and part brick.

To improve their houses was another goal of these families. During the six-month period of this study, almost 20 percent of the families were doing some kind of remodeling, and two other families (2, 9) were planning to do it in the near future. Improving housing conditions also followed a pattern: first is the construction of an inside bathroom (families 1, 5) followed by improvements in the kitchen (families 4, 11).

Although only one family (13) lived in a house that showed visible signs of deterioration, four others (families 5, 10, 16, 19) could be included in the category of poor conditions. They all lacked a ceiling, did not have enough light or windows, and there was space for rodents and insects to come into the house as well as the cold, humidity, and

winds. A second group of houses had deficiencies too, but not as much as this first group. They had problems of ventilation (families 1, 4, 14, 17, 18), close proximity to other houses (families 6, 16), or too much humidity (family 7). It was only the most recent constructions that followed all the minimum requirements of light, ventilation, heat, and safety.

The number of rooms in each house ranged from one (family 10) to six (family 22), with four to five rooms, excluding the bathroom, being the most frequent. Although the size of the rooms differed, crowding was not common among the families. With the exception of families 10 and 14, all had a bedroom for the parents and another for the children. Only families who still had small children (families 9, 13, 17) had the baby sleeping in the parents' room, but in a separate bed. All children but those in families 10 and 13 had their own beds.

The kitchen is the place where the family members spend most of their time when at home. It is there that the mother makes lace and the father the nets, the children do their homework, and close friends and relatives are invited to sit for a cup of black coffee. The kitchen furniture always included two kinds of oven (gas and wood) and a big table and chairs, besides the refrigerator and a cabinet. Only five families did not have a refrigerator (families 5, 7, 15, 16, 19) while only a few families could afford a mixer and blender (families 3, 8, 9, 22).

The living room is the part of the house used least by the families, but in contrast it has the most expensive furniture. Formal visitors are received in this part of the house. For example, usually the first interview by this investigator took place in the living room,

while the subsequent interviews were all done in the kitchen. Only a few families did not have a living room (families 5, 7, 10, 13).

Regarding the furniture, families can be grouped in four major groups: those who had insufficient furniture (families 10, 13), those with just the minimum required for the family (families 4, 5, 6, 7, 16, 17, 19, 21), those with enough and in good condition (families 1, 2, 8, 9, 11, 14, 15, 18, 20), and a few whose furniture could be classified as luxurious (families 3, 12, 22). In addition, all families had a black and white TV, medium-sized. However, in two families (5, 15) the TV was not working and there was no money to pay for the repairs.

Sanitary conditions. Of the 22 families, only 13 had an inside bathroom including shower and toilet facilities (Table 11). The remaining nine families had latrines built a few meters from the house, covered by a roof and with wood walls. The families who did not have a bathroom bathed in a basin with the help of a can.

There is no community sewage disposal system, and those families with an inside bathroom have an individual system that includes a septic tank made of concrete. Families who use a latrine do not use any special treatment. In addition, some of them also face the problem of having the used water from the kitchen constantly running into their backyard. This creates the opportunity for the presence of insects, and there is usually a bad smell.

The majority of families get their water from a spring (Table 12); it is distributed to the homes through a system of rudimentary pipes. There is no special protection of the spring to prevent contamination, and the pipes are frequently in need of repair because the cattle step on them and break them. Some of the families complained about constant

TABLE 12

Housing Conditions - Sanitary

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Total	
Light, Ventilation and Heat																								
Inadequate					x				x				x											3
Some problems	x			x		x	x		x					x					x					8
Adequate		x	x					x			x	x			x		x	x			x	x		11
Water																								
Spring	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		20
Well						x	x														x			3
Garbage Disposal																								
Collected	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		19
Burned					x		x				x													3
Buried		x					x													x				3
Animals					x											x								3
Dumped						x														x				2
Hygiene																								
Poor					x	x				x			x											5
Fair				x			x							x					x		x			7
Good								x														x		6
Excellent	x	x	x						x			x												4
Washing Clothes																								
Home			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		16
Fountain	x	x								x														6

TABLE 12 (continued)

Housing Conditions - Sanitary

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Total	
Backyard																								
Small yard									x					x					x					3
Nothing planted							x					x									x			4
Chickens					x	x																		4
Vegetables			x	x							x					x								4
Fruit		x										x												3
Flowers	x		x																					4
Cows		x													x									1

shortage of water (families 1, 6). In this case they had to use the public tap to get water for the whole family. In general, all families considered the quality of the water excellent and safe and not in need of any treatment. Just one family (18) used a filter, and the families who had small children preferred to boil the water for them (families 9, 13, 17).

Most of the families used the public system for collecting garbage (Table 12). A truck came from downtown three days a week to collect the waste from homes and the beach. But there were some families who preferred to burn part of it (families 5, 7, 11), to bury leftover fish (families 2, 7, 20), to give it to the chickens (families 5, 6, 16), or just to throw it in a hole (family 20) or on empty land (family 6). The use of the truck is not without problems. First, the collection is only three days per week and families have to get rid of the garbage on a daily basis because of the presence of dogs, rodents, insects, and the hot weather. Second, the truck goes only on the main street and half of the beach; therefore families have to walk a great distance with big bags of garbage. And finally, plastic bags are expensive and some families cannot afford to buy them.

## CHAPTER V

### FINDINGS AND ANALYSIS

This chapter presents the results and analysis of the data. It includes sections in which the families' perceptions of health and illness, explanations of causation of disease, preventive measures, and the management of illness situations at home are described. At the end each main section, the themes emerging from the data are identified. In the final part of the chapter, a model for conceptualizing the families in health and illness situations is suggested.

#### Families' Concepts of Health and Illness

At the beginning of the study, when this investigator interviewed families about the meaning health and illness had for them, she got only a few and evasive answers. After some trials, it became obvious that it was easier for families to describe the characteristics of a healthy person than to talk about an abstract idea such as health in general. Therefore the informants were asked to present a picture of a healthy child, woman, man, and old person, which are depicted in Tables 13 to 16.

Healthy child. Families' perceptions of healthy people are based on four main categories that point out physical/behavioral characteristics, work and related activities, state of mood, and the



presence/absence of illness. However, according to the age and sex, different dimensions within each category were emphasized and weighted. For children (Table 13), the most relevant category that expressed their health status was the presence of physical/behavioral indicators (17 families). Among these, eating patterns occupy first place (10 families), followed by sleeping patterns (7 families) and the color of the skin (rosy) (6 families). When questioned about the weight of the child and its relation to health, most of the families did not consider being fat a sign of health. The mother in family 10 expressed her opinion in this way, "There are fat and skinny sick children"; the mother in family 14 said, "Ana (her daughter) is thin but healthy."

The presence/absence of illness was the second category families used to specify a healthy child (14 families). Interestingly enough, no family expected a healthy child to be free of disease. On the contrary, most of the families (n = 12) expressed that some health problems occur but they should not be serious (3 families) and, most of all, of short duration (12 families). As the mother in family 8 stated, "During childhood, some diseases are normal, like colds, sore throats, and worms." Further, for some parents, a healthy child is not supposed to go to the doctor. Family 6 was one of these families: "Mario is healthy because he does not go to the doctor, does not complain of anything. He only has colds sometimes."

Mood, or state of mind, was another indicator of health in families' perspectives (13 families). This is translated into the dimensions of being content (10 families) or having a good disposition (4 families). Closely related to it is the fourth category in which informants described a healthy child as one who enjoys playing.

TABLE 13

Descriptions of a Healthy Child

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Physical/Behavioral Problems</u>																						
Eats well			x						x				x		x	x	x	x	x		x	x
Sleeps well	x				x				x				x				x					
Rosy coloring	x			x		x		x				x						x				
<u>Mood</u>																						
Good disposition	x	x																		x		
Cheerful			x	x	x	x		x	x		x	x				x		x				
<u>Work/General Activity</u>																						
Plays		x	x	x		x		x	x	x					x	x		x		x		
<u>Presence/Absence of Illness</u>																						
No serious problems			x																			
Only temporary problems						x	x	x		x	x	x		x	x	x			x	x	x	
Does not complain						x	x															
Does not go to doctor frequently						x								x								
Does not take medicine						x	x							x								
<u>Other</u>																						
Does well at school			x																			
Normal development for age								x														x
Gets along well with family																						

Family 2's definition depicts these last two categories well: "A healthy child has the disposition to play; if he/she stays at home and does not want to play, he/she is sick." Family 8 expanded this idea by saying, "A healthy child is happy, plays, is naughty. It is the activity of the child that tells how healthy he is."

There were some families (n = 3) who added some indicators to the previous dimensions, denoting a concern with the child's growth and development and interactions with others. Family 3 was one of them: "A healthy child does not have any dangerous disease, eats well, develops well at school, enjoys playing, has disposition to do whatever comes up. He/she also has good relations with the family."

Healthy woman. In representing a healthy woman (Table 14), the category most frequently cited by the families was the presence/absence of disease (20 families). A total absence of disease was mentioned only by four families, and a great number of informants (n = 11) said that "a healthy woman does not complain of anything". When this dimension is compared to the other groups, it is apparent that this was an indicator of women's health status for the villagers. This aspect is evident in the opinion of the mother of family 20:

A healthy woman is the one who works, does not feel anything, has disposition to work, and does not complain about pain. I am not healthy because I am always complaining of pain. My children are not healthy, either. They always have something like colds, pontada, infection. Angelica is healthier than Diana.

As opposed to children, the dimension regarding seriousness of an illness is more important than frequency in the case of evaluating women's health. It suggests that health problems are expected in a woman's life; however, they should not be of great severity.

TABLE 14

Descriptions of a Healthy Woman

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
<u>Physical/Behavioral Problems</u>																							
Eats well										x													
Good teeth								x															
Rosy coloring							x		x														
Strong							x				x												
Sleeps well																							
Normal periods					x																		
<u>Mood</u>																							
Disposition to work	x		x			x		x		x					x	x							x
Content				x		x						x			x	x							
Does not worry much	x																	x					
<u>Work/General Activity</u>																							
Does housework		x	x	x	x			x		x			x		x	x		x	x	x	x	x	x
<u>Presence/Absence of Illness</u>																							
No disease					x									x							x		x
Only temporary problems			x						x														
No serious problems	x					x				x			x		x	x		x	x				
Does not complain				x		x		x					x								x		
Does not go to doctor frequently														x									
Does not take medicine			x																				
No hospitalization																							x
Is not bedridden	x																						x

Second in frequency, families referred to the work/related activities category. As children are expected to play, a healthy woman has to be able to do the housework. If a woman is capable of taking care of the house, cooking, and raising the children, she is considered healthy. As the mother in family 12 explained,

A healthy woman is always working, walking, and doing her housework. I consider myself healthy. A person can have a health problem and be healthy if she can do her job and does not stay in bed.

While "to be content" is a sign of a healthy child, the dimension "disposition to work" assumes greater significance in adult life. As the mother in family 6 stated, "A healthy woman is happy, content, has disposition and enjoys working. A sick woman is sad and does not want to work." This emphasis on disposition as a component of health makes a difference between working as an obligation and working because one enjoys doing it. The father in family 22 asserted, "Work by itself is not a sign of being healthy; it is the fact that you do it because you want to, not because you have to."

Interestingly enough, the last component of health for women is related to physical/behavioral indicators. This category, which occupies the first place for classifying a healthy child, seems to lose its significance for adults. Only a few families (n = 6) made references to it, with the color of the skin (rosy) being the most common dimension (3 families).

Healthy man. A description of a healthy man follows the same general model as for women, with some specific differences in detail (Table 15). As with women, the category of presence/absence of disease occupied first place in the informants' point of view of a healthy man. But the dimensions emphasized within this category are different. For a



TABLE 15

Descriptions of a Healthy Man

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Physical/Behavioral Problems</u>																						
Eats well	x																					x
Rosy coloring		x									x											
Strong		x									x											
Sleeps well		x	x																			
<u>Mood</u>																						
Disposition to work			x												x				x			
Content						x						x						x				
Energetic						x				x												
<u>Work/General Activity</u>																						
Works	x	x					x	x	x	x			x		x	x	x	x	x	x	x	x
<u>Presence/Absence of Illness</u>																						
No disease		x			x												x					
Only temporary problems																x						x
No serious problems						x		x		x	x	x	x		x						x	
Does not complain							x							x								
Does not go to doctor frequently							x															
Does not take medicine																						
No hospitalization																						
Is not bedridden		x										x										
<u>Other</u>																						
Practices sports			x																			x
Does not drink or smoke			x																			x
Stable behavior																						

man, what is most important is to not have a disease (5 families) and, if he does have one, it should not be a serious one (10 families).

The dimension of complaining loses its significance when compared to women (5 families), and self-dependence (not bedridden) begins to appear with more frequency (5 families). Here are some perspectives on man's health which represent some of these concepts.

Family 6: Nene is healthy. He went to the hospital only because he had an accident. He has hemorrhoids and "goes to the feet" (has diarrhea) frequently, but this does not prevent him from working. He does not need to stay in bed.

Family 11: My husband is healthy, except for his back pain. He does not suffer from anything else. (This back problem bothered him many times during this study.)

Family 14: My husband is healthy. He does not complain of anything, does not take medicine, does not go to the doctor, and does not stay in bed.

The next category in significance, work/related activities, is closely related to the first one. For the families, a man who is able to perform his activities, does not have a serious health problem that prevents him from working, and is self-dependent is classified as healthy.

State of mind (mood) occupies third place, with only eight families including it as an indicator of a man's health. The disposition to work, so essential for women, was cited by four families, and only three included contentment as a dimension of men's health.

The last category, regarding physical/behavioral dimensions, was described by only five families. As with children, eating and sleeping patterns were the most evident signs of being healthy for men as well.

There were a few families (n = 3) who presented other characteristics, such as exercise and sports, not smoking or drinking, and having a stable behavior. The father in family 22 was one of them:





"I consider myself healthy. I have only small problems like contusion and colds. I work, I don't drink or smoke, I practice sports, and I eat well."

Healthy old person. Although the health of an old person was evaluated according to the same general categories as for other groups, it has its unique indicators, too (Table 16). As such, in the category of presence/absence of disease, a new dimension - chronic diseases - appeared in the reports (7 families). As family 1 asserted, "In old age stroke, diabetes, and back problems appear", or in family 3, "Every old person has some health problems such as rheumatism, high blood pressure, and diabetes", and family 4, "I think my father is healthy. Because he is old (80 years) he has some health problems, but this is normal for his age."

In the work/related activities category, old people were also expected to have some limitations. Even though 13 families mentioned work as a sign of health, most of the families made reference to a less strenuous type of work. Family 8 described it in this way: "An old man has some restrictions because of his age, but if he is content, active, and does something, he is healthy." The mother in family 2 said about her grandparents, "They are healthy. They have some problems, but they still can do some work, not so hard, but they do it."

Mood is a category that is also relevant in evaluating old persons' health status (9 families). There was emphasis on the disposition to work (6 families); however, to be content was a dimension almost as important. Families gave examples of old villagers who were healthy, Sr Hilario being one of them. Family 14 said about him, "He is healthy because he sings and dances and is always content."

TABLE 16

Descriptions of a Healthy Old Person

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Physical/Behavioral Problems</u>																						
Strong						x	x															
Walks	x				x								x					x				x
<u>Mood</u>																						
Disposition to work			x			x			x	x								x		x		
Content			x			x		x					x									x
<u>Work/General Activity</u>																						
Works						x	x				x							x				
Works not so hard	x	x						x	x	x			x						x			x
<u>Presence/Absence of Illness</u>																						
No disease																						x
Only temporary problems																						
Problems from age	x	x	x	x					x	x						x	x					x
No serious problems																						
Does not complain																						
Does not go to doctor frequently																						x
Does not take medicine																						
Is not bedridden	x													x								x

Finally, in the last category, families introduced a new indicator of health that is related to mobility. At this point in life it seems to families that being able to move, to walk, and just not stay at home is a sign of being healthy. This can be inferred from the following notes.

Family 2, the father: Da Alice (his grandmother, 90 years old) is a healthy woman. She walks, goes to church; she does not stay at home.

Family 8: Sr Hilario is healthy; he walks a lot.

In summary, in the families' perspectives on the health of old people, it appears that some limitations are expected. These limitations refer to the presence of health problems, restrictions in working, and even in mobility. However, it is important to know that not all families shared the same opinion about limitations. There were those who did think an old person has the same strength and energy to work as other adults and does not have illnesses. Here are some comments of these families.

Family 7: They are strong. I know some of them. My grandfather was healthy. He worked until one year ago. Now he is sick in the hospital.

Family 10: I think old people can be healthy. I know a lady who is 85 years old. She has a farm and still works every day.

Family 11: They have disease once in a while, not all the time. My mother-in-law is healthy. She washes clothes, picks up wood on the hill, and works; therefore she is healthy.

Sick person. For families, a sick person is situated on the opposite side of the health continuum line. The same categories used to classify the health status of a person (physical/behavioral, state of mind, work/related activities, and presence/absence of disease) are

present in peoples' definitions of being sick, now with a negative connotation, as can be inferred from these descriptions.

Family 6: A sick child is sad, quiet, inactive. If the child is pale, he/she has a problem.

Family 22: A sick child is sad, always sitting, quiet, does not play, and does not eat well.

Family 5: A sick man has problems all the time that interfere with his work; stays in bed most of the time and does not eat well.

Family 10: Is always complaining, going to the hospital and doing treatments; is not able to do his/her job, does not have disposition, and does not eat or sleep well.

Two new indicators assume relevance in families' views on a sick person. First is the emphasis on lack of mobility, expressed by "being quiet, inactive, bedridden", and the other is the time dimension. While, for healthy people, problems could happen but are expected to be of short duration, in the case of sickness the words "all" or "most of the time" permeate families' definitions, making a clear separation between health and illness.

### Emerging Themes

The first characteristic that is apparent from the interviews with the families is that health is a multidimensional concept that involves at least four major categories: physical/behavioral, state of mind, work/related activities, and presence/absence of illness. As the mother in family 1 stated, "To be healthy is much more than just not having a disease." As such, to be healthy goes beyond the relationship between the person and the health system. It focuses on the individual as a member of a family, performing social roles and interacting with other members of the community.

To have some health problems is expected and accepted as part of being healthy at all ages. As a matter of fact, children are expected to have colds, sore throats, worms, evil eye, "zipra", grubs, and lice besides some transmittable diseases such as whooping cough, rubella, and measles. Further, for women, common aches and pains such as headaches, back pains, vaginal discharge, and hemorrhoids are expected and, for men, back pains, rheumatism, and intestinal problems. When becoming older, high blood pressure, heart problems, and rheumatism are added to the list.

One factor that distinguishes a person from being healthy or sick is, for children, the frequency and seriousness of an illness; for adults, the seriousness and interference with work; while for old people, even the presence of chronic problems is accepted if they do not restrict activities too much. By implication, this type of reasoning about health leads adult and older family members to wait for a long time before seeking treatment in the case of problems they consider mild or not serious, as common to their age. The field notes on informants' health status clearly demonstrate this attitude. In almost every family there was a member who had one "not serious problem" for which no special treatment was sought. For example, in family 1 the mother had constant headaches; in families 4 and 15 the wife had a vaginal discharge, in families 2, 11, and 15 the husband had back pains, and in families 7 and 16 the father had chronic toothaches. Although they were regarded as physical disturbances, they were not considered serious enough to warrant special attention. Most of these informants, when asked to evaluate their own health status, classified themselves as healthy, the mothers in families 1 and 4 being the only exceptions.

Another aspect of this multidimensional perspective on health is that all four components are interrelated. In the same way that a person who has a physical disturbance is considered healthy because it does not restrict his/her daily activities, working, by itself, is not enough to consider a person as healthy; one has to enjoy the work and be in a special state of mind. Physical/behavioral conditions, although not directly related to the others, seem to be the basis for making the development of other categories possible.

These multiple components of health and illness vary in significance in the different stages of the life cycle and according to gender. As Table 13 shows, physiological components are the most important indicators of children's health while, for adults and old people, it is the presence/ absence of disease. However, great variability is found within each category. Thus, while for children the existence of temporary problems is the most frequent dimension, for women it is the absence of complaining, for men it is the absence of serious problems, and for old people it is accepting the idea of chronic problems.

Being healthy has also a temporal dimension. In considering their own health status, informants would always look at their health in a long-life perspective and not just the present situation. The conditions "always, temporarily, sometimes" make up one of the criteria to distinguish between being a healthy or a sick person. Even among children at school age, this concept is already present, Fabia, the oldest child in family 12 classified herself as health "because I can play, eat well, sleep well, and have gone to the hospital only once". On the other hand, a past with many health problems such as dehydration,





"pontada", or sore throats would make family members classify themselves as less healthy, even if at the time of this study they did not present any complaint.

Families' views on health and illness have a dimension over which they have different degrees of control. Families locate themselves on some point of a continuum that goes from perceiving disease as an uncontrolled occurrence, to the other extreme, where people are seen as having the power to control health and illness situations. Among the families who belonged to the first group was family 2 who stated, "Health is granted by nature. Whoever is to be healthy will be so from birth; whoever is to be sick will be. Only God can change it, not us." Another group of families, whose opinions were situated almost in the middle of the line, is exemplified by family 12: "Sometimes I think that health is destiny, is driven by the family, but at the same time there are things that can be done, such as treating the baby teeth or going to the doctor as soon as someone is sick." And finally there were those families located at the other end of the continuum, such as family 11, who asserted, "I am concerned with prevention. We can have control over disease, and I believe we can do things to prevent it."

Families also distinguished different levels of being healthy. On the highest level are those who possess all four categories or indicators of health, and on the lowest level are the sick ones. Between these extremes, people are classified as more or less healthy according to the dimensions they fit into. For instance, in family 5, Rita is considered healthier than her sister because the sister has a history of colds, pontada, and dehydration. In family 1, the mother classified her daughter, Lorena, as being less healthy than her brothers

because she does not have a good disposition. This is also true for adults. The wife in family 3 does not consider her husband very healthy because "he does not have the disposition to work; he only likes to hunt and to fish. He always wants to wake up late and go to bed late." The parents in family 8 introduced the idea of a line to measure health. The mother said, "On a line from 0 to 10, he (the husband) is in the middle because of his back pains." The father disagreed with his wife's classification and said, "On that line I give myself more than 5, maybe 7 or 8."

Thus, the evaluation of self and others of a person's health status can differ. Although the same general indicators of health (physical/behavioral, state of mind, presence/absence of disease, and work/related behaviors) are the basis for the definitions of both self and others, people locate themselves or others differently on the health scale. One of the reasons for this fact can be that tolerance and sensitivity to health problems have individual variations. A clear example of this is family 12, who defines the grandfather as being a healthy old person. His sight and work limitations are considered normal for his stage of life. However, Sr Ananias, when asked to defined his health status, told this investigator, "I am a sick person. I almost cannot see any more and work is difficult." As can be seen, there is not always agreement between family members' definitions of who is sick or healthy because of individual differences. However, family members try through a process of negotiation (which involves communication and role-taking, giving up some points of view and accepting or modifying others) to achieve some kind of agreement toward a definition that encompasses the family's characteristics.



In summary, families' perspectives on health and illness are based on a rationale that integrates physiological, psychological, occupational, and presence/absence of disease components. This rationale is present in all families' definitions, denoting a shared or community model based on exchange of knowledge, beliefs, and values among the people living in the village. This commonality between families should not, however, obscure the existence of variations between them. They differ in relation to the indicators of health and illness, with some families weighting each dimension differently than others. In addition, there are also families who add new indicators which are not present in other families' definitions. Furthermore, families seem to adjust the community rationale into a family model. This model is not only the product of the interactions between the family and the reference groups in the community or outside it, but it acquires and develops its own characteristics as a result of their daily life experiences with health and illness, the family's life history, and the processes of negotiations that occur within the family unit.

If, on one hand, the family model of health and illness is greatly influenced by the community, it also relates more or less extensively with the scientific medical system. There are some families who adopt the medical indicators of illness more than others, and all of them include the utilization of medical facilities as part of being sick. However, there are few indications of what the relationship is between the families and the health system specifically regarding health. The families' descriptions on this point seem to imply that to be healthy means no need for using the scientific health system.



### Families' Perspectives on Causation of Disease

In order to get a better understanding of informants' perspectives of health and illness, families were asked to describe at least three major causes of disease. The information as given by family members is presented in Table 17. This investigator classified them initially into two major categories: natural and supernatural sources of causation. Classified within the first group are all causes that have a physical or real existence, such as food and eating patterns, weather and climate, hygiene, physiological conditions, occupations and work, habits, and emotions. Within the supernatural realm are grouped those causes proceeding from an order of existence beyond the physical universe that is observable and capable of being experienced by ordinary means, or relating to God, spirits, and the devil (Webster, 1983). Among this second category are the families' explanations of evil eye and the presence of spirits of dead persons.

Weather and climate. Among the natural causes, the category of weather and climate plays an important role in health and illness as well as in other aspects of the villagers' daily lives. Fishermen wait for the right wind to go to sea; each season brings its own type of fish and requires different kinds of nets. The moon is observed in all its details for predictions of rain or good weather. Their influence on disease is also evident in Table 17 where all families refer to at least one cause of disease as being related to weather and climatic conditions. Some of the families' reports are transcribed here.

Family 5: When we are hot from the oven and go out in the rain, we can get "zipra" (a folk name for infection).

Family 6: South wind brings cold and "pontada" (bronchial pneumonia). It is bad even for the fish. Hot weather can cause dehydration because of the strength of the sun.

TABLE 17

## Causes of Disease/Ailments as Described by Families

Category	Family																						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
<u>Food and Eating Patterns</u>																							
Heavy foods	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Rotten foods	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Warm fruit	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Cold drinks	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Ripe/green	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Not eating enough	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Mixing foods	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
<u>Weather and Climate</u>																							
Coldness	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Weather changes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Winds	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Hot sun	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Insufficient clothing	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Getting wet	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
<u>Physiological</u>																							
Low blood pressure	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Thyroid	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Eruption of teeth	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
<u>Work/General Activity</u>																							
Working hard while young	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Lace making/fishing	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	

TABLE 17 (continued)  
Causes of Disease/Ailments as Described by Families

Category	Family																					
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Hygiene</u>																						
Worms	x			x				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Animal excrement	x	x	x																			
Insects	x						x															
Germs from the beach				x				x														
Dirty sand											x							x				x
Going barefoot														x								
Lack of hygiene										x	x											
Contact with something dirty									x								x					
<u>Habits</u>																						
Smoking									x													
Drinking																						
Children's bad habits				x																		x
<u>Emotions</u>																						
Frights									x													
Nerves	x	x	x			x		x	x				x							x		x
<u>Supernatural</u>																						
Spirits of the dead		x		x	x	x	x	x				x			x	x		x	x			
Jealousy/Evil eye	x		x	x	x	x	x								x	x						



Family 22: To take a bath and go out in the wind can pull the mouth out of shape and cause paralysis of the face.

Hygiene. A second cause of disease referred to by families is related to hygienic problems (19 families). The field notes show that families identify at least three different sources of disease in relation to this category. The first one deals with environmental problems such as the presence of worms, dirty sand, and animal excrement. Among these, worms occupy the first place and are responsible for the great number of families being in this category. It was common to hear a mother relating her child's refusal to eat, abdominal pain, and even shortness of breath to the presence of worms. "Worms" is a general word that includes all types of intestinal parasites. Families usually did not make distinctions between types, size, or ways of transmission of the parasites in their explanations about causation. There were only two families who clearly stated that "oxiurus" caused genital itching in their children (families 18, 22).

Intestinal infestation by parasites is not a new health problem in the village. According to the information given by grandparents and the health history of the families, worms were among the most important causes of mortality until recent years. One grandmother (family 22) described, "In the old times children used to die from "cansaço" (tiredness, but better translated as shortness of breath) or attack from worms; I myself lost one child from this problem. After the child was in the coffin, the worms would come up from the ears, nose, and mouth, a lot of them."

When talking about worms, families distinguished at least three different kinds of health problems, such as "pain due to worms" where mothers have to calm the worms; it is frequently related to the phases

of the moon. More feared, however, is the "cansaco" (shortness of breath) that "has to be treated immediately". The most dangerous form is the attack from worms which "usually kills the child if it is not taken care of in the first 24 hours", according to parents' descriptions. During the period of my study, one child in family 12 had to be hospitalized with the diagnosis of "occlusion by ascaris" (mother's information) after taking a dose of Ascarydil prescribed by the physician. The mother reported, "They told me it is because the dose was not enough, but my father says it is because I gave the medication in the wrong moon." And this last information was given to me by some other families, reinforcing their belief in the relationship between the phases of the moon and worms.

After the introduction of vermifuge and its routine use among the families, mortality by worms is not common. There are families who give this medicine every three months, even without a laboratory examination. However, the most common period is every six months. This made a noticeable decrease in mortality but did not change the high incidence of parasites among children, as identified by the health census. Nowadays, intestinal parasites have become a problem that all children have, even though controlled, or as the mother in family 8 stated, "It is normal for children to have worms."

A second cause of disease in the category of hygiene regards the personal body care, with six families referring to walking barefoot, wearing dirty clothes, not washing hands before eating, or not taking daily showers as examples of lack of personal hygiene. There were also references to contact with dirty things (2 families) which can induce another ethnic disease called "cobreiro" (similar to herpes in

scientific terminology). Family 9 had a case of "cobreiro", and the mother explained it this way.

Two days after I took the child to the hospital, he began having blisters on his back. I am sure it was because the nurse lay the child down on a dirty blanket while the physician was examining him! Now he has different types of blisters, some beginning with a liquid inside, others getting better. But they are only on his back.

A third variation of the category of hygiene deals with the manipulation of food, which is exemplified by the concern of parents with children eating fruit without washing them or picking up food with dirty hands. Environmental and personal hygiene conditions are usually linked to gastrointestinal disorders, with abdominal colic and diarrhea being the most often cited ailments. However, they can also affect the respiratory system (coughs and sore throats) and the skin (rashes and grubs).

Different from the first two themes, lack of hygiene and related problems do not seem to generate the same feeling of fear as cold temperatures, south winds, rains, and certain types of food do. One possible reason may be that villagers have learned that they have control over some of these ailments, by wearing shoes, taking vermifuges, and through personal body care.

Families consider ailments caused by environmental and personal hygiene conditions as mainly pertaining to the period of childhood. To have worms or grubs seems to be part of being a child, of playing in the sand, or eating with dirty hands. This idea is reinforced by the frequency of symptoms, the number of laboratory examinations, and doses of vermifuge taken. However, there is some evidence that adults also are infested by intestinal parasites, as some family health reports indicate (families 6, 8, 10, 19).

Food and eating patterns. A great number of families (n = 16) regard food and eating patterns as being related to many health problems. A first dimension pointed out by families is in regard to its composition or conditions related to the food itself, such as "heavy" foods, fatty foods, or the temperature and ripeness. According to family 5, "a heavy food (comida corregada) is ray and other fish without scales (peixe lixa). These are dangerous for women because they thicken the blood. For men there is no problem; they can eat them. Children also should not eat shrimp and mussels." The link between heavy food and gender is also apparent in family 6's explanation: "A woman, when she gets her periods, should not eat ray." Other references to heavy food were made by family 1, whose mother's headaches and stomach pain were said to be caused by the turtle she had eaten two days before. In family 19 the same symptoms were caused by mullet eggs. Both turtle and mullet are considered very tasty by villagers but also belong to the group of "heavy" foods.

Another dimension in the food and eating category includes human behaviors and decisions about food. Thus, the mixing of some components are considered unhealthy, such as mixing milk with fruit, bananas with potatoes, watermelon with grapes, or eating fruit at meal time. However, not all families agreed that mixing foods can cause disease. As reported by the mother in family 12, "In my father's opinion we should not mix fried and raw bananas, but we do it and nobody gets sick." The amount of food ingested is another concern present in informants' descriptions. While eating too much leads to vomiting, indigestion, and abdominal colic, not eating sufficiently is also an indicator of sickness. The handling of food is another aspect that, if

not conducted adequately, can cause physical disturbances, the lack of hygiene being the most common cause cited by informants. Another dimension of diet with significance for health is the temperature of the food. Eating warm fruit is seen as causing digestive problems, while iced foods and drinks bring about respiratory problems. And finally, the families recognize that members can have susceptibilities to certain kinds of food, expressed by the assertions of "foods that do harm".

The influence of these beliefs about diet goes beyond the area of causation of diseases. They have an impact on what foods the families select to buy, the way in which meals are prepared, and even when and how they are consumed. As a consequence, there are some foods, essential to a healthy nutritional balance, that are not included in a regular meal because of this selective process of the families. These factors, not just the low socioeconomic status of many families, are probably the major causes of the monotonous style of meals these families usually have.

Emotions. In this group, causes related to nerves were the most frequent (8 families) and, although cited most often by women, it was also found among some fathers. There are a variety of symptoms described as being related to the nervous system, or just "nerves". The father's diarrhea in family 1, the numbness of lips in families 4 and 9, headaches in family 2, seizures in family 13, and shortness of breath, nausea, and numbness of feet in family 20 are a few examples of how families perceived "nerves" as causing symptoms.

Another belief about causation found among some families (n = 2) was referred as "susto" (fright). The wife in family 3 explained she had a spontaneous abortion after a fright (she witnessed an accident),

and in family 9 the mother lost a greater amount of blood than usual during her periods, also because of fright.

Occupational and work. For eight families, working conditions can determine illnesses in some specific conditions. Age is the first one and, as families stated, "Working hard at a young age causes disease in old age" (families 5, 10). The type of activity is also related to a certain group of health problems. "Working as a fisherman in water and coldness brings rheumatism" (family 15) and "Washing clothes and making lace are responsible for our back pains and rheumatism" (families 1, 13).

Physiological conditions. This category was included because some of the informants mentioned an organ or system of the body as being the cause of a physical disturbance. As such, the mother in family 4 asserted that her dizziness came from low blood pressure, while the mother in family 9 maintained that her nervousness was caused by the thyroid. In addition, mothers with infants blamed the eruption of teeth for the child's diarrhea.

Habits. A not very frequent cause cited by families (n = 4) includes children's bad habits (which families called "vice"), drinking, and smoking. Drinking, a problem described previously as being frequent among villagers, was considered as a health problem by only two families. In the same way smoking, another common habit among males, was mentioned by just one family. Families look at smoking and drinking as part of the male role. The mother in family 2, while talking about her plans for her children's future, said

I am concerned about Roberto's future because he can become a drinker or a drug addict. I do not think too much about Lea because she as a woman does not face this kind of problem.

Supernatural causes. The first and most common cause of disease pointed out by thirteen families in this groups concerns the presence of spirits. The mother in family 7 referred in her health history to a case of "encosto" (the presence of a spirit in her body).

It was my uncle's spirit. I was 12 years old and got very sick, lost weight, and nobody knew what was happening. My mother took me to the Spiritualist Center to be blessed, and they had to light candles and to throw many flowers in the ocean.

As in the case of weather and climate and the evil eye, spirits or souls of dead persons that return to earth are not only related to health and illness; they are present in other aspects of the villagers' lives as well. The father in family 11 told me about a frightening experience he and his wife had once in the field with a wild horse, which in reality did not exist but which appeared in the same place one of the villagers committed suicide. The husband in family 13 also described the presence of a dead priest who used to appear on the beach near family 21's house.

Evil eye (mau olhado) is the second most important supernatural cause of disease (9 families). According to family 3, evil eye "usually happens when a person admires a beautiful and chubby child, but it can also happen to adults, animals, or plants. The child begins to lose appetite, gets sleepy all the time, does not have disposition for anything, and the only treatment is to bless." During my field work, one of the children of family 4 had a "case of evil eye". These are my notes on the subject.

March 3. Pedro (3 years old) is not okay, he is losing weight, does not have an appetite. Last Monday his mother took him to the doctor who asked for a blood, urine, and feces exam.

March 10. His mother went to the ambulatory clinic to see the results, but the physician did not show up. She had to wait for another week to have another appointment.

March 15. Pedro still does not want to eat. Mother decided to go to the local clinic to show the doctor the exams. The physician prescribed Giarlan and Combiron.

March 17. Pedro is taking vermifuge; still not eating well. Right now he is sleeping with a wool blanket (it is hot, it is summer here) and his pacifier.

March 24. He is sleeping with the blanket and pacifier. Mother says he is not improving, still eating poorly.

March 31. Pedro only drinks his bottle. Mother does not know what to do. Her mother-in-law says she should take the child to be blessed. She says probably it is the evil eye because Pedro is so cute. Artur (the father) is also concerned about the child. Now Pedro is asking to rest every 2-3 hours.

April 2. Pedro finished the Giarlan; now he begins with Combiron. Still not eating well.

April 5. The same situation with Pedro.  
Observation: During the home visit I finally saw Pedro awake, because every time I have gone there he was sleeping. He was all sweaty and wanted to lie down. His mother says it is weakness. Artur came and put him to sleep.

April 7. Pedro ate fish today. It is the first time after more than one month. His mother took him to Saco Grande to a lady who blessed him. She told Maria it was an evil eye and blessed the child, the bottle, and his clothes with a cross. He has to return two more times.

April 12. Pedro is playing with a hatchet. He is eating better, rice and black beans.

April 14. Pedro is fine, eating better; in the morning, coffee, milk, and bread, and at lunch, rice and black beans.

April 19. Pedro is eating better. Now he wants to eat at the table with the family (he never did before). Mother is still taking him to be blessed.

The evil eye pervades other aspects of family life, not only health and illness. Family 6 stated that some of their chickens died because of evil eye, and the mother of family 15 visited a healer because her husband was not catching any fish for almost two weeks. According to



her, "This was also a case of envy, and a special treatment was performed to remove it." Evil eye is a belief widespread among the families in this study. However, not all believed in it. One example is the mother of family 11: "I am like my mother. I don't believe in evil eye; if it were true, many people would die from it."

Ailments. This general scheme of causation is reinforced and somewhat expanded by the information given by families in the interviews on ailments. Cold, the first one discussed with families (Table 18) shows the great impact of weather and climate in people's perceptions of disease. All families without exception pointed out at least one dimension of this category as responsible for causing colds, with winds being the most frequently mentioned (16 families), getting wet (13 families), and coldness (13 families). Exposure of the body to rapid changes of temperature (hot/cold) is another cause of colds often pointed out by the families.

Family 1: Colds come from coldness, south winds, rains, and walking without a coat. For adults it is to get up warm from bed and walk barefoot in a cold or humid place or to sleep without a blanket.

Family 2: Where someone takes off their clothes near an open window or door when there is a change in the weather, if someone has wet feet, or gets out warm from bed and goes to the coldness, like fishing.

Family 12: Colds come from south winds. There is no cold when the weather is warm. In summer nobody has colds.

In summary, colds for families are the direct result from environmental or bodily conditions related to weather and climate and changes in body temperature. No family made any reference to specific agents such as germs, nor is the idea of contagiousness apparent in their explanations on colds.

TABLE 18

Causes of Cold

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
<u>Weather and Climate</u>																							
Coldness	x			x	x	x	x	x		x	x	x				x	x	x	x	x			
Rapid weather changes		x		x				x															
Winds	x			x		x	x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
Getting wet	x		x	x	x		x	x	x	x	x		x	x		x		x			x		
Insufficient clothing	x					x												x					x
Being warm/cold	x	x	x		x	x		x													x		x

Sore throats (Table 19), another common respiratory problem among villagers, is seen by families almost exclusively as a consequence of a previous cold (16 families). Only a few families considered other categories, such as food and eating patterns (iced drinks) or weather and climate conditions (coldness and winds) as related to sore throats. Here are some of the families' descriptions about this ailment.

Family 2: I don't think there is any special cause for it. For myself, it comes after drinking iced drinks. Lea (her daughter) gets it from coldness or walking barefoot in the wet.

Family 18: It comes from colds and pharyngitis.

Families made a distinction between a common sore throat or "dor de garganta" (pain in the throat), which is considered a mild case and is treated with home remedies, and the "garganta inflamada" (infected sore throat), when fever and discharge are present. In this second case, families take a different approach to treating it.

Even though the incidence of sore throats was very high, there were some families who did not know its cause. As the mother in family 10 stated, "I don't know the cause nor the treatment because my children never had it". Or the mother in family 7 who stated, "I don't know; we never experienced this problem at home."

"Pontada" (sharp pain) is an ethnic expression that is used for acute respiratory problems characterized by high temperature and discharge. Families distinguish different forms of pontada: "inicio de pontada" (beginning), which is a mild form, "pontada", and the most serious form, "pontada dupla" (twice), which is equivalent to having the problem in two lungs. It is a frequent illness, and each family history had at least one reference to a case of pontada. My notes on family 7 show how the mother described Carlos' sickness:

TABLE 19

Causes of Sore Throat

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
<u>Food and Eating Patterns</u>																							
Iced drinks	x	x																	x				
<u>Weather and Climate</u>																							
Coldness		x	x																				
Winds																			x				
Barefoot in wet places		x																					
<u>Illnesses</u>																							
Colds	x		x	x		x		x	x			x		x	x	x	x	x	x	x	x	x	x
Pharyngites																							x
Wounds in throat														x									
Doesn't know					x		x																
Other											x												x

Carlos is sick. He began with a cold and I waited for two days. When he got the fever I took him to the health clinic. The physician said it is a beginning of pontada. He has to take antibiotics and stay at home.

A more serious case of pontada was described by the mother in family 2:

My husband was in the hospital last October with pontada. He was very weak and spitting blood from the mouth. He had to stay there for one whole month.

The major cause of pontada, as seen by the families, is a bad or complicated cold (11 families). A few families considered this ailment the direct result of coldness (1 family), getting wet (1 family), and south winds (2 families). As with sore throat, it also happens that although pontada is a frequent problem, there are still families who don't know the cause (n = 3) or only know about the treatment (n = 6). This is one of the few illnesses where almost all the families agreed that home remedies do not work. As the mother in family 17 asserted, "The treatment is to run to the doctor. There is no home remedy that cures it." Or as family 22 said, "Only the X-ray shows if the child has pontada, and the treatment is to give antibiotics."

Coughs are another health problem that families deal with on a daily basis. There is always a member in the family who complains about coughing. Usually it is not an ailment that is feared, but it can become serious for families if there is the presence of discharge, fever, or a suspicion that it is caused by worms or bronchitis. Families link coughs mostly to colds (12 families), weather and climate conditions (7 families), and worms (4 families). During the field study, this investigator had various opportunities to see how coughing was related to worms in the families' model of causation. The mother in family 8, after her son had been coughing for some time, said, "Albert has an irritating cough that I know for sure is from worms." Another

instance occurred in family 1 but was repeated in other families: "Fabiano began to cough last Saturday. He was getting worse on Sunday. I thought maybe it is worms. Then I gave him garlic to smell and rubbed olive oil on his chest and wrists. As he did not get well by Monday, then I took him to the health clinic."

This relationship between worms and coughing probably comes from families' long experience with the children being infested with worms. It is known that some parasites, before they locate in the human intestine, have a pulmonary cycle when they simulate some of the same symptoms of other respiratory diseases. Although the scientific explanation is not known by the families, they have experienced this many times throughout the generations.

Earache is mostly seen as a problem related to childhood, although some adults also have it. For most of the families (n = 9), it is a consequence of colds. However, there are families who also relate it to coldness (4 families) and wind (5 families). In this last case, it can be the wind by itself or drafts from winds. It was described in the following way by three families.

Family 5: I think it comes from the cold. My children do not have it any more. Camila had it once when she was 3 months old, and I dropped maternal milk in her ear.

Family 18: Mauro has it frequently. It usually comes from colds, but not always. Sometimes it can be caused by sinusitis.

Family 19: It comes from walking in the wind without an ear protection or from drafts. Cleuza had this problem when smaller.

As with previous ailments, there were some families who did not know its causes (5 families). Family 15 expressed it this way: "I don't know where it comes from; we never had it."



"Zipra" is another illness related to the weather and climate category. It is another ethnic expression that means a problem in the skin. Family 3 described it as "when you have a cut or a wound in the arm or leg, and you get wet, the hands or feet will get swollen, a red area appears, the person feels shivering and, if it comes too strong, it becomes 'erisipela'." The mother in family 1 said, "Airton got 'zipra' because he had a cut on one of his feet and got it wet while playing soccer." Although for the majority of families "zipra" is a consequence of getting wet if there is already a wound, "zipra" can also appear in the case of a nursing mother whose breasts get swollen and hard.

A second group of ailments deals with gastrointestinal problems, diarrhea, vomiting, and abdominal colic. This group differs from the first one in its emphasis on the category of food and eating patterns and environmental and hygiene conditions, although not exclusively. In the case of diarrhea, fourteen families related it to food and eating patterns, with foods that do harm (8 families) and fatty foods (4 families) being the most frequent explanations given by families. Among foods that do harm are milk for the father in family 6, black coffee for family 16, and chocolate and sausage for the children in family 5. The second most common cause of diarrhea is worms (8 families). The eruption of teeth also occupies an important place in causing diarrhea, mostly for families who have children at this stage of growth and development.

Vomiting, another feared ailment, is seen by families primarily as a result of food and eating patterns (12 families), with foods that do harm (8 families), mixing foods (4 families), and eating too much (3 families) the main causes. Other explanations for vomiting include



worms (3 families) and a group of illnesses such as sore throats (5 families), infections (3 families), fever (3 families), and "other" (4 families).

The last ailment of this group, abdominal colic (Table 20), is found repeatedly in the sample studied. For the families, it is caused by worms in the first place (14 families), followed by conditions concerning food and eating habits (10 families). When a child complained of abdominal colic, the first explanation given by mothers was, "It is probably worms; it has been some months now since he/she took the medicine for worms (vermifuge)."

A third group of ailments, which includes worms and grubs, is determined, according to the families' perspectives, by poor personal and environmental hygiene. In the case of worms, fifteen families pointed out the lack of hygiene as the principal cause and includes walking barefoot (9 families), dirty sand (5 families), dirt in general (4 families), and eating fruit without washing them (4 families). There were also some families who thought worms were caused by food and eating patterns (6 families), such as drinking milk, eating guava, or eating too many sweets (4 families), while not eating well was pointed out by two families. Interestingly enough, there were some families who reported not knowing which factors motivated the presence of worms (3 families). Included among these was at least one family who had had a recent experience with the illness which required medical care.

Grubs. Grubs, a thick, worm-like larva of an insect that usually penetrates the skin of the foot (Webster, 1983), is another health problem common to children and adults and is viewed by the families as being caused by animal excrements (14 families) and dirty



TABLE 20

Causes of Abdominal Colic

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Food &amp; Eating Patterns</u>																						
Heavy food								x											x			
Fatty food						x																
Too much sweets									x					x								
Mixing foods		x												x							x	
Food that does harm		x												x								x
Cold water after meals																						x
<u>Weather &amp; Climate</u>																						
Coldness																						
Hot weather	x																					
<u>Hygiene</u>																						
Worms	x	x		x			x	x		x	x	x	x	x		x		x	x	x		
Doesn't Know																						x
Others																						x

sand (9 families). This ailment, although very common, is feared by the families because they relate it to zipra and tetanus. This last belief was reinforced in the village when two years ago one of the children in family 16 was hospitalized with tetanus after having removed a grub. The fear of grubs increased among the families, and the story about the child was brought up every time a question about grubs was asked.

Fever, an ailment that all informants had experienced at some point of family life, is another feared problem in the village. All families with the exception of two (families 3, 5) consider fever as being determined by problems such as sore throats (13 families), colds and infections (9 families each), pontada, and wounds (5 families each). Headaches, on the other hand, are associated with a variety of causes, illness (colds and sinusitis) being the most important (11 families), followed by emotional problems (7 families), physiological disturbances, and weather and climate conditions (3 families each).

Rashes, a common problem among villagers, are identified with allergy (5 families), physiological conditions such as heavy blood (5 families), lack of hygiene (6 families), and heavy foods (4 families). Heavy blood (sanguie carregado) appears as a new condition, usually related to skin problems. The mother in family 13 said about her children's skin wounds, "The doctor says it is allergy, but I am sure it is due to heavy blood." In addition, the mother in family 17, when talking about her pimples, asserted, "They say it is heavy blood, but I did all blood tests and there is nothing wrong."



### Emerging Themes

The first theme that emerges from the data is that families employ a multicausality model in looking at causation that includes both natural and supernatural sources. Among these causes, people identify components in the physical environment (meteorologic, climate and weather conditions, foods), biological (insects, cattle, worms, germs at the beach), social (working conditions), spiritual (evil, spirits), as well as human conditions (physiological and psychosocial). These different dimensions, however, are seen by the families as interrelated and interdependent in such a way that it sometimes becomes impossible to determine if there is only one cause for an ailment. Examples of this integrated approach is that, in order to catch a cold, not only is the presence of a cold temperature required, but the person has to be with inadequate clothing as well. In the case of worms, it is a result of being barefoot and playing or walking in dirty sand. Even in the case of evil eye, there is the person with envy or strong eyes and the beautiful and chubby child.

This model also adopts a holistic view, where causation of disease is part of the families' broader views on life. This is easily understood because the same causal factors (rain, sun, winds, sand, animals, spirits, envy) that are considered as leading to disease are also a part of their daily life, work, religious beliefs, children's play, and even human social interactions. Furthermore, this model has a developmental dimension. There are illnesses considered as common among children, such as diarrhea because of the teeth, worms, evil eye, dehydration, or abdominal colic, while others are expected to appear



during adulthood, and a third group is seen as a result of aging (diabetes, rheumatism, cardiac problems).

Another characteristic of this multicausality model of disease is the belief that a person lives in balance with his/her internal and external environment. Disruptions in the equilibrium lead to different kinds of problems, disease being one of them. The families apply this idea of balance in different ways. First, it is found in regard to temperatures. The families relate disease to the temperature of different elements, such as environmental (high/low), seasonal (summer/winter), food (iced drinks, warm foods), and body conditions. In this last group, informants distinguished an external or actual temperature, which is evaluated in terms of being feverish or not, and an internal temperature, usually measured by the kind of symptom (cold in the kidney or uterus, "calor de figo"). But not only exposure to temperature extremes produces disease. Rapid changes from one to another is considered prejudicial as well. Some examples are "being warm at home and going out in the cold", "warm from bed and walking barefoot on the cold floor", or "being hot from the oven and going into the cold wind".

Temperature is not only used in its literal sense that can be verified by instruments and scales, but also in a more abstract or figurative sense. As the grandmother in family 9 stated, "If you treat diarrhea caused by the eruption of the teeth, the 'hot' will be retained and the child will get fever." Although there seems to be a greater number of health problems related to cold temperatures, both high and low conditions are responsible for illnesses feared by villagers, such as "pontada" and dehydration.



Wetness is another dimension of the families' balance model. "Getting wet" is an expression frequently found in families' reports as causing a series of symptoms (see Table 17). Informants referred to getting wet in different ways, such as "going out in the rain", "walking barefoot in wet places or mud", "being warm at home and going to the sea", "having a wound and wetting the feet", each one usually leading to a different kind of illness. It seems that the circumstances in which a person gets wet is the main factor to understanding the type of symptom it generates. As such, in normal conditions, a person walking in the rain is expected to catch a cold, going to the sea after eating will cause "congestao" and death (according to family health histories), "zipra" is the result of having a wound and getting wet, and bathing newborns before the seventh day causes tetanus, or affliction of the seventh day.

Still under the principle of balance between man and his environment, there is the belief that air currents and especially south winds are causes of disease. Winds guide many activities in the village. According to the type of wind, fishermen will go or not go to sea, women will catch "castela" (a kind of shell) to cook, or wash clothes, and children are allowed or not allowed to play outside. The south wind is known on the island as being responsible for bringing rain and cold temperatures. People often say, "Our winter is the south wind." Thus it is not difficult to understand the link between winds, temperature, and rain in the villagers' views on causation of ailments. Winds are among the most frequent causes of disease as described by families. There was a total of 14 families who mentioned south wind or exposure to cold winds as causing illness (Table 17). In addition,

winds are the major cause of colds (16 families) and the second most important cause of earache (5 families). Families also considered winds responsible for common headaches and other health problems. For instance, the mother in family 9 said, "I had 'recaida' (relapse) after my last delivery because they removed the stitches while the south wind was blowing." Families also related some pains as predictors of south winds, such as the mother in family 15 who stated, "I am feeling pain in my back bone. I am sure the south wind is coming." or the mother in family 1 who said, "Rheumatic pains in old people predict south wind."

Another theme underlying families' conceptualizations is the roots in "living experiences". These experiences are at the level of the community: "I don't know about eye infection; it is not common in the village" (family 14) or "It is a frequent problem here; right now two people have it" (family 22, talking about hepatitis). But they also have a family connotation as well. As such, a families' knowledge of causation of disease is based upon the members having or not having experienced the ailment before. This experience has to be within the family itself or with very close relatives. Illnesses not experienced in such situations are only partially known. As the mother in family 9 described diabetes, "My sister has it, but I only know that it is sugar in the blood; this is all that I know."

A second characteristic of "causation as a family living experience" is that knowledge of causes of disease is personal; in other words, it is always related to a certain member of the family who has experienced it. Families, when asked about an ailment, always would mention the member who had it. As a consequence of this kind of thinking, diseases are not seen as having an entity separate from the

individual who gets it. In addition, they become so integrated with the person who has it that it is common to find such explanations as, "My sore throat comes from iced drinks and Cleuza's from south wind" (family 19).

Furthermore, symptoms are usually "situated". In describing an ailment, families usually bring up the whole situation in which it occurred, with all the small details. Family 18, when talking about Arnaldo's first crisis of bronchitis, said,

It was noon when we took him to my mother's house while my husband and I went to visit some friends. When we left him he was okay, playing. My mother left him in the room playing, and the window was open. Suddenly there was a change in the wind, and Arnaldo began coughing, and after a while he had problems with breathing. He was getting worse, and we tried everything.

As a result of this family experience with disease, people develop a notion of susceptibility, where some members are seen as getting a disease more easily than others. As the mother in family 8 said, "South wind is dangerous for my husband but not for me. I never get colds or sore throats", or the mother in family 15 said, "I never had pontada, but my sister has it every time she gets pregnant."

Families' models of disease have their own definitions of illness, types of disease, and explanations on how a cause is identified and related to a determined problem. To begin with, families usually describe a health problem in terms of the physical disturbance the member is experiencing at the time, instead of connecting it to a determined disease. Thus when the investigator would ask about the health status of one member, the answer would be that he/she is not eating well, is feverish, has a cold, is coughing, has discharge, does not sleep well, has pain in the throat, and so on. Even when a medical



diagnosis had been made, families still would focus on the problem of the patient and not on the disease itself. The mother in family 20 knew about the urinary infection of her daughter but always referred to her general status of well-being or her fever or back pain; she would never talk about the evolution of the disease separately.

The configuration of symptoms in a specific disease, characteristic of the scientific model, is thus not common among families unless it is an ethnic illness or a disease very well known and common among the villagers. For instance, in the case of zipra, families do diagnose the different disturbances such as fever, the infected area, and edema as signs and symptoms of the same problem. It also occurs in the case of worms where not eating well, abdominal pain, shortness of breath, or coughing lead families to suspect intestinal parasites.

The families' model of disease is made up of ethnic illnesses, physical disturbances, and a few medical diseases. Among the ethnic illnesses, informants referred to zipra, pontada, maligna, cobreiro, trisa preta, evil eye, fright, and affliction of seven days. Some of them have equivalents in medical terminology, which are also known by villagers; for example, pontada means respiratory problems, usually bronchopneumonia, affliction of the seven days is known as tetanus, maligna is dehydration, and trisa preta is hepatitis. There are others, however, that are only of ethnic origin, and families are conscious that health professionals do not believe in them. This is the case of zipra, evil eye, arca caida, and encosto, among others. Finally, there are those diseases that families have recognized and accepted from scientific medicine such as tuberculosis, diabetes, intestinal parasites, sinusitis, and urinary infection. However, it is important

to note that the fact that families have accepted scientific terminology does not mean they share the same sources of causation professionals use.

Although no family explained clearly how a specific cause determined a physical disturbance, this investigator identified at least two lines of reasoning families developed to link a health problem to a source of causation. First is to associate the physical disturbance to a previous event. This association is sought first in an event in the immediate past. For example, the mother in family 1 associated her headache to the turtle she ate two days before; the mother in family 12 associated her sore throat with the fact that the previous day she was working very hard and wet her feet in the mud. This kind of association, when repeated over time, reinforces ideas on causation. Villagers' beliefs about tetanus in the newborn is only one example of this type of explanation. Grandma in family 19 told me,

Children in old times used to die from 'mal de 7 dias' (affliction of 7 days, or tetanus). Now that they are being born at the hospital, they do not have the disease any more.

When I asked the reasons, she explained,

Lay midwives used to wash the babies as soon as they were born, and after one week they would get black, in pain, and die. But now that the children are delivered in the hospital, they do not wash the babies. They wait one week to bathe them.

When I asked what midwives would put on the umbilical cord, she told me smoke and pieces of dried grass, but no references were made to them as possible causes of tetanus. This information was given to the investigator by other families as well.

Another line is to look at causation as a succession of health problems, where one disturbance is seen as the cause of another one.

One example of this chain reaction is found in cold, which is caused by winds, rains, or coldness, and at the same time gives origin to sore throats and earaches which, in turn, are responsible for vomiting, fever, and so on. This kind of reasoning in succession has consequences for the ways families treat and follow up illnesses at home, which is different from health professionals, who group a series of signs and symptoms under the heading of a disease and the treatment is focused on the latter rather than on its components; the families' approach to illness adopts the opposite point of view, that is, to alleviate each different disturbance at a time.

Last, family members also try to negotiate their individual definitions of causation of disease in such a way as to come to some family agreement. Both the wife and the husband come to marriage with their own knowledge and beliefs about causation, which is a product of their earlier experiences. This set of knowledge is exchanged over time between the couple, the differences are recognized and, doing this, they negotiate what will be plausible for the family. In discussing causes of ailments with parents, the fact that both can have different ideas or emphasize different categories became evident, as well as the way they tried to coordinate their knowledge. There were a few families in which the father or the mother would just accept whatever the other would say about disease, but the greater number of them tried to make some compromises. In family 8, the father insisted on weather and climate conditions as being the main causes of disease while the mother, although not totally convinced, would accept it just to please the husband. In family 22, the mother's ideas were just added to the father's in most of the cases, and points of disagreement were





overlooked. In family 9, the mother was in charge of health problems because the father was working far away the whole day, and usually her definitions were promptly accepted by the husband and the whole family.

In summary, the families' approach to causation of disease is one firmly rooted in their culture that provides them with a general perspective on life, of which the concept of health and illness and ideas on causation are one integrated aspect. However, this does not imply that all families conceptualize illness in the same way. Based on this common denominator, each family, through its life cycle, develops its own model of causation. Because it is built on the families' living experiences, this model is not static. It evolves through the years, and knowledge and beliefs are added, modified, or reinforced according to family members' contacts with disease and the process of interaction within the family as well as with other reference groups. It changes over time and over generations, with the introduction of scientific medicine being one of the factors influencing this change.

Although modern medicine is available and at low cost, it is not enough to modify the villagers' views of causation. Germs as agents of disease are not a frequent explanation for the ailments, even though words such as "infection" are found among informants. Ideas about contagiousness are shared by some families, but differently from the concept of health professionals. It is seen as socially induced (closeness to people, lack of care) and not to the presence and transmission of germs.

Families' Measures to Promote Health and Prevent Disease

Table 21 presents the measures for promoting health and preventing disease as reported and performed by families during the period of the field work. The measures are grouped into eight main categories that closely resemble the families' definitions of health and illness and

Food and eating patterns. This preventive measure was described by 18 families. The dimensions most frequently cited refer to quantity (13 families), combination (6 families), type (4 families), and hygiene (4 families) of foods. Families expressed a constant concern as to whether their members were "eating well" or not. In most cases, this was measured by eating enough during meals. However, there were some families (n = 6) who specified the type of food that should be eaten, such as strong foods (black beans, milk, meat, vegetables). Eating well or eating enough was a daily matter of concern among informants. Families often classified their members in two groups: those who ate well and those who ate less. Although the idea of eating less was not totally acceptable, those who did so were still considered healthy, but families always kept a close watch on them, and special kinds of food were prepared to please them and to make them eat more. Changes in the diet were made not only for the purpose of getting family members to eat more, but also to modify habits that were not considered healthy. Sweets was the most frequent case. In order to prevent an excess of consumption of chocolate, ice cream, and candy at school, some mothers prepared cookies, cakes, or chocolate milk at home, or bought them at a known bakery, to assure that their children would at least eat sweets of a better quality. This was the case of mothers in families 3, 9, 11, 12, and 22. Others would give their children money to buy a snack,



TABLE 21

Families' Measures to Promote Health and Prevent Disease

Family

Category 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

NATURAL

Food and Eating Patterns

Not eating heavy food x x  
 Vitamins x x  
 Eating enough x x x x x x x x x x x x x x x x x x  
 Not mix foods x x x x x x x x x x x x x x x x x x  
 Strong foods x x x x x x x x x x x x x x x x x x x  
 Washing fruit x x x x x x x x x x x x x x x x x x  
 Filtered water x x x x x x x x x x x x x x x x x x  
 No iced drinks x x x x x x x x x x x x x x x x x x

Weather and Climate Measures

Against coldness x x x x x x x x x x x x x x x x x x  
 wear shoes x x x x x x x x x x x x x x x x x x x  
 wear warm clothes x x x x x x x x x x x x x x x x x x x  
 use blankets x x x x x x x x x x x x x x x x x x x  
 don't go out in cold x x x x x x x x x x x x x x x x x x x  
 Against wetness x x x x x x x x x x x x x x x x x x x  
 don't walk in rain, wet, mud x x x x x x x x x x x x x x x x x x x  
 Against air currents x x x x x x x x x x x x x x x x x x x  
 don't go out in wind x x x x x x x x x x x x x x x x x x x  
 Against hot temperatures x x x x x x x x x x x x x x x x x x x  
 don't walk in sun x x x x x x x x x x x x x x x x x x x  
 Against changes in body temperatures x x x x x x x x x x x x x x x x x x x  
 don't walk from warm bed to cold x x x x x x x x x x x x x x x x x x x  
 don't take cold bath x x x x x x x x x x x x x x x x x x x

TABLE 21 (continued)

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Personal Hygiene</u>																						
don't wear dirty clothes								x			x											
don't eat with dirty hands								x			x								x			
wash hands after bathroom								x			x											
daily shower								x			x								x			x
short nails								x			x								x			
be clean								x														x
don't play in sand								x				x										
<u>Leisure Activities</u>																						
Visit relatives		x																				
Maintain good relations																						
Mental disposition			x																			
Travel																						
Go to fountain																						
Others																						x
<u>Work/General Activity</u>																						
Don't overwork while young											x										x	
<u>Physiological</u>																						
Rest																						x
Exercise																						x
<u>Dental Practice</u>																						
Treatments																						x
Brush teeth																						x

TABLE 21 (continued)

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Medically-related Practices</u>																						
Vaccination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Checkups	x	x	x	x				x	x	x								x				
Cancer prevention			x					x														
Follow-up during pregnancy		x						x														
Follow-up during disease	x				x		x		x				x			x		x				
Taking vermifuge periodically	x	x		x			x		x		x		x		x		x		x			
SUPERNATURAL																						
Use of prayers/blessings	x			x	x	x	x		x		x		x		x		x		x		x	x

advising them to buy a sandwich, fruit, or chocomilk instead of candy (families 1, 8, 14, 15, 21), while others would recommend that their children eat the meal prepared by the school aides. Only a few mothers let their children buy sweets without any advice.

The second most important preventive measure in this category concerns the combination of foods. Family members were advised not to eat fruit during the main meals, not to mix fish with other meat, and not to eat two different kinds of fruit at the same time. Although mixing foods, especially fruit, was a preoccupation for some families (n = 6), there were those who considered vitamins or fruit a healthy practice. The mixing of fruit with milk was a daily custom for the father and children in family 17, the best way to feed the youngest - who did not want to eat salty food - in family 9, or to satisfy the constant hunger of Fabiano, the chubby child in family 1.

There was also an emphasis on eating at home. Although the easiest explanation for this is that homemade foods are cheaper, this did not seem to be the reason. In reality, no family gave this explanation. The underlying reason for eating at home, as Darlene, one of the children in family 4, stated, is "You always eat fresh food and you know who prepared it." This is consistent with family practices of preparing a fresh meal every time and not leaving food from lunch until dinner. This investigator was admonished many times by villagers for eating in restaurants instead of eating homemade food. As the grandma in family 2 stated, "When you think you are eating shrimp balls, in reality you are eating balls made of an ordinary fish. They cheat the customers." The father in family 1, when he invited me to have lunch with them, said





"Now you are going to eat fresh fish, not the frozen ones they serve you at the restaurant."

Even though there were no differences between generations on the significance given by family members to diet as a health-promoting and disease-preventing measure, they did differ regarding the dimensions they considered most important. For the older generation, it was the mixing of fruit and eating heavy foods, while the school-age children emphasized the need to eat vegetables, to plant them in the backyard, to drink milk, and to eat meat or fish daily.

Finally, to eat enough and adequate food seemed to be for the families not only a question of maintaining health but also an indicator of the family member's health status. It showed if the person was healthy, going to be sick, or had an illness already. For instance, the mother in family 15 said, "Julio is only eating fried eggs and bananas; when he begins like this, I know he has worms." And the mother in family 7 replied to one of the investigator's comments on Ines, the oldest daughter's, skinny figure, "But she is fine; she is eating very well."

Weather and climate. Protection against weather and climate conditions is one of the greatest concerns apparent from families' reports. Practices recommended by the families include those dealing with different dimensions such as temperature (to protect against cold as well as heat), air currents, and wetness (resulting from walking in the rain, mud, or still water). One of the measures, the wearing of shoes, had a double purpose; it protected against the cold, the wet, and worms as well. The first reason, however, was pointed out more

frequently by parents than the last one. Family 6's descriptions illustrate this point:

A person should be careful with the feet. He/she should not walk without shoes, does not walk in the wetness, does not put warm feet in the mud or cold water.

These practices were true for the whole family, with little difference between adults and children. Fishermen worked at home fixing nets on days of heavy rain or winds, mothers did not go out to the fountain, and children missed school. The practices also were reflected across the generations. The same concern with winds, rain, and cold was found in all three generations interviewed. All the children would include at least one dimension of weather and climate in their explanations about health promotion.

Personal hygiene. According to the families, a third kind of preventive practice involves personal hygiene (8 families). Here, as in the two previous cases, families only mentioned individual measures, with no family referring to a change in sanitation or environmental conditions. For the families, taking a shower before going to bed is the most important measure besides wearing shoes. There are some references to wearing clean clothes and having short nails (3 families each), but the number is not very large. There are fewer families in this third category, but those who mentioned it were very strong about it and usually described two or more dimensions of personal care. Here are some of the notes in this area. In family 22 the father says "to have hygiene, to brush the teeth, to take a daily shower" and the mother adds, "wear shoes, not get wet, not walk in the rain, and not go out in the wind". Parents in family 11 described it in this way, "To have good hygiene, not to eat with dirty hands, that brings worms; wash the fruit



before eating and take a shower before sleeping." The mother in family 12 added, "Don't walk barefoot, do not wear dirty clothes, don't go to sleep without changing clothes, have short nails, and don't play in the sand."

Even though the importance of cleanliness was a theme shared by the families and there seemed to be general rules for all members, there was special care with children. It was common to find "bathing the children before going to bed" included in the mothers' descriptions of their daily activities. This not only referred to the youngest child but also to their school-age children as well. The mother in family 8 said, "I like to bath Alberto (9 years old); at least I am sure he is clean." Jucira (11 years old), the oldest child in family 16, informed me, "I usually wash myself, but my mother has to remind me every day. She also needs to help me in washing my back and my hair."

Emphasis on cleanliness as a preventive measure was more apparent in the youngest generation. Children's reports mentioned daily bathing, washing hands, and brushing teeth more frequently than did their parents. In addition, they were more concerned about dental care than their parents or grandparents. A possible explanation for this can be the teaching of dental care at the local school. This investigator many times saw children brushing their teeth at the public tap after having their snack at school.

Leisure measures. Leisure measures were reported by seven families and are included in a fourth category. To visit relatives, to travel, or just to go to the fountain where the scenery is beautiful are the most common pieces of advice for promoting health and preventing disease. There was one family who referred to "maintaining a good

disposition" as a requirement for promoting health. This is how the mother in family 3 described it: "A person has to work to be optimistic, to have a good disposition. Health is not only absence of disease, it is also the way we face life."

Occupational/Physiological. These two categories involve measures concerning work and physiological conditions. In the first case, there is a concern with not working too hard while young because it brings health problems at old age (4 families), while in the second one a few families cited the need for exercise and resting as ways of protecting an individual's health.

Measures to prevent problems of supernatural origin, although not stated formally, were also a part of the families' daily lives. Prayers to ask for good health, the wearing of "blessed" clothes or "breves", the maintenance of good relations with neighbors (to prevent envy), and not exposing small children to people who may have "strong" eyes are some of the practices that fall within this realm.

Medically-related practices. Medically-related practices is a category that deserves some comment. With the exception of one case (family 3) who spontaneously referred to periodic medical checkups as a preventive action, when asked the question "What are the things you consider important to promote health and prevent disease?", no families reported any specific western medical practices at this point. It was only after the investigator asked questions about a specific measure, such as vaccination, or during the family health history or the weekly visits, that the families would add the other dimensions. It is important, then, to have in mind that these actions, although they are



practiced, are not included by the families in their general model of prevention.

According to the parents, almost all the children were vaccinated in the first year of life. However, their knowledge about the kinds of disease the children were immunized against is minimal. A common answer found among the mothers was, "They were vaccinated while infants, but I do not remember against which diseases, and I don't have their cards any more to show it." Knowledge can also be distorted, with family 20 being an example.

I vaccinated all my children, but it was not worth it. Even though they had even taken reinforcements, they had everything - measles, rubella, whooping cough, small pox, and mumps. I believe in vaccines, but with my children it did not work. Maybe because with me everything goes wrong.

It is important to add that ten years ago there were no vaccines available against rubella, mumps, and measles. In addition, her children had chicken pox, for which there was no immunization either, rather than small pox.

Families differed in their beliefs about the efficacy of the vaccine. There were some families who did not believe the vaccine could prevent disease. The mother in family 2 stated, "I do not believe in vaccines; do you think this small amount of liquid can do any good?" There were others who believed that vaccines worked. Family 11 was one of them. The parents said, "See, Aldo had all the vaccines and did not get the diseases, while Mila did not complete the scheme and got whooping cough." But most of them believed that the vaccine could prevent or alleviate the form of disease. The mother in family 14 was among this last group. She asserted, "Anita was immunized against measles, and when she got the disease, it was a very weak form."

While doing field work, this investigator had the opportunity to observe families' practices toward vaccination. Although most of the school children were indeed vaccinated, families reacted in different ways. First, there were families who encouraged their school children to take the vaccine while the infants and preschool children stayed at home (families 1, 4, 5, 7, 9, 13, 17, 22). The fact of not vaccinating the youngest children, who actually were in most need of it, because of their susceptibility was explained by some mothers.

Family 1: Fabiano is just recovering from severe burns. I will wait.

Family 5: Camila got the vaccine, but I did not take Rita because she is doing so well and I am afraid of zipra.

Family 9: I will wait until he gets older (the baby was 6 months old) and he gets better from the whooping cough.

A group of parents let their children decide if they wanted to be vaccinated or not. In this case, there were children who did not want to receive it (family 6) or, as in most cases, one member of the family would get the immunization while the other would refuse it (families 2, 10, 16). The most frequent reason for children refusing to be vaccinated was that they were afraid of the injection. A last group of parents sent their children because they felt compelled to by their own relatives, husband, or physician (families 2, 7, 8). As the mother in family 7 said, "If I don't vaccinate them and they get sick, the physician will accuse me."

Medical follow-up during pregnancy is one measure that almost all families reported having done in previous pregnancies. Of the six mothers who were pregnant at the time of this study, only one was not being followed by a physician. When asked why she was going to the doctor, the mother in family 2, who was two months pregnant, said,



I will have a medical follow-up because I believe it will help me to have a healthy baby and also because if there will be any complications at the time of the delivery, the physician will know my case and what to do. In addition, if I don't have a physician, I will not get the insurance.

Having periodic checkups is a common practice only among fathers, although only one family included it as a preventive action. For most of them, it was a job requirement and done routinely every six months. As the father in family 14 informed me, "Because I was working with food, I had to renew my license every six months" (which included a medical examination and lab exams). Mothers, on the other hand, talked about Pap tests for cancer in their health histories. Their reaction to this examination (which is free to all women at the Public Health Department) varied. There were mothers who did it every six months to one year (families 3, 8, 15, 19, 22), those who did it once in a while (families 9, 14), those who never did it (families 2, 6, 17), and those who were afraid of it (families 9, 10, 11). Mothers in general did not like to have this exam, and a general fear of the results was apparent among most of them.

Taking vermifuge every six months was a common observation made by a great many of the families. Again, this was not described by parents as a preventive measure; however, this investigator included it in this category because of its frequency and the way the families talked about it and acted upon it. For instance, when asked about shortness of breath due to worms, the families' usual answer was, "Now that they are taking vermifuge regularly, it does not happen anymore." Or when mothers would give information about the health status of the children, they would say, "He has abdominal colic. It has been more than six months since I gave him vermifuge the last time. He has to take it

again." (family 13). Furthermore, when the investigator began the study in March, more than half of the families had taken their children to the health clinic to do a feces exam without any other complaint than abdominal colic, paleness, or not eating well.

The last dimension in this category refers to medical follow-up in the presence of an illness. All the families included in this dimension had a health problem for which they looked for medical treatment during the period of field work, and all of them complied rigorously with the medical orientation and followed the whole treatment during the months. This did not mean, however, that other types of treatment such as blessings and home remedies were not also included to help the healing process.

One comment has to be made in relation to family planning measures. The majority of the families were very concerned about preventing new pregnancies. However, the knowledge they have about the different methods of birth control and their practices for the most part do not correspond to any scientific theory. Pills are taken only the days the couple has intercourse; women stop taking them or start again without any medical orientation. Medical follow-up and examinations are not done and usually the pills are bought without prescription. As a result, many unplanned pregnancies are possible, as was the case of most of the pregnancies in the sample studied.

Dental practice. Finally, the category of dental practice is one that the fewest families (n = 4) reported as a significant preventive measure. Interestingly enough, toothache was one of the most frequent health problems found during the study, and the field notes include many references to the bad condition of the teeth of family members. There

was a general fear of going to the dentist that was shared by adults and children alike. Some family members used to link the decision of not going to the dentist to previous painful experiences, others to the quality of the dental service, others to the high price, but for the majority it was the fear of the treatment. The few families who did go to the dentist used to encourage others to do the same. The mother in family 15 said, "Mara (family 13) told me I can go to the dental clinic at the university where I can get a denture", and the parents in family 8 stated, "They told us Albert can get a treatment to correct his teeth at the university."

#### Emerging Themes

Families base their preventive actions on a rationale that is coherent with both their views on the nature of health and illness and the causation of disease. Thus, there were families (8, 11, 18, 22) who, believing in human control over disease, prescribed a great number of preventive measures, while a second group did it in a less extensive way (families 5, 12, 19, 20) and, finally, a third group who only mentioned a few (families 13, 15, 16, 17, 21). In addition, the influence of families' theories of causation is identified in the number of health measures dealing with food and eating patterns, weather and climate conditions, and hygiene.

On the other hand, families' preventive measures have an additional category which shows the influence of the scientific health system on their lives. Although not totally integrated in the family theoretical model of health and illness, they have been actually practice by family members for some time.

Families' rationales about prevention were, as in previous schemes, integrated in their life style. The families do not reserve a special place or time to perform these measures. They were part of their daily activities, just as going to work, going to school, or washing the clothes were. In addition, preventive measures were usually followed by all members of the family. Thus measures to protect against rain, wind, and cold, as well as the care with food and hygiene were shared by the whole family. There were, however, levels of significance according to the age of each family member. Children were the focus of more attention than adults, and among the children, those who were seen as more susceptible were observed more carefully in relation to prevention. As Cleuza, the older daughter in family 19, said, "I wish I could go out and play in the wind as Clenir (her sister) does. But I can't, because if I go out I will get a sore throat." There were also some stages in life that were considered to require more care than others, such as being pregnant and the postnatal period.

In contrast, medical measures were sporadic actions and occurred mostly when there was a stimulus such as advertisement, or a special program as in the case of vaccinations or gynecological examinations, or when it was a job requirement. The only preventive measure that families did without any outside motivation was prenatal care. But even this was only until the child was delivered. Follow-ups after delivery were not common among village mothers. In addition, villagers were afraid of most of the measures involving medical and dental care. This fear was found not only among the children, but was evident in the behavior of adults as well. One very common example was the fear of pain, which prevented parents and children going to the dentist. The

fear of pain also stopped school-age children from getting their vaccinations. But there was another kind of fear - of receiving a bad result - which was one of the most frequent reasons given by mothers for not having a Pap smear taken.

The families' conceptualizations on prevention of disease were firmly based on the contact with their reference groups in the community: parents, relatives, and neighbors. After marriage, the grandmother on both sides became an important element in teaching health care to the new family. The mother in family 4, when asked from whom she learned about prevention, exemplified this. "I learned many things at home with my mother, and after I got married, whatever I need I ask my mother-in-law." A new source of information is found among the youngest generation who also included the school as one of the sources of learning about health. Furthermore, families' preventive measures have also a unique perspective as well, which results from each family life and the interactions within the unit. As such, individual members' susceptibilities, contributions, and experiences are taken into account, and some kind of agreement is achieved to guide their actions toward health and illness.

A family's scheme of prevention also involves a series of actions besides the knowledge, beliefs, values, and experiences with health and illness. In this specific group of families studies, these actions toward health were mostly personal and family oriented. There was no mention of community or group preventive actions such as a collective sewage system, water treatment, or improvements in environmental conditions related to hygiene and sanitation.

Since it is a family matter, actions toward prevention are in some way divided among the family members. As such, mothers played a significant role by preparing the meals, cleaning the house, bathing and dressing the children. But the fathers' participation is not any less important. Because they spend many hours outside the home, usually their major influence is in teaching the children about cleanliness and diet. Children, on the other hand, not only learn and apply preventive measures but also affect the family's model of prevention by bringing home all they have learned at school about health and illness. Although not all information was accepted, it did seem to have an impact on the families' practices as well.

Finally, preventive measures also have a developmental approach. Although they are applied to the whole family, there are some stages of the family life cycle when individuals are seen as more in need of special care, as in this study is the case with children and mothers during pregnancy.

In summary, family preventive measures follow a consistent and holistic model of health and illness. It is based upon folk and scientific models of health and their influence on each family varies. Further, each family interprets and modifies these influences according to its own experiences, the life history of the family, individual susceptibilities, the life cycle of the family, and the contributions of individuals. Finally, the adoption of a modern scientific model seems to be slow, characterized by sporadic actions, some general feeling of fear, and dependence on advertisements or earlier successive experiences. Measures that do improve situations perceived as

threatening by families are those more easily adopted by both the families and community members.

#### Family Management of Health Problems

Family health problems. Families face a variety of health problems in their daily lives. Even those who do not have a member with a disease requiring special medical attention, as is the case of the families under study, it was common to find some kind of complaint in at least one member of a family during each home visit. The number of visits this investigator found families reporting all members doing fine ranged from 6 (families 5, 6, 7) to zero (families 12 and 17). The mean of family visits without complaints was 2.1 (see Table 22).

In addition, there were variations among families in the number of health problems described per visit. Some of them (families 3, 16, 17) had more health problems than others, with a mean of 1.7 health problems per family per visit. The frequency of complaints per family members is not equally distributed either. Husbands seemed consistently to complain less than the children and wives. The average of problems per visit for men varied from 0 (families 19, 22) to .7 (families 8, 16) with a mean of .3, while for children the mean was .4 and for women, .6. One explanation for the wives having a higher score can be the presence of pregnant women who reportedly had more problems than others. This is the case of the mothers in families 14, 19, and 20, who had the highest scores in the sample. This investigator, however, does not exclude the possibility of some of the differences being a result of the fact that women were in the most cases the informants on the health

TABLE 22

Average Number of Health Problems of Families per Visit

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Husband</u>	.2	.5	.6	.1	.2	.3	.1	.7	.1	.2	.3	.1	.6	.2	.1	.7	.2	.1	0	.4	.1	0
<u>Wife</u>	.6	.3	.8	.8	.3	.3	.2	.7	.6	.5	.4	.8	.5	.8	.5	1.0	.6	.8	1.1	1.3	.1	.2
<u>Children*</u>	.3	.6	.8	.8	.3	.1	.1	.7	.3	.2	.5	.5	.3	.1	.7	.3	.5	.2	.3	.3	.3	.2
<u>Family Average/Visit</u>	2.0	2.0	3.0	2.5	1.1	.7	.7	2.1	1.6	1.3	1.7	1.9	2.6	1.1	1.3	2.9	2.8	1.5	1.7	2.3	.8	.8
<u>Total Health Problems</u>	34	42	51	50	25	11	12	34	35	22	27	30	29	15	13	26	38	12	15	21	6	8
<u>Visits Without Health Problems</u>	2	2	1	1	7	6	6	1	1	2	2	0	1	3	3	1	0	1	2	1	2	3
<u>Average Upsetting Events</u>	.4	.5	.5	.4	.2	.4	.4	.8	.8	.2	.4	.4	1.0	.3	.8	.6	.1	.2	.3	.5	.4	.1

\* This is the average number of health problems per child in each family.





status of the family and, as such, were inclined to report their own health conditions more accurately than for the other members.

Family health problems, as they were described by the families, are depicted in Table 23. This investigator grouped them into eight general categories that most closely resemble the families' theories of causation of disease. The first, and major, category includes those complaints regarded as being mostly caused by weather and climate conditions. A total of 185 problems were reported, the most frequent being colds (82 cases), coughing (39 cases), and sore throats (24 cases). Health problems were counted as a new one every time families complained about some disturbance with the exception of those that, after being reported once, were considered as an improved condition the next visit. For instance, a cold or sore throat were only considered once if in the following visit the family member would assess him/herself as getting better, even though some signs or symptoms were still present. On the other hand, problems that did not improve, even after treatment had been initiated, were included every time a member would complain about it. This was the case of the mother in family 16 who had wound in her legs and was following a medical treatment. Every time she would refer to the wounds as causing pain or some other kind of physical disturbance while describing her health status, it was included as a problem.

Aches and pains comprised a second category of complaints, with a total of 90 cases. All 22 families reported at least one case of aches and pains during this study. In this group are included all types of pain families related to work, rheumatism, weather, and climate. The

TABLE 23

Health Problems of the Families

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
<u>Weather &amp; Climate</u>																							
Colds	7	4	9	3	13	4	3	8	4	2	6	4	2		4	4	5	2	1			1	
Coughing	1	1	9				2	3	3	4	4						9				2	1	
Discharge			4																		1		
Stuffy nose																							
Sneezing																	2						
Nose bleeds	2															1							
Shortness of breath	2		1	1								1			1	1	1		1				
Sinusitis												2											
Bronchitis										1													
Pontada							1									1							
Sore throat	1	2	1	5			1	1	3		2	2		1	1	1	2	2		1			
Earache			1		3			3					2			1	1						
Zipra	1				1							1			1	2							
<u>Aches &amp; Pains</u>																							
Toothache		2						2	2	1	2	1	1		3			1		1		1	
Headache	6	5	3	6				1	1			2		1		1	1	1	2	1	1	1	
Back pain	3	3	1							2		2	2		1				2	2			
Neck pain	1					1						2	1										
Leg/arm pain					3						2	1		4	2		2	2				1	
Foot pain						1							2				6						
Chest pain													2	1					1				





number of families complaining of headaches (n = 13), toothaches (n = 10), and pain in legs and arms (n = 8) warrants attention.

Another class of problems were included under the heading of food and eating patterns, with 18 families presenting 83 problems. The most frequent complaint in this category was stomach/abdominal pain (30 cases), nausea (n = 16), and not eating well (n = 14). Although most of these problems are viewed by families as consequences of eating habits, there are some that were also related to frequency and worms.

The next category includes most of the problems families see as determined by physiological disturbances. There are 60 complaints in this group, with wounds being the most often cited problem (35 cases). Wounds are listed in this category because, in most of the cases, families related them to conditions existent in the blood (thick blood, levante do sangue, etc.). In the case of allergies (n = 11), families consider both physiological causes and food conditions as being responsible for this type of problem.

The fourth group of problems is most viewed as being caused by lack of hygiene, with 16 families reporting 37 cases. The most common complaint in this group is infestation by worms (n = 14) and lice (n = 9). There were also cases of blister, which families called "cobreiro".

Families also had to deal with accidents of different kinds in their daily life. During this study, 14 families reported 35 cases of accidents that ranged from common cuts, bruises, and contusions to broken bones and burns (1st, 2nd, and 3rd degree). They occurred mostly at home or while playing in the streets or backyards and at school.

Emotional problems were not infrequent among families, either. A total of 10 families reported 16 problems, the most common being "urinating in bed" in the case of pre-school and school-age children. Families consider this kind of problems as the result of tensions at home, in school, or with friends.

The last category, "general complaints", involve all those for which the families had no specific cause or which can be related to a variety of origins, such as fever, loosing weight, or dizziness.

Upsetting events. In addition to the health status of its members, families usually mentioned the events that have upset them at the time of the home visit. Table 24 shows that the average of upsetting events per family varied from 1 (family 13) to .1 (families 17, 22), with a mean of .2 per visit. It means that each family faces an upset event at least every 18 days. A distribution of the upsetting events by causes (Table 24) shows that health-related problems (illness and pregnancy) are responsible for 26 percent of all family upsets, which can increase to 37 percent if drinking problems are included in this category. Within the group of health-related problems, not all complaints worried the family in the same way. Usually it was the serious or acute problems requiring medical assistance, such as children's burns in families 1 and 7, or those complaints that don't go away easily when treated, such as the mother's earache in family 5 and Pedro's lack of appetite in family 4, or even problems that families are afraid of, such as vomiting in family 8 and fever in families 9, 15, and 20, that worried most of the families. Hospitalization is another source of family stress (families 1, 12, 13). The simple suspicion of being pregnant (family 3) or the confirmation of an unwanted pregnancy





TABLE 24

Causes of Events Upsetting to Families

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Socioeconomic Problems</u>																						
Job					1					1			3	1	1	2	1					
Money	2						3			1			2		2	1						
School/education			2	1	4	4	3	4	5	2	2	2	1	1			1			1	1	1
Drinking	1	4					3			1	2		1		1					1	1	1
<u>Health-related Problems</u>																						
Illnesses	4		3	2	3		1	3	5	1	1	1	1	2	1	1	1	1	1	1	3	
Pregnancy		2	1																2			
<u>Interactions</u>																						
Husband & wife		2	1	3				3		1	2	1	1	1	1	1					2	
Grandparents & parents		1	1	2					1		2	1	1									
Relatives/neighbors & family		1						1	2				1		1	1						
<u>Childrearing Practices</u>		1	1			3		3	2	1			1	1	1	1		1			1	1

(families 2, 19) are reasons for great concern. As the mother in family 19 asserted, "I did not plan this pregnancy; I wanted so badly to save money to buy a house, and now all our plans have to be postponed."

Drinking problems, although not listed as a health problem by the families, are considered a constant source of tension in family life. The fact of drinking by itself is not referred to as very important, but its consequences on family relations can be disrupting because of verbal and physical acts of violence. This not only affects the husband's and wife's relationship but also that of the father and his children, who try to find security from grandparents, relatives, and neighbors.

Interactional problems within the nuclear family, or the extended family, friends, and neighbors, are also causes of upsetting events. The main reason for disagreement between the couple is, according to their reports, the father's drinking habit, jealousy, and economic problems, while for grandparents and other reference groups, it is mostly their interference in the internal affairs of the family.

The school also concerns parents in this study. The families are worried not only about the children's report cards, but also about the hygiene and quality of food served at school, the level of teaching, discipline, and interactions between the teachers and students.

A last concern shared by parents with the investigator is related to childrearing practices. The most frequent areas that parents described as difficult for them to manage were sexual education and ways of handling differences in personalities among their children. Problems of discipline were also discussed, mostly because mothers expect their husbands to have a more active role in education at home.



### Types of Treatments Used for Health Problems

Families, while facing health problems, utilize different kinds of resources, such as home treatments, faith healing (blessings), and medical, dental, and nursing assistance. Table 25 shows the types of treatment and the number of times they were used during this study. For a total of 556 health problems reported, the families used 235 home treatments, 10 blessings, 112 visits to the doctor, 23 to the dentist, and 13 to the health clinic for nursing care. In contrast, 240 - or almost half - of the problems did not get any treatment at all.

Home treatments. Home treatments are commonly used for all members of the family and follow specific criteria. As a norm, it is the first measure taken to solve a complaint unless the problem is so serious or acute that immediate hospitalization is required. Home treatments are also indicated in cases of recurrent problems such as aches and pains. But home remedies are prescribed concomitantly with other measures such as blessings or medical and dental treatments. For instance, the mother in family 1, when asked what she was doing for her burned child, said,

The physician told me to wash the area with boiled water and then put mercurochrome on it. I am washing it with dwarf-mallow tea, and after this I put on the mercurochrome. I also asked Sr Ananias to bless against zipra. He has already come here three times.

For home remedies, the families include different types of measures (Table 26) such as over-the-counter medicines, herbal teas, sinapisms, massage, compresses, baths, drinking liquids, curatives, and resting. Almost half of the treatments reported by families were over-the-counter medicines (111 cases). Families used them in a more or less extensive way, and they include analgesics, antiperetics, muscle relaxants, and

TABLE 25

Types of Treatment Used by Families and Frequency Used

Family

Treatments	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
Home Treatments	16	18	26	21	18	5	5	11	13	12	15	6	1	3	4	19	14	4	4	9	7	3	
Blessings	1		1	1	1			2				1	2	1	1		1	1					
Nursing (local clinic)		3		2					1				5					2					
Medical Visits	7	4	13	5	7	1	4	5	12	1	7	7	9	2	1	5	4	4	5	8	0	1	
Dental Treatments		1						1				15							5			1	
No Treatment	11	19	15	23	9	5	3	18	10	10	12	16	12	11	8	4	22	6	8	13	2	3	

TABLE 26

Number of Home Remedies Used by Families

Treatments	Family																					
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Over-the-Counter Meds	7	15	11	11	7	2	2	2	2	3	2	3	3	2	2	1	1	1	1	1	1	1
Herbal Teas																						
To drink	7		4	6	4	2	3	3	2	3	2	3	5	2	2	1	2	3		1		
To wash skin	1			1	1										1	1						
To gargle							1	1	1	1		1							1			
Sinapisms																4			1			
Massage & Rubbing	1	3			3													1				
Compresses/Baths			1		1		1				1						1	1				
Drinks																						
Water & sugar			1							1										1		
Rum, lemon, & sugar			1						1										1			
Hot milk, honey, & olive oil			1					4	1	1												
Hot milk & eggs			3																			
Black coffee & margarine									1												1	
Curatives	1			1	1	1	1	1	1	1	3	1	1	1	3	1	1	1				
Resting			2	1	2				2			1									1	
Other			2	1												1						

antispasmodics (53 cases), antiacids (n = 4), antidiarrhetics (n = 5), antiallergenics (n = 15), antiparasitics (n = 5), cough depressants (n = 5), antiseptics (n = 5), antibiotics (n = 10), different pomades (n = 6), and others (n = 2). With the exception of one family (9) who frequently asked the pharmacist's opinions, all other families stated that they had learned about medicines from their parents, relatives, or friends, from TV advertisements, and from previous medical prescriptions. This last was the case for most of the antibiotics given by the families. As the mother in family 17 said,

I went to the doctor for the first time he prescribed an antibiotic; the second time he repeated the prescription. Now, every time the child has the same problem, I first give him the same medicine.

Over-the-counter medicines can be used alone, but more frequently they are given concurrently with other kinds of home remedies such as teas, massages, drinks, and so on. Herbal teas are also used extensively by the families as a home treatment. They are indicated for drinking, gargling, or washing wounds. There are three major indications for herbal teas. First, there is a group of teas such as citron, orange, and lemon that are used in cases of colds, coughs, and other problems caused by weather and climate conditions. As the mother in family 5 asserted, "There is nothing better than a hot tea to treat a bad cold." Another type of tea (mint, black tea, camomile) is employed for stomach and abdominal colics and pains. A third type of tea is dwarf-mallow, which is indicated for washing the mouth, gargling in cases of toothache or sore throat, and for local treatments of wounds.

Although many families refer to sinapism as a treatment for high fever and headaches, actually only two families applied it during this study. The mother in family 16 makes a porridge of water, flour, and





rum and applies it locally to prevent zipra. She did it after removing a grub and, in the case of the youngest, for wounds in the gums. A different kind of sinapism (with onions) is applied by the families to children's feet in order to bring a fever down. According to villagers, sinapisms make the fever go down from the head to the feet. Other types of sinapisms referred to by the families are slices of potato on the forehead for headaches and peach leaves in cases of complications from worms.

Massage with pomade is another home treatment to alleviate back aches and rheumatic pains. Furthermore, in the case of shortness of breath caused by worms, mothers recommend rubbing the wrists with garlic. According to the mother in family 15, "Garlic is good to help to bring back the breath."

Compresses and baths are also home measures. Hot and dried compresses are indicated for earaches and hot baths for internal colds, while warm baths are used for skin problems and hemorrhoids. Cold compresses were not described in any case, and the mother in family 9 told about it.

I got mad at the nurse in the hospital because she wanted to put a cold compress on the baby to bring the fever down. She should know that it is dangerous to put something cold on a feverish child.

Families also use beverages as home remedies, for example a glass of water and sugar for nausea and vomiting, a mixture of rum, lemon, and sugar in cases of colds in adults, a cup of hot milk with honey or egg, and black coffee with margarine for children's coughs.

Families do make some small curatives at home, such as cleaning a wound with boiled water or special teas and using mercurochrome. Besides this, there are some families who apply other substances as



curatives such as ear wax and gasoline for grubs (family 2), powder of black coffee (families 5, 9) and green leaves (family 19) to stop a cut from bleeding, warm fat for wounds (family 16), or a strong bathroom disinfectant for toothache (family 15).

Rest is also indicated as a method of healing. Families prescribe it for treating nervousness (family 3), dizziness, bad colds (family 10), dislocation of muscles (family 22), and falls (family 14).

Other treatments, as in the case of treating lice, are grouped under "Other". Some mothers still use neocid to kill the insect and vinegar to remove the eggs. Daily washing of the hair and very short hair cuts are also part of this treatment.

Medical treatments. All families except family 21 visited the local clinic or the ambulatory clinic downtown at least once during the course of the field study. Table 27 presents all the causes the families indicated as needing medical advice. The families who visited the physician most often were family 3 (13 times), family 9 (12 times), and family 13 (9 times). The mean was five medical visits per family over a period of three months. Frequency of medical treatments also varied within the family. Only two fathers visited a doctor (families 3, 13) a total of five times, while 14 mothers had a total of 35 visits, with a mean of 1.6 visits per mother. Almost half of the mothers' reasons for going for medical treatment were related to pregnancy, a few were for follow-ups of treatments (families 16, 18), while the other 14 cases were for acute problems such as earache (family 5), toothache and dizziness (family 9), and different kinds of sudden pain (families 6, 12, 13). Children, on the other hand, had a mean of 1.3 visits per child per family, with 18 children going to the doctor 28.8 times. The



TABLE 27

Health Problems for Which Families Sought Medical Treatment

Category	Family																							
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22		
<u>Weather and Climate</u>																								
Shortness of breath	x																							
Sore throats		x	x					x	x	x	x	x			x	x			x					
Coughing		x	x				x																	
Colds			x		x			x									x							
Earache			x		x			x																
Secretion/discharge			x																					
Pontada							x																	
Sinusitis												x												
<u>Aches and Pains</u>																								
Back pain			x																					
Pain in foot/leg																								
Toothache																								
Other																								
<u>Food and Eating Patterns</u>																								
Stomach pain			x																					
Nausea			x																					
Vomiting																								
<u>Physiological</u>																								
Tumor in breast																								
Diarrhea																								
Pregnancy			x																					
Wounds																								

TABLE 27 (continued)

Family

Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<u>Hygiene</u>																						
Disturbances related to worms	x	x		x							x		x									
<u>Accidents</u>																						
Burns	x				x		x															
Broken bones											x				x							x
Dislocated hand	x																					
<u>General Complaints</u>																						
Fever			x	x			x		x	x						x						
Paleness		x																				
Dizziness			x						x													
Losing weight				x																		
<u>Other</u>							x		x													

most frequent reasons for taking a child to the clinic were sore throats, worms, fever, and accidents.

Although there were differences in the frequency of medical treatment, families' decisions for seeking professional help seem to follow the same pattern. First, there are the cases in which home remedies have proven to be not enough to solve the problem. Second, there are complaints that are complicated with the appearance of a new disturbance such as colds and fever, colds and coughing, abdominal pain and vomiting. There are also problems that families know through experience only medical treatment can solve, as in the case of pontada, worms, and broken bones. A fourth indication for a medical appointment is problems the families are afraid of, such as vomiting, diarrhea, and high fever. Accidents and other emergencies make up the last group of problems for which professional assistance is considered a priority.

The time from when a problem first appears and the decision to seek medical treatment is made varies from a few hours to a month. It takes only few hours until a person injured in an accident (burns, broken bones) is taken to the hospital downtown, from one to two days in cases of fever and shortness of breath, two to three days for vomiting, diarrhea, earaches, and acute pain, three to five days for coughs and discharge, and two to three weeks for suspicion of intestinal parasites.

Dental treatment. Utilization of the dental clinic is minimal. As a matter of fact, there were five families who visited the dentist during the study period, only two on a regular basis. When these family members are compared to those who complained of toothache (10 families), it is evident that for some reason home treatment is preferred to professional treatment. The most common explanation given by informants





was being afraid of the pain or the dentist. A few raised the problem of lack of money to pay for the treatment while others made comments about the quality of dental care offered by public clinics.

Blessings and other faith healing processes. Blessings, visits to faith healers, and spiritualist centers comprise a third source of treatment. During this study, eight families utilized these measures along or in conjunction with other treatments. For family 4, it was to treat Pedro's "evil eye", for family 5, to help to heal an ear problem, for families 9 and 17 a case of "cobreiro", for families 12 and 15, "zipra", for family 18 a foot problem, while for family 13 it was to prevent new seizures. Blessing as a treatment has its own indications. It is the first treatment for evil eye, cobreiro, zipra, and muscle dislocation, but it can also be used concomitantly with other forms of treatments when the problem is considered serious or when home or medical treatments do not seem enough to cure the symptom, as in the cases of earache and pain in the foot in the families studied. It can also be used as a last resort with other treatments have failed, as with family 13. According to the mother, medical and psychiatric treatments had not solved her problem, which disappeared after she began to frequent the spiritualist center.

Besides blessings, families also ask God and the saints' help in healing a sick member. This help is sought by a person who trusts in his/her creator who has the power to make the ultimate decision about who is to live, be cured, or die. It is not a substitute for other treatments. All families who reported saying prayers, making promises and pilgrimages, had made use of all the health resources available to them. In their prayers, they asked God for health and healing and made



promises. Family 1 promised to take their burned child, dressed as a saint, in the annual procession of Our Lady. This investigator had the opportunity to see a religious feast in a nearby village where there was special bread in the form of hearts, legs, hands, and other organs which people offered in order to be cured by intercession of the Holy Spirit.

No treatment. Finally, there are problems that families decide not to treat or to wait for its evolution before making a decision. Actually, almost half of the problems reported by families were not treated at all. Some of the criteria used by families to select the "no action" attitude are described below.

First, there are those problems that families know by experience will solve themselves, such as colds, coughs, and headaches. A second group includes problems for which the families know the cause and evolution and therefore decide on the "right" time to go to the doctor. These include not eating well, paleness, and abdominal pain when worms are suspected. A third criterion is when families know there is no specific or reliable treatment, as for back aches and rheumatic pains. Families also do not look for treatment when a problem is common or very frequent in the village, such as urinating in bed. A fifth case is when a physical disturbance is not considered important because it does not interfere with their daily activities (hemorrhoids, adult stomach/abdominal pains, diarrhea). And finally there is the component of fear of going to the doctor. In this last group are included those problems related to the genito-urinary system.

Emerging Themes

From informants' descriptions on how health problems are managed at home, the family indeed acts as a unit of care in illness situations. This denomination is appropriate, first of all, because of the number of health problems that are identified and treated within the family context. Health and illness situations are part of the daily life of families, not just for those who have a sick member undergoing medical treatment. The problems an average family faces range from the most serious to trivial ones, from acute to recurring episodes of ill health, from known treatments and origins to totally unknown. And the families, independently of having or not having knowledge and resources, must face these problems and make important decisions about them.

As a unit of care in illness situations, the families have their own rationale which helps them to identify an illness, explain it, and decide on the type of measure to be taken to restore the member's health. This rationale is an integral part of the families' model of health and illness and, as such, is consistent with their views on the nature of health and illness and their theories of causation. As a consequence, families' management of illness situations embraces both traditional and scientific measures. Within the traditional model families utilize natural (teas, massages) and supernatural (blessings, prayers) sources for treatment, where principles of hot and cold, dry and wet, thin and thick, heavy and light, good and evil are applied in order to restore the body to its balance. Side by side with these folk measures, the families adopt treatments prescribed by health professionals. The amount of acceptance and practice of each one of these systems varies according to each family. There are those who



adopt more scientific than folk measures, others use both systems, while still others prefer the traditional ways of healing. However, there was no family who could be categorized as using one system of health care exclusively.

The family as a unit of care in illness situations has a humanistic approach when dealing with its sick members. The ill member's feelings, pains, attitudes, and activities are assessed; as mentioned earlier, families do not separate a disease from the person who has it. The whole process of recognizing and treating an illness becomes a family affair, and decisions about treatment take into consideration the individual and not just his/her illness.

Families do not act toward illness situations instinctively. Actually, they go through a complicated process which starts with the identification of the problem and ends with its solution. This process can be activated rapidly, in cases of emergency, or can take longer, according to the nature of the problem and other factors. The first step consists of the assessment of each member's health status, which is done on an almost daily basis. This assessment is both individual and familial. Information on health status is interpreted according to the family's indicators of health and illness, and an initial definition of the problem is made. This definition, however, is submitted to other family members and, at this point, agreement is reached or not reached, depending on the negotiations. For instance, the father in family 3 was always complaining of pains and his definition of the situation differed from his wife's, so agreement was only partly reached. On the other hand, in Pedro's case of evil eye, not only his parents but also his grandparents defined the situation in the same way.

The next normal step is to make a decision about the treatment. As the data show, the families have a richness of resources to solve their health problems. But here again, the families' general model of health and illness guides them about possible alternatives they have. Deciding on a treatment is also a family matter and usually involves more than one member. Although the mother seems to be an important element in this step, findings show that fathers are also involved in the process of decision making. This family involvement appears to be more evident in the case of children.

The families' role in illness does not stop when a decision has been made and a treatment initiated. Whatever kind of medical system is adopted, or even if both are used simultaneously, families go through the steps of observing and evaluating the results. The time given by parents for a treatment to show results varies. In the case of Pedro, family 4 waited almost one month, while the mother in family 5 gave the physician one week before she changed to another professional. The fact that families are constantly evaluating the evolution of an illness has significance for health professionals, who sometimes take for granted that families accept their advice without question. The process ends with the incorporation of the whole experience into the family's health history and, as such, into their model of health and illness.

In summary, the family emerges as the unit of care in illness situations, with its unique rationale for assessing, identifying, and treating illness at home. This rationale is consistent with the families' general model of health and illness, which is made up of knowledge, beliefs, and practices from two different medical systems which are interpreted and modified by the family's experiences.

Families' dealings with illness situations also are the result of a complicated process of interaction that involves a series of steps that begin with the appraisal of the health status of family members and end with the evaluation of the outcome of each measure taken to treat the sick member.

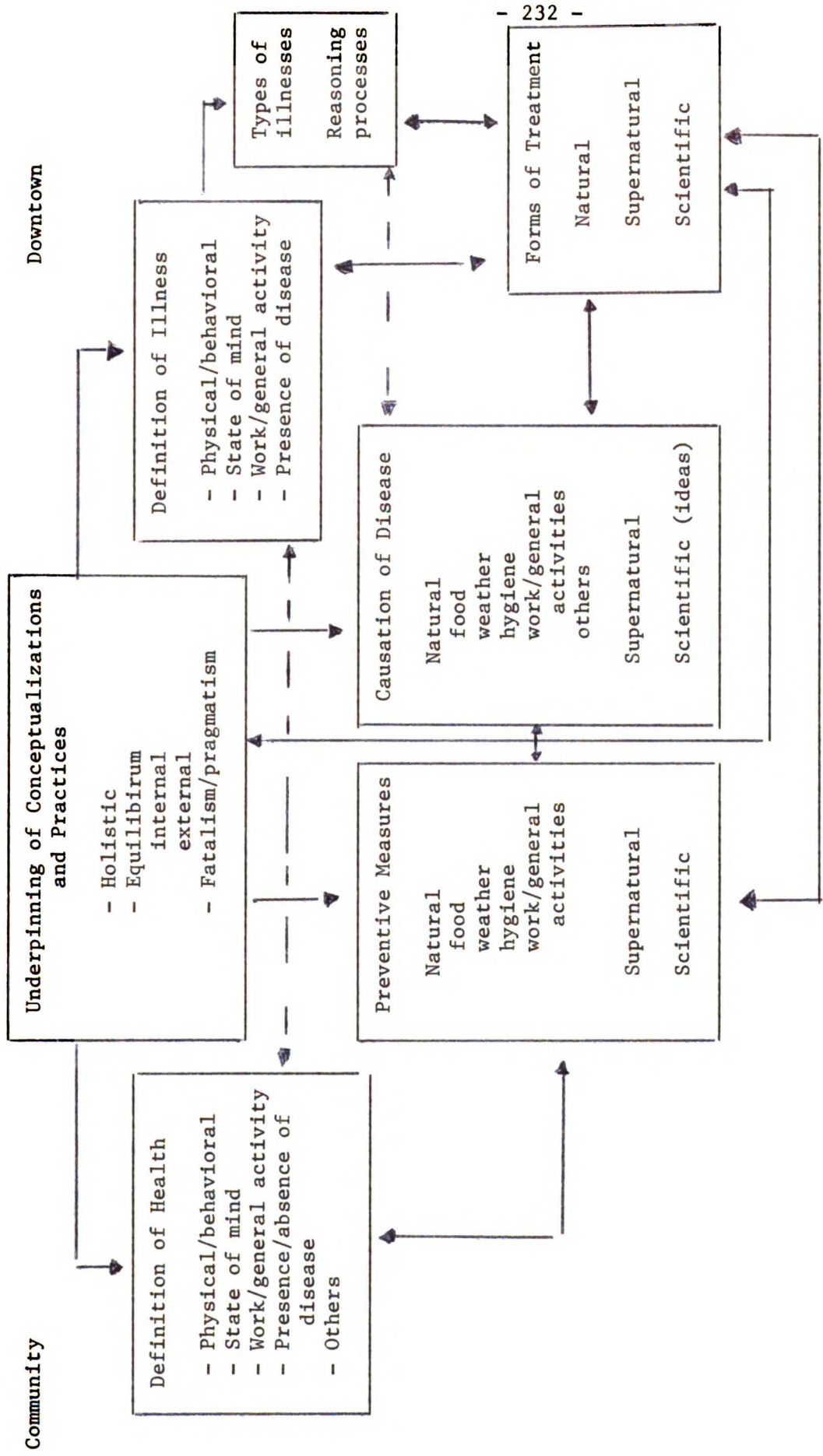
#### ANALYSIS

According to Spradley (1979b), the next stage after describing the data and classifying it into initial categories and domains is to find possible lines of connection between them. In order to achieve this final integration of the data, this investigator made use of diagrams in which the findings and themes are described. To elaborate on the diagrams, this investigator had in mind to depict the following aspects of the data: 1) the content of the families' conceptualizations and actions toward health and illness as well as possible relationships between them, 2) the connections between the family and other systems in the community, and 3) the steps a family goes through when facing health and illness situations. The final results of this activity have been presented below.

#### Thematic Structure of Families' Conceptualization of Health and Illness

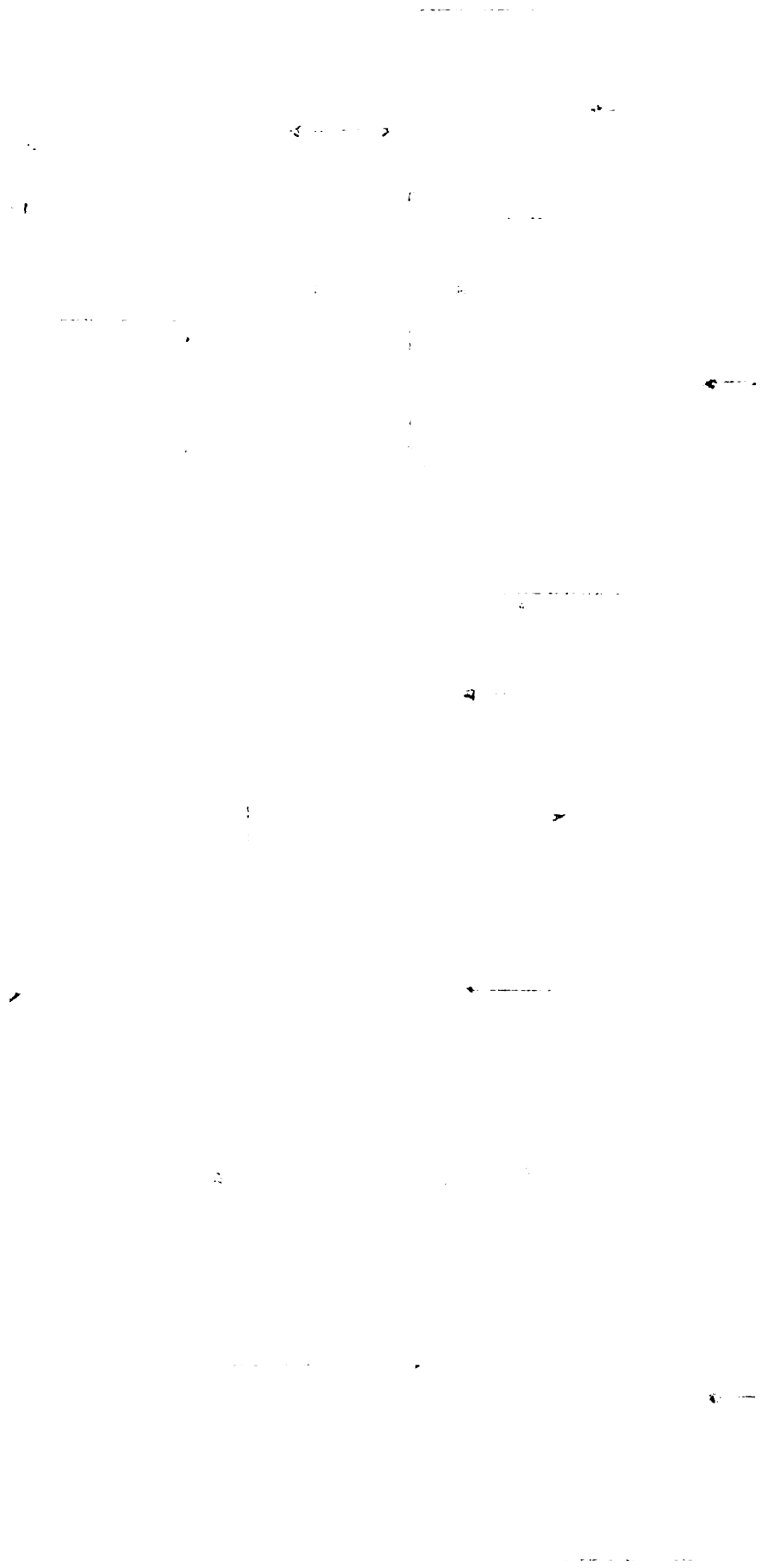
As a result of the first diagram that depicts families' perceptions of health and illness and their related behaviors, a thematic structure was developed (Figure 2). At first glance it shows that the families' knowledge and practices do form an integrated model where lines of relationship, interdependence, and sequence are established. This





Thematic Structure of Families' Conceptualizations of Health and Illness and Their Practices

FIGURE 2



family model also demonstrates its connection with other systems located in the community or outside of it. An analysis of the content of the model shows that central to it are the families' themes and domains that guide their actions toward health and illness. According to the data, the major theme underlying conceptions of health and illness is that health and illness are the result of a balance or imbalance between man and his internal and external environment. This last includes components in the natural (physical, biological, social, and cultural) as well as the supernatural environment. This main theme is translated into principles where forces such as hot and cold, internal and external, wet and dry, clean or unclean, thin and thick, heavy and light, good and evil have to be maintained in correct equilibrium. A second theme underlying the basic notions on health and illness is the ability of man to have or not have control over his health. The families' position on this issue will have consequences on all the subsequent steps of this model. Third, there is the assumption that health and illness are an integral part of the family model and as such are firmly interrelated with other aspects of a family's life. This holistic view on this subject permeates the whole idea of causation, treatment, and prevention as well.

These guiding themes do not stand alone and constant over time. There are conditions in the family life that have a direct effect on them. During this study, some of them were identified as related to:

- 1) the individual - age, gender, susceptibilities, and contributions,
- 2) the family - stage of life cycle, health history, and experiences with health and illness, and
- 3) interactions occurring within the family and with reference groups in the community and outside of it.

Based on this broad frame of reference are the families' definitions of health and illness, which are considered the result of a positive or negative balance between forces. Both are seen as multidimensional concepts situated at the extremes of the continuum of health and illness. However, they are not static; people are assumed to be moving along this continuum. Each dimension defines a different but interrelated component of an individual's life (physiological, emotional, or psychological, including activities and social conditions) besides the presence or absence of disease or symptoms. Dimensions of health and illness are also subject to changes according to the age and gender of each family member.

Theories of causation, types of illness, and alternatives for treatment are also seen as dependent on the frame of reference and definitions of health and illness. These three components are all connected and dependent on each other. As such, themes underlying theories of causation are essential to understand families' treatments, types of disease found in each family, and preventive actions taken. Families' theories of causation include mostly natural and supernatural agents.

Natural causes show up in the families' models as those conditions belonging to the physical and social world, such as weather and climate, food, activities, and human characteristics (physiology and emotion). The supernatural realm of causation is still strong among the present generation of families and is basically related to God, saints, spirits of dead persons, and jealousy and envy. The influence of scientific theories of disease is minimal in this model, even though contact with health professionals is frequent. On the other hand, forms of

treatment, another component of the model, have already incorporated many scientific methods of healing. In fact, there is no family who has not at one point or another received the benefit of professional care. However, it is important to note that traditional themes of treatment (of natural and supernatural nature) are present in the families' everyday life, and it does not look as if they will be replaced soon by modern forms of healing.

The last component of this model includes health promotion and prevention. They are also firmly rooted in the frame of reference, definitions of health and illness, and theories of causation. They include a series of measures regarding natural and supernatural sources. Here again appears the influence of scientific medicine through measures such as vaccination, medical follow-ups, use of medicines, and dental practices. It is important to note, however, that these last measures were not stated by families but observed by this investigator during the field work. They were only discussed after the families were questioned directly about them. It appears that, even though practiced, these measures have not been totally assimilated and incorporated in the families' frame of reference.

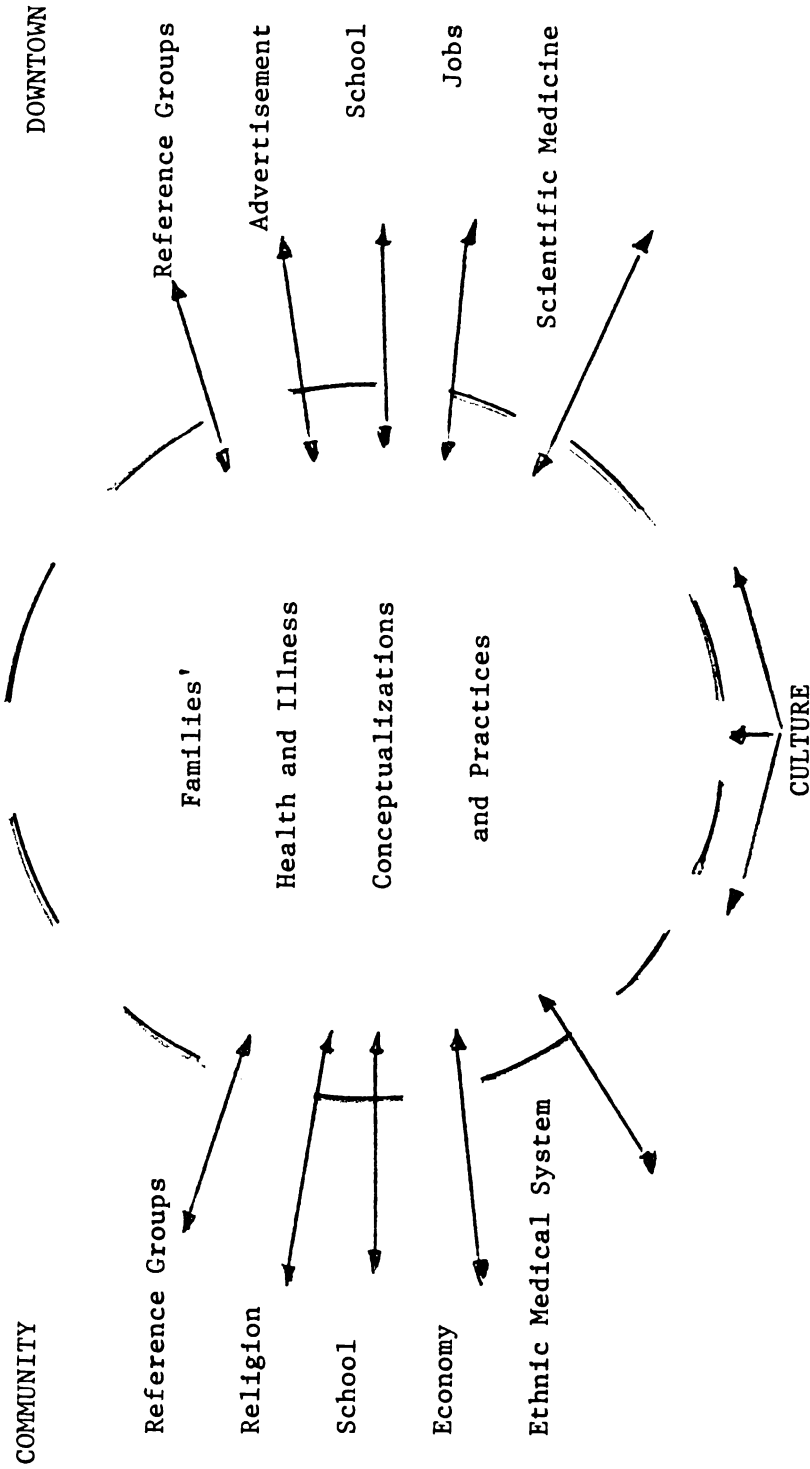
This conceptual framework of the families has some characteristics that need to be emphasized in order to be understood. First, each family has a unique model. Although families share many categories, domains, and themes, each family constructs its own model as a result of its members' unique experiences, contributions, and interactions within the family unit. Second, this model changes over time, depending on the family's life cycle, health history, relationships with reference groups, and the outcome of each family's health or illness experiences.

It is also a pluralistic model because it integrates sources from ethnic and scientific medicine. Each family incorporates these two systems in its own model in a different way, which is one of the reasons for variation between families. There are those families whose model has more folk concepts and theories while others have assimilated more scientific notions on health and illness.

#### The Family's Model in the Context of Sociocultural Environment

An extension of the families' models (Figure 3) depicts the connections between the families and the external world. According to this diagram, the families of this study are mediators between their individual members and society, here represented by the community, both the village and downtown. Families' models of health and illness are clearly influenced by conditions existent in both communities. Some of these conditions identified in the local community are religion, reference groups (especially for the oldest generation), socioeconomic conditions, school, and the ethnic medical system. Among those pertaining to outside or downtown are job conditions, higher education, TV programs and advertisements, reference groups, and the scientific medical system. As a consequence of these interactions between the family and the two communities, the families' models can be considered pluralistic.

Although the families' models include two systems, it does not mean that the families accept and integrate knowledge, beliefs, and practices from both systems directly. It is believed that families interpret both worlds at the level of a family's limitations; they are accepted, rejected, or even modified to take care of the family's needs before



Family Health and Illness Conceptualizations and Practices  
in a Context of Sociocultural Environment

FIGURE 3





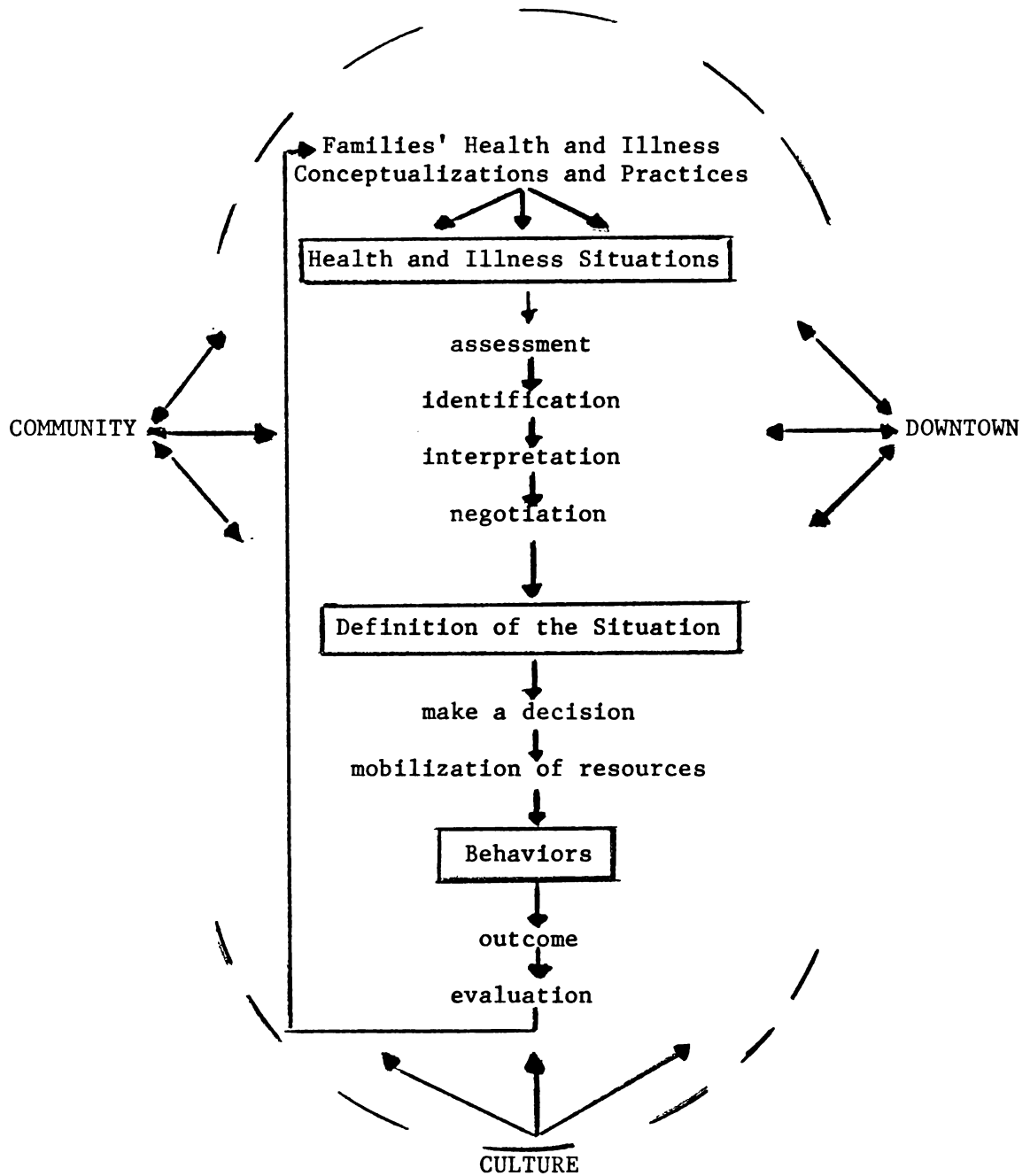
they are incorporated into the family's model of health and illness. A closer look at the model shows that arrows are depicted going in both directions. This means that not only external factors influence the family, but it is expected that the family also has an affect on the larger society.

#### The Family's Model in Everyday Practice

A final diagram of the steps followed by families while facing health and illness situations is depicted in Figure 4. As this figure shows, families go through a whole process from when they first face a situation to the time they actually perform a behavior. The first step in this process is the assessment of family members' health status. As observed, this occurs on a daily basis and is performed by the member him/herself, other members of the family, or even by close relatives and friends. This appraisal is usually made through observation, using the indicators for health and illness.

Once a problem appears and is recognized because of changes in behavior, physical appearance, or complaints, a more detailed assessment is made in order to identify the problem. In this case, besides observation, physical examinations or collecting of specimens (i.e. urine, feces, discharge) are also performed. Families in this study had no kind of home equipment such as thermometers or scales.

The next stage is to interpret the situation, which is done in light of the family's model of health and illness and the individual's contributions. In case of unknown situations, families refer to reference groups. Once interpreted, a situation is negotiated among family members in order to reach a family definition of the situation.



Families' Health and Illness Conceptualizations and Practices in Everyday Life

FIGURE 4

Differences among family members' views are common; however, there are negotiations in order to achieve a common or family definition of the situation. This definition does not always mean that all agree about the cause of an illness or the specific measures to be taken. It usually indicates that the family has achieved a consensus as to whether something is really wrong with a family member and if measures should be taken in order to solve the problem. Once a definition is achieved, the next step is to make decisions about treatments and to mobilize the necessary resources, which can involve people, time, medicines, money, or trips downtown.

After treatment has been initiated, family members constantly reassess the situation. At any time they can decide that a new definition of the situation has to be made and a new course of action is decided. Once a problem has been solved, the whole experience is incorporated into the family's model of health. This same process and its stages also occur in health situations or in regard to preventive measures as well.

Underlying the family process are some general features. First, families' reactions to each step can vary. For instance, in making the assessment and identification, families can identify more or fewer problems according to the type and number of categories included in their definitions of health and illness and their frame of reference. In the case of negotiations, families may utilize different ways of achieving an agreement. As mentioned previously, there are family members who just give up their personal opinions and accept opinions of others, some make concessions, while still others try to impose their interpretations of the situation of the family. One of the implications



of accepting variations and negotiations within the family unit is that the management of health and illness situations at home is not the role of just one individual.

A second feature of this model is that the process is activated in different time frames. In case of an emergency, the steps are developed rapidly. For instance, in the case of burns, the families completed all stages in a few hours. In contrast, in the case of evil eye it took almost one month after the identification until the decision was made and resources were allocated. In cases of disagreement on the definition of the situation, it can take months or years before the process is completed.

Finally, it is an open process. At any step, new information can be received from inside or outside the family. Families do vary in the level of openness, with some families not allowing the intrusion of people outside of the nuclear family. But even in these cases, there is always the possibility, for instance, of the school teacher sending a note about the child's health or a neighbor or friend making a comment about resources available for treatment, which in one way or another will contribute to the development of the family process.

## CHAPTER VI

### DISCUSSION AND CONCLUSIONS

In the first part of this chapter the findings are discussed and compared to studies reported in the literature. The discussion focuses on four main areas: health and illness definitions of the families, causation of disease, preventive measures, and the families' management of health and illness situations at home. The usefulness of symbolic interaction as an approach to the study of health care and families in a sociocultural context is also discussed. The final part of the chapter describes the limitations of the study, its implications for clinical practice, and recommendations for future research.

#### Families' Conceptualizations of Health and Illness

Health and illness emerge from the data as multidimensional concepts involving at least four main categories: physical/behavioral, state of mind, occupational, and presence/absence of illness. Although not all families identified the same number of dimensions, almost half of them reported three to five dimensions when describing a healthy child, woman, man, or old person. These findings are consistent with studies of Bauman (1961), Ailinger (1974), and Maloof (1979), which pointed out that laymen utilize more than one category when assessing their health status. There are similarities between Brazilian families'

dimensions and those found in the literature on different cultural groups. The names of the categories used by people from various ethnic backgrounds are different but, overall, their meanings are similar. Thus a Brazilian family's "state of mind" corresponds to Bauman's (1961) and MacDonald's (1981) "feelings of well-being", to Ailinger's (1974) "emotional disposition", or Maloof's (1979) "cheerful, happy disposition". Further, a family's emphasis on work and related activities fits with Bauman's (1961), DiCicco and Apple's (1958), Apple's (1960), and Schulman and Smith's (1963) descriptions of ability to perform daily activities. And last, the physical/behavioral dimension for the families resembles the physical signs of body functioning cited by Schulman and Smith (1963) and the physical characteristics and behavioral traits cited by Ailinger (1974) and Maloof (1979).

In contrast, references to the presence/absence of disease in a person's health career, frequently referred to by the families in this study, are mentioned less often in the literature. Such mention was made by Bauman (1961) in regard to his sample of American patients and medical students and by Freidson (1973) in his study of the American working class. Dunnell and Cartwright (1972) also cited both adults and children who classified themselves as being healthy but who had had some kind of symptom in the previous two weeks.

Although similarities are found among people from different cultural backgrounds, variations are also present within each dimension itself. For example, while for Brazilians eating and sleeping well are the most frequent subcategories in physical/behavioral conditions, looking well is important for North Peruvians and a well-fleshed body

and good skin tone and color are important for Spanish-speaking villagers in New Mexico and Colorado (Schulman & Smith, 1963). In the same way, plumpness, a sign of a healthy child for Mexican-Americans (Anchor, 1978), has almost no significance for Brazilians. This same pattern of internal variation is found regarding other dimensions as well.

The data also show that families' definitions vary according to age, which is supported by studies that have looked at this factor (DiCicco & Apple, 1958; Maloof, 1979; Schulman & Smith, 1963). However, differences related to gender, found in the families' reports, have not been described in other studies. One possible explanation for this omission can be related to the way researchers have formulated their questions, for example "describe a healthy adult" instead of "describe a healthy woman . . . a healthy man".

On the other hand, being sick for the families means to be at one extreme of the health/illness continuum. The health status of family members was viewed as being somewhere along this line and, as such, different levels of health can be identified. This complex view of the levels of health and illness is not so distant from that expressed by professionals nowadays. For the families, being sick is the human experience of having a disease. Thus, it influences not only different organs and systems but also alters the individual's state of mind and activities. In addition, for the families, a disease does not seem to have a meaning if not related to the individual member who has it. This perspective of illness as it is experienced by an individual confirms Mechanic's (1962) and Eisenberg's (1977) formulations on the meanings of illness as opposed to disease.



The families' holistic approach to health and illness, where a person is seen in his/her totality (body and mind) and in harmony with the physical and sociocultural environment, somewhat resembles Hippocrates' views on man as being in equilibrium with his internal and external environment (Mettler, 1947). In addition, comparing the informants' definitions of health and illness to biomedical, psychological, and sociocultural models shows that the families' approach is a very comprehensive one and, in some ways, includes all the components stressed by each model (physiological, sociological, and psychological).

#### Theories of Causation

The data show that the families utilize a multicausality model to explain diseases, in which natural as well as supernatural factors are stressed. Among the natural causes, weather and climate, foods, and hygienic conditions were the most frequently cited. The emphasis on weather and climate conditions, with exposure of the body to rapid changes of temperature, wetness, and drafts, has also been found in other Latin American studies, but it does not seem to have the same intensity as presented by this Brazilian sample. For Maloof (1979), to relate weather and air conditions to disease is common among Arab-Americans and has its roots in early Egyptian theories on causation of disease. It is also consistent with Hippocratic theories of disease, which include meteorologic, climatic, and geographic conditions besides gastroetiologic and humoral explanations (Maloof, 1979, p. 134).

Another theme underlying families' descriptions of disease is that food and the human body have some properties such as heavy/light,

thin/thick, and strong/weak. Although there is no mention of the words hot/cold as expressed in humoral theory, they do follow the same principle. Maloof (1979), in analyzing explanations of the properties of food for Arab-Americans, asserted that "hot" foods are considered "heavy" for the stomach or very "fatty", which corresponds to reports of the Brazilian families on food and eating patterns as sources of illness.

This approach to causation falls within what Foster and Anderson (1978) call a naturalistic theory of causation. The essence of this theory is that any upset in human balance coming from without or within, such as hot and cold or strong emotions, can produce a disease (p. 54). According to these authors, although the equilibrium in the naturalistic theory can be stressed in different ways, hot and cold imbalance is a common threat to an individual.

Brazilian families share this naturalistic perspective on causation with other Latin American groups, as described by Saunders (1954), Clark (1970), Cosminsky (1977), Logan (1977), MacDonald (1981), and Messer (1981). References to this theory are also found among Helman's (1978) British sample, Maloof's (1979) Arab-American families, and even in Blaxter's (1983) middle-aged Scottish women. This confirms Foster and Anderson's (1978) assertion that naturalistic theory is widely spread through different cultures.

A second group of causes of disease cited by Brazilian families are classified in the supernatural realm. For Foster and Anderson (1978), this involves a different model of causation, also known as a personalistic medical system. It is characterized by the belief in an active, purposeful intervention of an agent who may be a supernatural

being (God or deity), a non-human being (ghost, ancestor, spirit), or a human being (witch or sorcerer) (p. 53). In this classification are included informants' descriptions of bad spirits and "encosto" (intrusion of a spirit) and some cases of evil eye. For Glick (1967), an agent, in order to be considered supernatural, must clearly show its intention of doing harm. Since, for some families, evil eye can be caused by people who are unaware of their power to induce disease, these cases have to be excluded from the supernatural realm, leaving only those definitely considered the result of a purposeful act.

Using these same criteria, "susto" (fright) falls in the naturalistic system rather than in the personalistic one. For Brazilian families, as opposed to other Latin American populations, fright is explained as being a strong emotion with no connotation of supernatural origins or purposefulness of intention.

The model of causation of the Brazilian families includes both naturalistic and personalistic systems. The presence of both in the same culture is not rare; they are also mentioned by Clark (1970), Cosminsky (1977), and MacDonald (1981). Although, in Foster and Anderson's (1978) opinion, medical systems can overlap, one will always be more prevalent than the other. Such is the case of the Brazilian families, where there are more references to the naturalistic theory of disease than the personalistic one.

The families' line of reasoning on how a disease occurs involves association and succession, two different but related forms of explanation. This again is closer to a naturalistic system, where a disease is sought in an impersonal and systematic way instead of

identifying an agent, which characterizes the personalistic model (Foster & Anderson, 1978).

The series of illnesses described by the families are somewhat similar to those found in studies of Latin American populations. However, a closer look shows that they do differ in many aspects. Thus, the emphasis on meteorologic and climatic conditions, contrast in body temperature, and the use of different terms to explain the properties of hot/cold regarding food are some examples. Further, there is no reference to neutral forms, such as warm or temperate, as found by Messer (1981) among the Zapotecs, and few informants used the notions of strong or weak, in contrast to Maloof's (1979) Arab-American families. And finally, the focus on strong emotions that permeates Spanish-speaking groups only corresponds to the forms of fright among the families studied.

Another type of illness referred to by Clark (1970) as due to dislocation of organs was found in only one family, who mentioned "relapse", which resembled the Spanish "fallen womb" (Foster & Anderson, 1978). However, in the Brazilian case, the explanation was linked to the presence of the south wind. Cases of fallen fontanelle, a common disease among the Spanish, were not found in this sample, but the investigator heard about it from other mothers with nursing babies. A possible explanation for the families not including this condition is because most of their children were older, while this problem is common only among infants. However, no mention of it was made even in the families' health histories.

Finally, there are some local illnesses such as "zipra" that have no correspondence in other studies, while still others do share some

similarities, such as "pontada" which is similar to "punzada", an illness characterized by shooting pains in the eyes and ears (Foster & Anderson, 1978).

In this author's opinion, based on the field work, families' explanations of disease are an integral part of the families' general perspectives on life. This was true not only in supernatural cases but also in those of natural origins, mostly weather and climate. This is a somewhat different position from that of Foster and Anderson, who said this occurs only in personalistic models. From their point of view, naturalistic etiologies are largely restricted to illness and are "not invoked to account for drought, bad luck in hunting, disputes, or other irritants in life" (p. 67). However, this investigator found that rain, winds, and the moon are related to the families' lives and not just to health and illness.

A final word is on causation and scientific medicine. Although the families do use words such as "germs from the beach" and "contagious", which are part of the biomedical model of disease, they actually have different meanings for the informants and, as a whole, are not integrated in the families' models of causation. In the same way, Clark (1970) called attention to the fact that her sample used a medical language with different meanings.

#### Families' Preventive Measures

In contrast to Samora's (1978) report that prevention is little understood among Spanish-speaking groups, the Brazilian families do use a series of preventive measures in their daily life. These include natural, supernatural, and scientific principles. The natural measures

involve eight different categories regarding weather and climate conditions, foods, activities, recreation, and hygiene, among others. Among the supernatural, families refer to the maintenance of good relations with others (to prevent evil eye), prayers, and the use of "breves".

Preventive measures, if isolated from the families' conceptualizations of health and illness, do not make too much sense. However, if examined in the light of their definitions, they become consistent and logical. This view of prevention is also shared by Foster and Anderson (1978) who asserted that preventive behaviors follow logically from disease causation concepts which, by explaining why a person falls ill, simultaneously teaches what must be done to avoid illness (p. 41). In addition, this investigator also found a relationship between the families' views on the nature of health (control/no control) and preventive measures. Informants who believed in human control or partial control over disease were inclined to develop more preventive behaviors than those who did not.

A last type of family preventive measure includes the use of medical services for prevention. As already demonstrated, medical services were only mentioned after being asked about, even though they were actually used. The utilization of overt behaviors, practices, and customs without a change in the belief system is also possible, according to Foster and Anderson. Furthermore, families were selective in the ways they made use of preventive services, with some utilized more than others, as in the case of medical follow-ups during pregnancy and taking vermifuge. This investigator suspected that this was related to previous positive or negative experiences, which in some ways

corroborates Foster and Anderson's position that people are remarkably pragmatic in testing and evaluating new alternatives in health care.

#### Family Management of Health and Illness Situations at Home

The families deal with health and illness situations on an everyday basis. First, there are the daily activities regarding food, weather and climate, hygiene, and recreation, which make up the core of measures to promote health and prevent disease. Second, there are those health behaviors in which families engage sporadically, mostly related to medical preventive practices. And finally, there are those problems affecting the health of the members that include a variety of situations ranging from the most simple ones to those of a more serious nature. Data on the great number of problems a Brazilian family deals with in its daily life is consistent with Alpert, Kosa, and Haggerty's (1967b) findings where the authors called attention to the number of problems not only identified but also solved at the family level.

The number and type of symptoms identified by the family has been discussed by Koos (1954) who linked them to social status, by Mechanic (1964) who linked them to the age of the child and the educational level and stress of the mother, and by Hetherington and Hopkins (1969) who linked them to age, gender, and religion. The position assumed by this investigator is that families' assessment and identification of ill health in their members depend on their own perspectives of health and illness. Age, gender, socioeconomic status, and other factors are seen not independently, but as factors affecting the families' perspectives rather than acting directly on their behavior.

Brazilian families make use of treatments involving natural, supernatural, and scientific sources. Their utilization of natural treatments basically follows the principle of balance and is consistent with a naturalistic medical system, while the use of supernatural sources is consistent with the personalistic etiology of disease, also adopted by the families. On the other hand, the introduction of scientific methods of treatment does not correspond to the families' conceptualizations of health and illness. However, according to Foster and Anderson (1978), this is possible and common in many cultures where people have adopted scientific methods of curing because of earlier positive experiences when dealing with this system.

Thus, the families' selection of treatments is based on a rationale where factors such as age, seriousness and etiology of illness, fear, level of incapacity, and earlier experiences play an important role. These variables, found in reports of the families, confirm earlier studies on the area of reactions to symptoms and illness behavior (Kasl & Cobb, 1966; Mechanic, 1972a; Suchman, 1972). The only point that this investigator considers important to add is that, underlying these factors, is the families' perspectives of health and illness, their theories of causation, and their views on the nature of health and illness, which are based on their ethnic background and their experiences with health and illness.

Finally, the emergence of the Brazilian family as a unique system of health care in everyday situations finds support in the literature, where references to the role of the family in the whole process of health and illness is stressed by Litman (1979), Schmidt (1978), and Pratt (1976). Going further, Levin and Idler (1981) defined the family



as the hidden health care system that mediates between the individual and scientific medicine. Although criticisms have been made of the family's performance as a unit of health care, as asserted by Litman (1974) and Parsons (1968), the family still stands on its own as care-giver. This is in part a result of its own nature and the kind of interactions that occur within the unit. To reinforce this position, it is important to note that an individual health carrier spends most of his/her time within the family system, while contacts with healers or health professionals have always been sporadic for most of the family members.

Health and Illness Conceptualizations of the Families from  
a Symbolic Interactionist Approach

One of the most important findings of this study is that families do conceptualize health and illness in similar ways, and most of their practices look alike as well. From a symbolic interactionist point of view, when community members define and interpret situations in the same way, they have a shared perspective (Shibutani, 1962); in other words, they have a common health perspective which is part of the larger culture. This commonality is the result of frequent interactions within the family unit and with other members of the community (grandparents, close relatives, neighbors, and friends) as well. Further, this study detected a growing frequency of interactions with people outside the village, which is leading to the acquisition of new meanings, values, and practices in relation to health and illness. In addition, changes in the families' and the community's perspectives are also occurring between the different generations, which were also identified in this

study. This confirms previous references of Beck (1979), Cascaes, (1979), and Halfpap (1980) to culture and change on the island of Santa Catarina. Again, this is consistent with the interactionist concept of the community as a dynamic process (Turner, 1978), where individuals are constantly evaluating and interpreting situations and, as such, reconstructing their world view.

Although the families do share a health culture with other members of the community, each family has its unique characteristics. Actually, there were no two families with the same conceptualizations and practices toward health and illness. This is also consistent with the framework adopted for this study, which emphasized that a culture offers a general guide for living but still leaves room for freedom and creativity (Blumer, 1962). In addition to cultural definitions offered to the families, their daily life is full of unexpected events which call for new and unique definitions (Stebbins, 1972), one of the reasons for variations between families.

Finally, the assumption of symbolic interaction that behaviors toward health and illness are constructed by family members through symbolic processes rather than simply by acts of release (Rose, 1962) is apparent when observing all the steps the families go through from the time a situation presents itself until a behavior takes place. As such, the simplest situation a family faces - for instance, abdominal pain - requires the family to make an assessment of the case (age, persistence, type, past experiences) to interpret it according to their model of conceptualization and practices in order to define the situation (is it serious or not, does it need to be treated immediately or not). Once the decision is made (to observe a while longer, to give a pain reliever

or teas, or take to the doctor), the families still continue to observe and assess the situation in a constant process of reinterpreting and redefining the situation.

#### Limitations

Several limitations were identified in this study. The first one is in regard to the time factor for gathering data. The period of six months allotted for field work, although enough to follow the families and answer the basic questions proposed by the study, did not give the opportunity to explore in more detail some areas that emerged relating to family and health care. Among these can be included the role of the older generation in the families' dealings with health and illness. Because of the time constraint, only half of the grandparents of the sample were interviewed in a systematic way. The same occurred with the analysis of the role of each member of the nuclear family in health and illness situations. Although interviews were done at least once with fathers and the oldest child, a longer period of time would have allowed the investigator to have more contact with the whole family and to get more insights on each individual member's participation.

A second point to be considered is that only one stage of the family life cycle was investigated. As such, there was the advantage of looking in depth at how almost all the families living in the village who were at this stage conceptualized health and illness, and the findings reported here are indeed characteristic of the families at this stage and therefore can be tested in other cases. However, it has its limitations as well. It cannot be assumed that any conclusion developed

in this study will be applicable to families going through other stages of the life cycle or to Brazilian families as a whole.

A third limitation of this research is related to the fact that the investigator had to leave the field before the analysis phase had been completed. As a consequence, the final steps and construction of the models took place far from the village and, as such, they could not be checked with the families for a final test of validity.

A final word is on the researcher herself who, it should be emphasized, plays an important role in a field study. By sharing the same cultural background as her informants, the investigator had some advantages. She did not face language barriers and rejection, and her entree to the village and the world of the families occurred smoothly. However, this shared culture also created some limitations. The most evident one was that sometimes the investigator took for granted descriptions given by the families instead of insisting on further explanations or more detailed observations, which the situation might otherwise have required.

### Implications

The findings obtained in this study advance knowledge for nurses and other health professionals in planning and delivering comprehensive health care to families. They will help health professionals in general to gain a better understanding on how the family as a unit deals with health and illness. In a more specific way, they contribute to nursing and the health sciences in Brazil by suggesting new approaches to family and health care. Furthermore, this study also expands the knowledge on

cross-cultural studies by describing health and illness conceptualizations and practices of a Brazilian subcultural group.

First, according to the results of the study, the family can be considered as a unique system of health care that has its own framework to guide it when facing health and illness situations at home. This framework has its roots in the culture and is developed throughout the family's life cycle. It will help families to assess the health status of its members, to develop measures to prevent disease, and to treat common illnesses at home.

The fact that families do have a framework for health and illness that may differ from that of health professionals has at least three major implications for nursing and other professions in the health field. First of all, it suggests to nurses and other professionals an approach to the family as a system of health care whose framework needs to be identified and accepted as such. Second, this approach also implies that families should be included as participants in planning and delivering health care for their members, instead of just being the recipients of professional programs and practices. Third, strategies should be developed within the health system to strengthen the family's role as the natural and sociocultural system of health care. In other words, health professionals are not expected to impose their own models on families; differences should be identified and openly discussed between families and health professionals, and the introduction of changes would be stressed in the cases where a family's behavior is recognized as prejudicial to its members.

A second implication of this study, for health professionals, is the recognition that families' models of health and illness are

culturally based and, as such, shared by other members of the community. This leads to the integration of cultural aspects at all levels, from the phase of planning and delivering care to evaluating health programs. Further, cultural theories on health and illness should also be taught as professional courses at the university in order to sensitize nurses, physicians, and other professionals to this relevant component of health.

Besides these general implications, which mainly call for changes in the attitudes of professionals toward the family, the culture, and health, the study also offers specific contributions for Brazilian professionals in their everyday practice while dealing with families at the preventive and curative levels. An initial suggestion is based on the fact that families' health-seeking behaviors are selective. As such, families do not bring to medical attention all health problems they face. Some of these problems are not treated at all, others are treated at home or with blessings, and still others are not even considered an illness. As a consequence, professionals have only a partial view of families' health problems. Considering these characteristics, health professionals are urged to develop new techniques to reach those family members most in need of scientific care. The use of the family health history instead of the individual's could help to identify some of the family's problems. In addition, more effective health programs at jobs, schools, and health clinics and educational programs at school or in conjunction with religious associations are some of the strategies health professionals could utilize to reach the population who otherwise do not come to the clinic.

Another contribution to practice in Brazil concerns the families' attitudes and behaviors toward preventive programs. Findings demonstrate that medically-oriented practices by the families are sporadic, feared, in need of external incentive to be performed and, most of all, are not yet integrated into the families' models. This poses a real challenge for health professionals in the area of health promotion and prevention of disease. One way of dealing with this problem could be through the integration of preventive measures in programs that families have already accepted such as, for example, follow-up exams during pregnancy, health education at school, and check-ups for workers. Health professionals should also make use of the opportunity of frequent medical visits (mothers and children) to include discussions about preventive measures. In addition, health professionals should plan programs to meet families' needs in such areas as alcoholism, childrearing problems, and family planning which, by themselves, constitute practices to prevent health problems. One word of caution, however, is necessary about these programs. They should consider the families' cultural backgrounds as well as their integrity as a family unit. Changes should only be introduced when absolutely necessary. Health professionals should constantly be reminded that culture and the family unit are the basis on which health programs are to be developed.

Finally, the study shows that management of health and illness situations are routinely done by families. Thus the family's role as health provider must be supported and enhanced by professionals, whose interventions should therefore, in most cases, be supplementary to the ones performed by the families. This requires health professionals to

be open to a more democratic relationship with the families, where treatment can be discussed, whatever its nature - scientific, natural, or supernatural - and lines of action can be taken in conjunction with each other.

#### Recommendations for Future Study

Recommendations for future research evolve from the application of a symbolic interactionism framework to the study of families in a sociocultural context, as did the study limitations and implications. The adequacy of symbolic interaction as a theoretical framework to focus on families' perspectives on health and illness recommends extending it to other stages of the family life cycle, from childrearing to old age. This will expand the knowledge on the family as caregiver and will also identify its needs and characteristics in each stage of life. Furthermore, because of its potential for uncovering cultural themes, symbolic interaction is recommended for use in studying families from other ethnic backgrounds in the state of Santa Catarina or other areas in Brazil, as well as cultures outside Brazil, in order to search for cross-cultural variations and similarities in perceptions of health and illness. A third area that could be explored through the framework is what the definitions of the families are when one of its members requires a prolonged stay in bed at home. Do definitions of the families change? Are there different cultural definitions for this kind of health problem?

A second group of recommendations are based on the study limitations. Initially, there is a need to test the model with families from different villages on the island to confirm or deny its accuracy



and applicability. Next, studies should also look at variations in the sample, for instance rural and urban populations, different levels of education and socioeconomic conditions, and religious affiliations as well.

There is a rich variety of studies that can be generated from the present research, based on its findings. One of these concerns the roles different family members play in health or illness situations at home. Studies have emphasized the mother's role, but few have actually explored the roles family members play in health and illness situations. Findings from this study suggest that fathers also play an important role, as well as the children. As such, future research could develop this line of inquiry. Another area requiring further study is the home treatments of families and their efficacy. They have been used (mostly herbs and plants) for many years, sometimes for generations, and the results are considered efficient. A systematic study of the composition of these treatments, methods of use, and healing effect is therefore required in order to identify if there are scientific principles which underlie these effects and their applicability to the health sciences. Finally, the findings show that families do influence other systems as well as being influenced by them. Further study should be developed to identify the actual extent of the interchange between families and the scientific health system.

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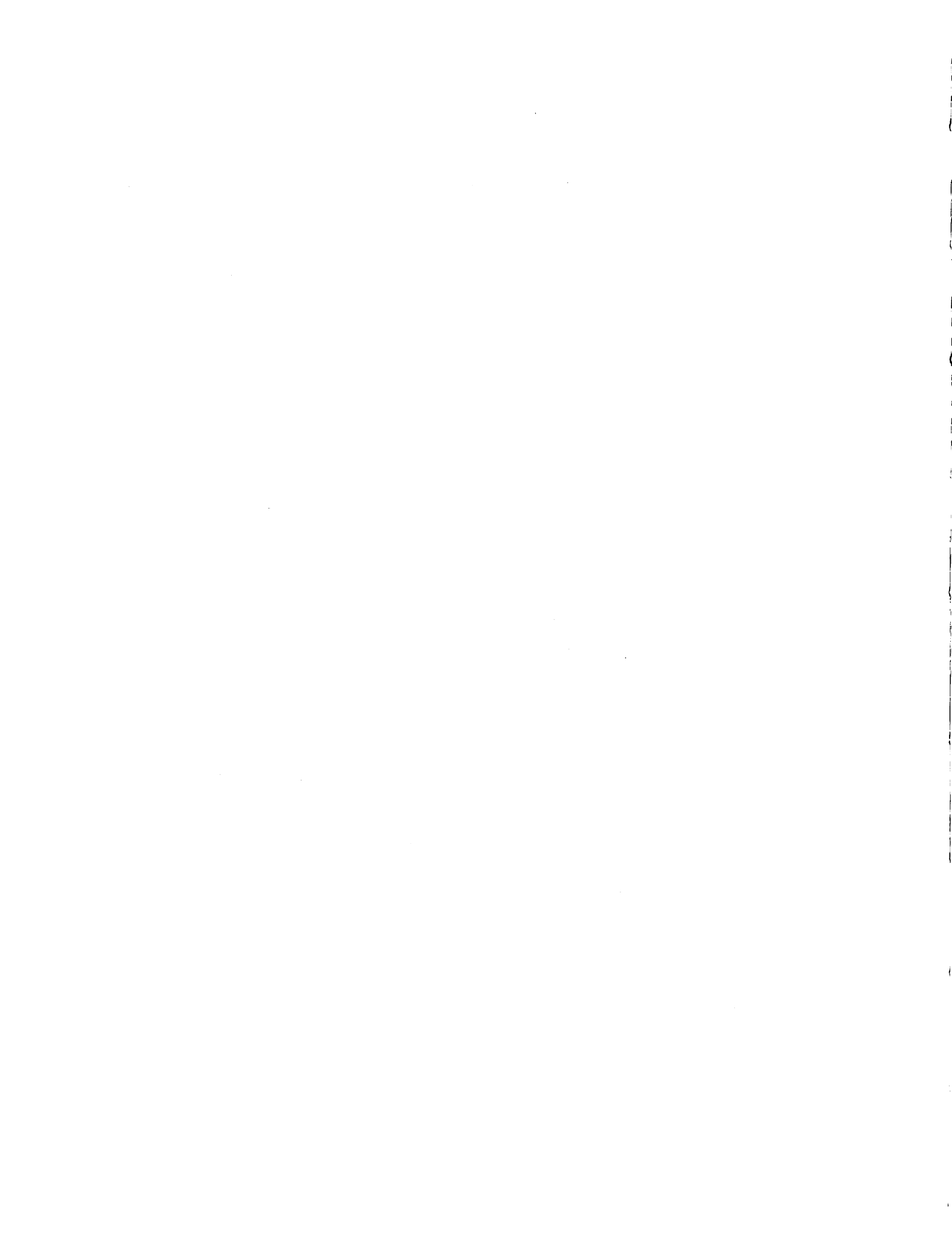


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APPENDIX A

CONSENT FORM

University of California, San Francisco  
Consent to Participate in a Research Project  
Consent to be a Research Subject

Study: Concepts of Health and Illness and Related Behaviors among  
Families in a Brazilian Fishing Village

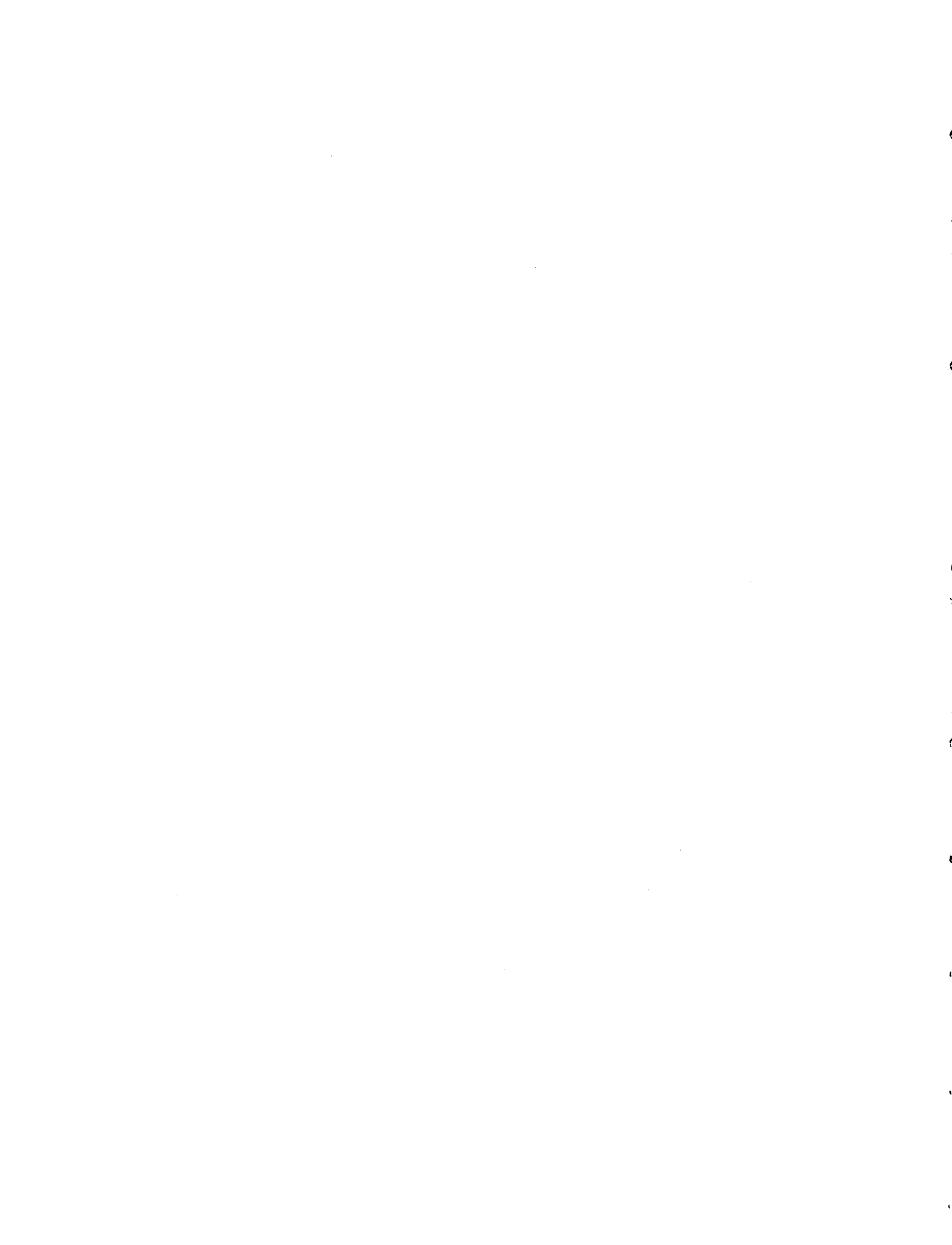
Investigator: Ingrid Elsen

Ms. Ingrid Elsen, a nurse and faculty member of the Federal University of Santa Catarina, currently a doctoral candidate at the School of Nursing, University of California, San Francisco, California, United States of America, is doing a study among Brazilian families to find out more about:

- a) What families think about health and illness
- b) What families do in everyday life to maintain health and treat common ailments
- c) Whose help families ask for when there is a health problem at home.

We agree to participate in this study which requires that the investigator will visit our family regularly over a period of several months and that she may ask to spend whole days with our family. This includes that:

- a) Husband, wife, and the oldest child answer questions in joint interviews
- b) Individual interviews will be given
- c) Observations of the family in their daily activities will take place
- d) Pictures will be taken when the family agrees.



The visits, interviews, and observations will be previously arranged and will occur at a time convenient for the family.

The investigator will take notes and in some cases, if we are willing, will use a tape-recorder during the period of interviews, visits, and observations. All information will be kept confidential. Any publication resulting from this study will include the necessary precautions to protect the identity of respondents.

Participation in this study is voluntary. We have been told that we may refuse to answer any question and that we may withdraw from the study at any time. We know that the findings of this study will probably not be of any benefit to us but may be of some benefit to families in the future.

If we have any comments about participation in this study, we will first talk with the investigator. If for some reason we do not wish to do this, we may contact the Committee of Graduate Studies at the Federal University of Santa Catarina, Monday through Friday. We may reach the Committee between 9:00 am and 6:00 pm at (phone #).

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Husband

\_\_\_\_\_  
Signature of Wife

\_\_\_\_\_  
Signature of the Oldest Child

APPENDIX B

OUTLINE FOR COLLECTING INFORMATION  
FROM THE VILLAGE

Outline for Collecting Information from the Village  
 (Based on Brownlee, 1978)

Dimensions	Description	Techniques
1. Physical Features	Terrain, vegetation, wildlife, natural resources, transportation routes, man-made structures, natural or man-made health hazards	Photographs, observation, maps, informal interviews
2. Sociodemographic	Population by sex, age, density, fertility rates, families, educational levels, households, level of income	Census, vital statistics, informal interviews
3. Historical	History of the village, particular events that have affected the health of the people, recent trends	Documents, informal interviews
4. Social Structure	Factors dividing the people into groups, how people are grouped (religion, social class, sex, occupation), sources of conflict, attitudes toward youth and aging	Observation, informal interviews
5. Economics	The community economy, attitudes toward work, how the village economy influences health and illness	Census, observation, informal interviews
6. Religion	Different religious groups and their perspectives on health and illness	Observation, informal interviews, participation in activities
7. Education	Number of schools, students, and health educational programs	Observation, census, informal interviews, participation
8. Environmental/ Sanitation	Water supply, disposal of human and nonhuman wastes, housing	Photographs, informal interviews, observation

APPENDIX C

MEDICAL SYSTEM OF THE VILLAGE



Medical Systems of the Village

Dimensions	Description	Techniques
1. Physical Characteristics	Location, building, material, and equipment	Observation, informal interviews
2. Organizational	Its structure and how it is related to other health care facilities, type of clients	Observation, semi-structured interviews
3. Functional	Programs offered to the community, problems	Interviews, observation
4. Morbidity Rates	Health problems by age and sex	Consult maps, interviews
5. Personnel	Number, category, roles	Semi-structured interviews, observation
6. Interaction	How health workers interact with villagers, how they see them	Semi-structured interviews, observation

APPENDIX D

GUIDE FOR INTERVIEWING LOCAL CURERS

GUIDE FOR INTERVIEWING LOCAL CURERS

1. What types of illnesses do you treat?
2. Can you explain how you treat them?
3. Where do you see your clients?
4. From whom did you learn to treat these problems?
5. What do you receive in exchange for your work?
6. How do people react to your work?
7. How is your work related to the Catholic church?

APPENDIX E

GUIDE FOR GATHERING SOCIODEMOGRAPHIC INFORMATION FROM FAMILIES

GUIDE FOR GATHERING SOCIODEMOGRAPHIC INFORMATION FROM FAMILIES\*

1. Family name
2. Address
3. Marital status
4. Years living in Solemar
5. Ethnic background of both parents
6. Family composition\*\*
  - Family member - relationship to head of the family
  - Birth date and birth place
  - Level of education
  - Occupation
  - Religious orientation
7. Socioeconomic situation - who is the breadwinner(s), does the family receive any supplementary assistance
8. Health insurance - what kind of health services family members use

\* Based on Bott (1971) and Friedman (1981)

\*\* Besides the names of members of the nuclear family, all names of relatives and nonrelatives living in the household were listed.

APPENDIX F

GENOGRAM

GENOGRAM\*

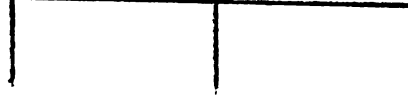
Line G (Grandparents)



Line P (Parents)



Line C (Children)



- Male
- Female
- M - Married
- S - Single
- W - Widowed
- Sep - Separated
- A - Abortion
- D - Death
- T - Twins

The health problem of each family member was written thoroughly as they described it. For instance, drinking problems, rheumatism, back pain, and so on.

Causes of death were also written in the way the parents told it.

\* Based on Jolly, Froom, and Rosen (1980)

APPENDIX G

GUIDE TO OBSERVING FAMILY STRUCTURE AND FUNCTIONING  
AS RELATED TO HEALTH AND ILLNESS SITUATIONS



GUIDE TO OBSERVING FAMILY STRUCTURE AND FUNCTIONING  
AS RELATED TO HEALTH AND ILLNESS SITUATIONS\*

1. Division of Labor: Who in the family performs the role of caring for the sick, teaching health principles, and taking the healthy child to be vaccinated?
2. Distribution of Power and Authority: How decisions on health and illness are made; who is the person in the family who makes decisions in this area?
3. Communication Patterns: How health practices are taught at home, how decisions are implemented.
4. Rituals, Taboos, and Symbols: At mealtimes, holy days, and religious observances, and how they affect the health of family members.
5. Values: What are the most relevant values of the family and how do they relate to health? Is there any conflict between them?

\* Based on Clemen et al. (1981)

APPENDIX H

FAMILY'S DEFINITIONS OF HEALTH AND ILLNESS

FAMILY'S DEFINITIONS OF HEALTH AND ILLNESS

(Both Parents)

1. How do you describe a healthy child, woman, man, old person?
2. Do you consider yourself healthy? Why or why not?
3. What about your children's health? Why?
4. Give me the names of some people you know who are healthy and why.
5. How do you describe a sick person?
6. What kinds of disease has your family had?
7. Give me three causes of disease.
8. What are the things you consider important to maintain health and prevent disease?

APPENDIX I

INITIAL LIST OF DISEASES

INITIAL LIST OF DISEASES\*

Health Problems	Cause	Treatment
1. Cold		
2. Vomiting		
3. Fever		
4. Diarrhea		
5. Sore Throat		
6. Earache		
7. Cuts		
8. Cough		
9. Nose Bleed		
10. Rashes		
11. Headache		
12. Eye Infections		
13. Insect Bites		
14. Colic		
15. Toothache		

\* Based on Spector (1979) and Schatzman and Olesen (1982)

To this initial list were added the following health problems, according to the local families' request:

16. "Zipra"
17. Rheumatism
18. Worms
  - 18.1 Shortness of breath
  - 18.2 "Ataque de bicha"
  - 18.3 Pain from worms
  - 18.4 "Alvorocai as bichas"
19. "Pontada" (bronchial pneumonia)
20. "Trisa"
21. Stomach pain
22. Diabetes
23. Evil Eye
24. Itching
25. Back pain
26. Bronchitis
27. Allergy
28. Hemorrhoids
29. Grubs
30. "Bicho geografico"
31. Heart problems
32. Lice

APPENDIX J

FAMILY HEALTH SURVEY

FAMILY HEALTH SURVEY

Family No. \_\_\_\_\_

1. Day and time
2. Family members
3. Health status
4. Causes of health problems
5. Measures taken to enhance health, prevent disease, or treat health problems
6. Sources of help
7. Sources of learning



APPENDIX K

CHARACTERISTICS OF THE HOME

CHARACTERISTICS OF THE HOME

A detailed description of each house was made, with special emphasis on possible sources of health hazards. The major characteristics considered during the observation were:

- Type of building, materials used, location, ventilation, heating, lighting
- Owned or rented, home's condition (new, old)
- Number of rooms, bedrooms
- Furniture and its adequacy
- Kitchen, utensils, and care in keeping food
- Bathroom facilities
- Water supply
- Cleanliness, neatness
- Sleeping arrangements, their adequacy
- Presence of insects and rodents
- Presence of specific health hazards
- Back yard, garden
- Presence of pets, how they are cared for
- Family's feelings about the house.

