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Female Clerical Workers in Brazil: Their Roles and Their Health

by

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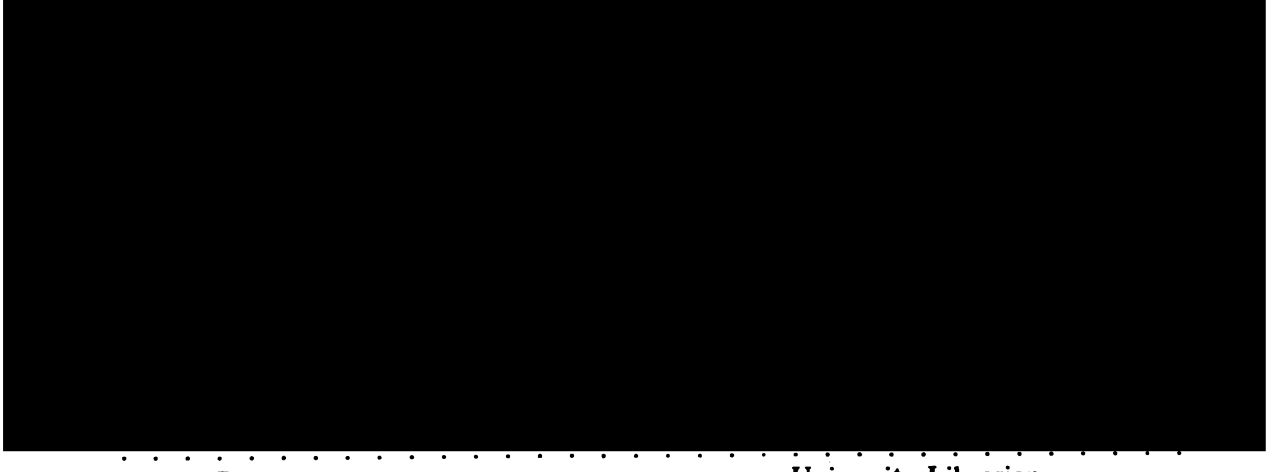

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Abstract

Most recent research on women's roles and their relationship to health has focused on middle-class North American women. This study examines the associations among role identities, role involvements, sex-role orientation and health perceptions in a sample of middle-class Brazilian women.

A stratified random sample of sixty clerical employees at a large public institution in Florianópolis, Santa Catarina completed a six-part questionnaire designed to measure these concepts.

The data were analyzed using statistical methods appropriate to each level of measurement. Sex-role orientation (whether traditional or feminist) was significantly associated with age. Women who were more involved in the care of a relative had lower perceived resistance to disease. Women greatly involved in their work had a positive conception of their current and overall health as well as their ability to resist illness, while women who reported high involvement in religious activities viewed their general health status, current health, and resistance to disease more negatively. No relationships were identified among health perceptions and health behaviors, nor were the important role identities of spouse, mother, or daughter associated with any of the other variables.

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Chapter 1: Introduction

The study of women's roles and their relationship to health and illness has enjoyed increasing attention over the past decade. Researchers have attempted to correlate increased or decreased role obligations with various measures of well-being to help define and clarify the range of women's life experiences. Most of the studies, however, have focused on fairly well-educated, employed American women who have access to a variety of health care services. Little is known about women in subcultural groups, such as minority women, low-income women, and women in low-status employment.

In examining the relationship between multiple roles and anxiety, Barnett and Baruch (1985) interviewed white women exclusively. Other important studies have concentrated on quantifying the responses of a well-identified population (wives, mothers, or female employees) to health questionnaires and other research tools (Woods, 1980; Hibbard & Pope, 1983; Kandel, Davies & Raveis, 1985). Focusing as they do on a particular stratum of North American society, these studies offer guidance for analyzing the health practices of women elsewhere, yet few research efforts have addressed specifically Third World women's social role expectations and their health behaviors. An examination of women's roles and health behaviors in Brazil will not only shed light on the actions of immigrant women

in the United States but by providing a framework for research will also promote the development of an international perspective from which to approach the study of women's experiences worldwide.

Objectives of the Study

The overall purpose of this study was to explore the relationships among role identities, role involvements, sex-role orientation, perceived health status and selected health behaviors of Brazilian women.

Significance of the Study

Studies of Latin American societal norms document the low-status position of women (Burns, 1980; Pescatello, 1976; Wood, 1982). The impressive empirical evidence describing low pay, high illiteracy rates and other manifestations of gender-based discrimination nevertheless does little in itself to explain the ways in which individual women juggle various responsibilities to self, family and sometimes employer while simultaneously attending to their own health care requirements. High cancer rates among Brazilian women suggest that their health care options and practices deserve further study to analyze the factors affecting the performance of diagnostic health behaviors.

The most recent Brazilian health statistics show that the prevalence of cervical cancer among women in the state of Santa Catarina during the period 1976-1980 was 39.2 per 100,000 (Brumini, 1982). By contrast, cervical cancer occurred at a rate of only 13.6 per 100,000 women in the

Standard Metropolitan Statistical Area of the five-county San Francisco Bay Area from 1973 to 1976 (Waterhouse et al., 1982). Breast cancer appeared in 16.5% of all women in Santa Catarina (Brumini, 1982) and was the third leading killer of Brazilian women in the 20-64 age group. It accounted for 17.8% of all cancer deaths in this age group; cervical cancer was responsible for 10.1% of the total female cancer mortality (Ministerio da Saúde, 1985). Early detection of these neoplasms greatly improves survival rates, but a certain degree of health awareness is required to make cogent decisions about seeking treatment. The critical questions thus are, do Brazilian women have access to the necessary means for learning about preventive and diagnostic health measures, and perhaps more importantly, how do their role responsibilities interact with personal perceptions of health care needs?

Recent studies in North America indicate that women with varied and numerous responsibilities do not necessarily suffer higher incidences of poor mental or physical health (Hibbard & Pope, 1983; Thoits, 1983; Woods, 1985), but these findings must be viewed against a social backdrop which condones and often encourages the gainful employment of women, independent decision-making and shared familial responsibility between spouses. As Harris (1982) points out, wives in Brazil still seek permission from their husbands to work outside the home--permission which can be withdrawn at any time. The social realms are sufficiently

different that any attempts to interpret Brazilian women's experiences using North American norms must be approached cautiously.

Insight into different cultures can be gained from nursing research in the international arena. This study offers the opportunity to test the ability of instruments developed in the United States to measure subtle social constructs in a foreign setting and to facilitate the exchange of research findings between host and donor country (Douglas and Meleis, 1985; Meleis, 1987). This research, aimed at discovering what Brazilian women perceive as necessary for their health and well-being, can promote understanding of their life situations and options while enriching and informing the study of women's roles and health worldwide.

Chapter 2: Review of Literature

Current research on women's roles and health has explored extensively the questions of role overload and role strain and their possible effects on health status. An emerging consensus argues that the number of female obligations influences wellness and illness. Kandel, Davies and Raveis (1985) found that women whose lives included children, spouses and employment reported the lowest overall number of psychological depressive symptoms in their sample. In an earlier study, Thoits (1983) likewise found that women with many involvements experienced less mental distress than women with fewer roles. Examining physical complaints, Hibbard and Pope (1983) reported fewer symptoms of illness among women with heavy role responsibilities.

These studies seem to indicate that women are not only capable of handling a large number of responsibilities, but that their physical and mental well-being are enhanced by varied role involvements. In an attempt to refine and clarify these general findings about multiple roles, some investigators have focused on the perceived quality of women's experience in various functions.

Examining role overload and anxiety in a sample of women aged 35 to 55 years, Barnett and Baruch (1985) asked respondents direct questions about the quality of their experience within each obligation. Interestingly, perceived satisfaction with role involvements proved a major

independent predictor of role conflict, overload and anxiety; thus, it seems that role satisfaction is more important than absolute number of role obligations in terms of health effects. In a similar vein, Verbrugge (1986) identified a curvilinear relationship between role responsibilities and health; women with very few or very many time constraints and pressures demonstrated poorer health than those with a moderate number of obligations. She also found that women who were dissatisfied with their lives were at greater risk for illness. Thoits (1986) compared role identities in women and men to attempt to account for the relative mental health advantage enjoyed by males. Her work indicates that although men in general performed a greater number of roles than women, this did not consistently account for differences in psychological distress reports. Closer examination revealed qualitative dissimilarities between the sexes in the types of expectations at each identity level. Women's obligations were perceived as lesser in status and value compared to parallel male obligations.

While important for their explication of certain types of female experience, the above studies are somewhat middle class- and Western culture-specific. Still, they provide a basis from which to analyze women's situations elsewhere. Because of more rigid social definitions of roles, an issue more germane to Brazilian women concerns the effect of sex role traditionalism on health and illness behavior.

Thompson and Brown (1980) used Spence's Personal Attributes Questionnaire to determine the degree to which survey respondents identified with sex role stereotypes, then compared the data with health services use. Women who were more feminine had more visits to the clinic, supporting the hypothesis that identification with cultural norms would create the conditions under which women could feel free to report illness symptoms. In two separate studies, Woods (1980; 1985) found conflicting evidence for traditional sex roles influencing health behaviors. The first study found no interaction between traditional sex role ideology and negative health consequences related to role proliferation. The later study, however, did demonstrate a positive correlation between sex role traditionalism and scores on the Cornell Medical Index mental health section. Traditionally-oriented women reported a higher number of anxious, tense, angry or depressive feelings. Employment status did not appear to be a factor in this part of the analysis. The variation in results indicates the need for further exploration of the influence of sex role orientation on role performance, acceptance and satisfaction.

Studies of Brazilian women's roles reported in English are rare. Rosen and LaRaia (1972) investigated the extent to which industrial development correlated with dissolution of sex stereotypes in five areas of Brazil situated along an urban-rural continuum. While demonstrating the persistence of the centrality of the extended family in Brazilian

society, they found that urban women were indeed participating more fully in family decisions and were in general more independent vis-a-vis traditional patterns of behavior. More recently, Brandão (1982) has argued that rising divorce rates, falling marriage rates and increased entry by women into the labor force mean a decline in female economic dependence with a resultant challenge to traditional values. Middle-class women in particular are beneficiaries of the expansion of higher education as well as the growth of technical and managerial jobs in the service sector. Crucial to an understanding of the complexity of Brazilian women's situations, Brandão asserts, are the effects of class divisions intensified by rapid and uneven economic growth, traditional *machismo* ideology, and the overall authoritarianism of Brazilian society.

Wright and Carneiro (1984) also point to the marginality of women in the decision-making process and the unpaid (and hence invisible) status of domestic work as factors which serve to maintain the existing gender inequalities in Brazil. Women are overrepresented in domestic work, childcare and low-paying service jobs, despite levels of education often superior to men. The authors' general statements are corroborated by Bills, Godfrey and Haller (1985), who found that Brazilian women, on average, are paid less than half the salary of men, irrespective of job classification or educational attainment.

Conditions of poverty add an important dimension to the social options of Brazilian women. With a great number of people living in depressed circumstances in Brazil, the situation of women becomes even more precarious, owing in part to their inferior societal position, their heavy workload, and lack of attention to women's specific problems (Barroso, 1982). Economic data specific to women for Brazil as a whole are not available, but in Santa Catarina, one of the richer southern states, 94.7% of economically active women in 1980 earned less than five times the minimum wage, which still represents a low income; of these, 44.5% earned less than one and one-half times the minimum salary (Censo Demográfico, 1983). In the same state, according to the Anuario Estatístico do Brasil (1985) 81% of wages earned paid for food and housing, with only 5% spent on hygiene. Additionally, inequalities in overall income distribution persist: according to 1980 figures, over half of Brazil's total household income was held by less than ten percent of the population, while the poorest twenty percent received only two percent of the total (Franklin, 1982). As might be predicted, the Physical Quality of Life Index, a composite score based on several social indicators and ranging from 0 to 100, ranks Brazil tenth among the seventeen Latin American nations with a score of 68, behind such countries as Colombia, Paraguay and Mexico (Malloy and Borzutzky, 1982).

Given the broad treatment of women's roles and health in the United States and the paucity of comparable studies of Brazilian women's social obligations and needs, an exploration of some of these issues is particularly appropriate.

Theoretical Framework

Much of the language of role theory emerges from the symbolic interactionist paradigm of social psychology. Of particular use in the present study, however, is identity theory, an outgrowth of symbolic interactionism developed by Stryker and Serpe (1982). Identity theory provides a narrower conception of symbolic interactionism by focusing on role-related choice behavior as a reflection of societal constraints on individual behavior. The three key concepts of identity theory are identities, identity salience, and commitment, each of which requires further explanation.

Identities are the roles enacted by persons in their daily lives, serving to define the characteristics of each individual. They may be self-defined, socially determined, or both, and thus identify how one views oneself as well as how one is seen by others. In the present study, women were asked to define themselves by indicating their involvement in various role activities.

Identity salience refers to the importance of each identity relative to other identities, as organized by the individual. The more salient an identity, the more time and involvment a person will give to that role identity. In

this study, identity salience is operationalized as reported degree of involvement in each role identity.

The concept of commitment embodies the structural aspects of role performance in terms of the individual's relationships with others. Degree of commitment to any role identity involves at least two factors. First, the number of people depending on performance of that role, as in the case of a single parent with several young children, and secondly, the quality of relationships centered around a role identity, which serve to reinforce positively or negatively the enactment of that role. Seen more generally, the concept of commitment provides a way to explain societal reaction to and influence upon role identities and identity salience. In this study, number of role involvements served as an indirect measure of commitment.

The model proposed by Stryker and Serpe (1982), then, hypothesizes that commitment affects identity salience, which in turn affects those behavioral choices that are role-related. Put differently, if a person receives encouragement in a role performance, then that role will become more meaningful; the person will then make behavioral choices consistent with the performance of that role.

The present study was not designed to test identity theory. Rather, the theory was used to guide the development of the role identity instrument and the collection and analysis of role identity data in a sample of

Brazilian women. The specific research questions which emerged through this framework were:

1) What are the number and kind of role identities assumed by Brazilian women?

2) What is the degree of their involvement in each role identity?

3) What are the relationships among role identities, role involvement and performance of selected health behaviors?

4) What are the effects of perceived health status and sex role orientation on the relationships among role identities, role involvements, and performance of selected health behaviors?

The first question addresses the theoretical concept of commitment by delineating the variety of roles assumed by Brazilian women. The concept of identity salience is approached in the second question, which assesses strength of role involvements. Question three attempts to relate behavioral performance to commitment and identity salience. Finally, the fourth question addresses the possible influence of specific cultural attributes of Brazilian women on the interactions.

Chapter 3: Methodology

The goals of this study were to investigate possible relationships among a number of social and health-related variables. Since little is known about the health behaviors, role obligations and perceived health status of Brazilian women, a descriptive study combining qualitative and quantitative techniques offered the most logical approach to data collection. A self-administered questionnaire, described in detail later, obtained information about roles and role involvements, sex-role orientation, perceived health status and selected health behaviors.

Setting

The city of Florianópolis, the capital of the state of Santa Catarina in southern Brazil, was the research setting. The city has a population of 218,853 and encompasses an area of 451 square kilometers (Civita, 1986). It is situated partially on the Atlantic coast mainland and partly on the Island of Santa Catarina, linked by a one-half kilometer bridge. The Universidade Federal de Santa Catarina, the state government offices and the administrative nuclei are located on the island, with mainland economic activity centering around commerce and light industry.

The socioeconomic makeup of island Florianópolis made it an ideal setting for a study of middle-class women. Nearly one-third of the economically active female

population in 1980 earned from two to ten times the minimum salary (Censo Demográfico, 1982). The same census data reveal that forty-two percent of women living in the city had completed at least eight years of education, four years beyond the legal minimum.

Sample

The target population was composed of clerical women workers. Clerical employees were chosen because of their reading and writing skills and the comparability of their work with United States workers. A computer listing of female employees at a large public institution in the job categories of Administrative Assistant, Educational Technician, Cultural Technician, Typist, Keypunch Operator and Finance Technician yielded a sampling frame of 462 names. These individuals perform clerical and lower administrative tasks with varying degrees of responsibility, but none have autonomous decision-making power. Godfrey, Bills and Haller (1982) use their Brazilian socioeconomic rating scale to place these occupations within the white-collar classification.

Percentages of the population within each job category determined the proportional stratification of the random sample of sixty women. It was deemed necessary to select a proportional stratified sample to account for any differences in responses based on occupational category. Table 1 illustrates these percentages and the number of women sampled in each category. Names of extra subjects

were drawn at the time of the initial sampling to allow for dropouts and refusals.

Table 1

Sample Job Classifications

Classification	Members	% of Total	n
Administrative Agent	245	53	22
Typist	120	26	16
Educational Technician	64	14	8
Cultural Technician	16	3.5	2
Keypunch Operator	10	2	1
Finance Technician	4	0.9	1
Social Communications Technician	3	0.6	0
Total	462	100.0	60

The women in the sample ranged in age from 21 to 54 years, with a mean of 31 years. Forty-two percent were single, thirty-five percent married, thirteen percent divorced or separated, seven percent were unmarried but living with a significant other, and two were widowed. Thirty-three women had one or more children. Although they were all clerical workers, their job responsibilities varied from semi-autonomous decision-making capabilities to total dependence on instructions from superiors. Stratification of the sample matched the percentages of women in each job category in the total population. Eighty-one percent worked a straight day shift, while the remainder worked a variable shift covering daytime and evening hours. The average workweek for the sample was 40.3 hours, with a range of 25 to 80 hours. One woman who indicated 119 hours wrote that

she considered her duties at home as well as in the office as work, and thus arrived at such a figure. Her response was excluded from the computation of mean hours of work.

Other sample characteristics demonstrate both similarities and differences with respect to the statewide population of urban women. In the study sample, only ten percent had less than a secondary education, while over sixty-two percent of the women who attend school in Santa Catarina do not continue beyond the primary level. In addition, the sample claimed to be 71.2% Roman Catholic as against 89.2% statewide. Nearly twelve percent of the women sampled identified themselves with the Espirita Kardecista religion, which contains a spiritual healing component. This religion is less well-represented in the statewide figures at only 0.4% of the total. Ethnically, the sample almost exactly mirrored the state's urban mix: 93.4% characterized themselves as white of European or Lusitanian origin, 3.3% as black, and 3.3% as brown mixed-race, identified by the Brazilian census category of *parda*. Table 2 summarizes these comparisons.

Table 2

Demographic Characteristics

	Sample	Statewide
Education		
Less than secondary	10.0%	62.5%
Secondary	30.0	30.3
Greater than secondary	60.0	7.2
Race		
White	93.4%	91.7%
Black	3.3	2.1
Parda	3.3	5.8
Asian	0.0	0.1
Undeclared	0.0	0.3
Religion		
Roman Catholic	71.2%	89.2%
Protestant	6.8	10.3
Espirita Kardecista	11.8	0.4
None	10.2	*

*not a census category

The monthly income of the sample placed them in the middle class; seventy-two percent of respondents reported family incomes six or more times greater than the minimum wage, while only five percent made less than three times the legal minimum. Seventy-seven percent characterized their income as insufficient or barely sufficient for family needs.

Variables and Measurement

Five variables were measured (Table 3). Although this study was primarily descriptive by design, the goal of examining relationships among the variables and selected health behaviors assumed directionality. Therefore, the variables of role identities, degree of role involvement,

sex-role orientation and health perceptions were considered independent for purposes of analysis, while performance of selected health behavior was classified as dependent.

Table 3

Study Variables

Variables	How Measured	Level
Number of Role Involvements (Commitment)	12-item list	Interval
Degree of Role Involvement (Identity Salience)	Six-point Likert 12-item	Interval
Health Perceptions (Two tools)	Modified Cantril Ladder 1-item	Interval
	Five-point Likert 32-item	Interval
Sex Role Orientation	Five-point Likert 16-item	Interval
Performance of Selected Health Behaviors	Yes-No answers to direct questions	Nominal

Number of role identities and degree of role involvement were measured by the Role Repertoire and Involvement Questionnaire (Meleis, Norbeck & Laffrey, personal communication). This questionnaire asked respondents to indicate their degree of involvement in twelve different roles on a five-point Likert scale ranging from zero (not applicable) to five (a great deal of involvement). Mean number of roles for the sample and mean degree of involvement in each role yielded single-score

interval level data. This questionnaire is in the development and testing phase, hence reliability and validity information are not yet available.

Sex-role orientation as an independent variable was measured by the Index of Sex Role Orientation (Dreyer, Woods & James, 1981). The ISRO is a sixteen item questionnaire which asked respondents to rate their degree of concordance with statements about women's behaviors, functions and responsibilities on a five-point Likert scale ranging from one (strongly agree) to five (strongly disagree). The middle position, three, is a neutral response. This questionnaire has shown excellent ability to differentiate traditional-thinking from feminist-oriented women, with a 96.2% sensitivity rating and a 95.5% specificity score. It is also a reliable instrument, with a split-half reliability coefficient of .92 (Woods, 1985). The high sensitivity and specificity values give evidence of the questionnaire's construct validity. Items on this questionnaire reduce to three statistically independent dimensions which will be analyzed in the following section. The subscales are male-female division of responsibility, conflicts between having children and having a career, and sex role issues surrounding work outside the home. All scales yield interval level data.

The independent variable of health perceptions was measured using two instruments. A ten-point Cantril ladder modified to measure health status (Palmore & Luikart, 1972)

asked respondents to rate their overall health on a scale of one (worst possible) to ten (best possible). This scale produces interval data. A second self-report of health was obtained using the Health Perceptions Questionnaire (HPQ) (Ware, Davies-Avery & Donald, 1978). This thirty-two item instrument asked respondents to register their agreement or disagreement with a series of statements about their health on a five-point Likert scale ranging from one (definitely true) to five (definitely false). Again, the middle position of three is a neutral response. This extensively tested tool reduces to six subscales, all of which have reliability coefficients greater than .60. The six subscales, all at the interval level of measurement, are: prior health, current health, health outlook, health worry or concern, resistance or susceptibility to disease, and sickness orientation. Construct validity of this instrument has been ascertained by measuring the associations among scales. Internal consistency reliability for all scales showed alphas greater than .90 (Ware, Davies-Avery & Donald, 1978).

Finally, health behavior was measured by asking respondents whether or not they had ever had a Papanicolau (PAP) smear, how often they repeat the smear, who performed the last smear, and what was the last result. They were also asked if they had ever had their breasts examined and by whom, and whether or not they practiced breast self-examination (BSE). If they answered yes to the latter,

they were then asked how frequently and at what time of the month they performed the examination. Only the behaviors of PAP and BSE were treated in the present analysis. All responses were fixed alternative type, with the additional category "other" included.

Method of Data Collection

The researcher approached each respondent and explained the purpose and goals of the study. Informed consent was obtained verbally or in writing (Appendix A). Verbal consent was offered as an option to those who did not wish to sign a statement. Subjects who agreed to participate then completed a self-administered six-part questionnaire in Portuguese (Appendix B) which contained fixed alternative responses, open-ended questions, Likert-type scales, a Cantril ladder to measure health status, and a demographic sheet. All instruments were professionally translated from English (Appendix C) into Portuguese, then back-translated into English by a second bilingual expert.

Method of Data Analysis

Since the data were obtained from a random sample of women clerical workers and can be treated primarily as interval level data, parametric statistical techniques are appropriate to use in the analysis. The next section reports the findings of the study, the correlations among interval-level variables, and the associations among the categorical items. One-way analysis of variance procedures tested differences between groups who had and had not

received Papanicolau smears, and between groups who did and did not perform breast self-examination.

Chapter 4: Results

Using the research questions to guide the data analysis, the study findings may be reported in a logical progression. First, the number and kind of role identities assumed by respondents were described. The degree of involvement in each role identity was then expressed as a mean score. Thirdly, the relationships among number of role identities, degree of role involvement and performance of the selected health behaviors of PAP and BSE were addressed. Finally, the effects of perceived health status and sex role orientation on the relationships among role identities, role involvements and performance of PAP and BSE were evaluated.

Number and Kind of Role Identities

In this study, number of role identities assumed by sampled women gives insight into the varied nature of their daily responsibilities. Mean number of role identities for the sample was 7.7, with a standard deviation of two. The role identities encompassed the activities of mother, daughter, spouse, volunteer worker, caregiver to a relative, employee, student, religious involvement, recreational involvement, social involvement, involvement in domestic duties and other involvement. Table 4 displays the role identities in descending order of frequency. It is shown that the employee role was most often listed, followed by involvement in domestic duties, social involvement, and

involvement as daughter. Least often named were the identities of spouse, student and volunteer.

Table 4

Rank Order of Role Identities

Role Identity	n	Percent of Total
Employee	58	96.7
Domestic Duties	54	90.0
Social Activity	52	86.7
Daughter	48	80.0
Recreational Activity	48	80.0
Religious Activity	41	68.3
Caregiver to a Relative	39	65.0
Mother	33	55.0
Spouse	30	50.0
Student	29	48.3
Volunteer	24	40.0
Other	6	10.0

Degree of Role Involvement

The degree to which respondents were involved in the various roles was measured on a Likert scale ranging from two to five. The responses of zero (not applicable) and one (no involvement) were excluded for this part of the analysis. Higher mean scores thus indicate greater role involvement. Table 5 presents the rank order of role identities as measured by mean degree of involvement in each role. The second column of Table 5 shows the rankings based on mean involvement scores of women involved in the role identity. Column three indicates the number of women actually involved in each identity, while column four expresses this as a percent of the total sample.

Table 5

Mean Role Involvements

Role Identity	Mean Involvement	n	% of Total
Mother	4.88	33	55.0
Employee	4.57	58	96.7
Spouse	4.53	30	50.0
Other	4.50	6	10.0
Student	4.28	29	48.3
Domestic Duties	4.20	54	90.0
Daughter	4.19	48	80.0
Volunteer	3.58	24	40.0
Caregiver to a Relative	3.27	39	65.0
Recreational Activity	3.00	48	80.0
Religious Activity	3.00	41	68.3
Social Activity	2.94	52	86.7

This hierarchy is structured according to the absolute mean scores of women involved in each role; it does not take into account the fact that only 50% of respondents are involved in the spousal role, for example, while 96.7% claim involvement in the employee role. To clarify the effect of subgroup size on mean degree of role involvement, it was necessary to adjust the involvement hierarchy. Table 6 shows the adjusted involvement hierarchy, calculated by multiplying the mean involvement scores for each role identity by the percentage of women involved in the role identity. This process standardizes the scores for the group as a whole. The adjusted rank represents aggregate involvement for each role identity. It is thus observed that although involvement in certain roles such as spouse and mother appears quite high when viewed in absolute terms,

those involvements lessen when the overall group scores are considered.

Table 6

Adjusted Mean Role Involvements

Role Identity	Percent Involved	Adjusted Mean
Employee	96.7	4.42
Domestic Duties	90.0	3.78
Daughter	80.0	3.35
Mother	55.0	2.68
Social Activity	86.7	2.54
Recreational Activity	80.0	2.40
Spouse	50.0	2.27
Caregiver to a Relative	65.0	2.13
Student	48.3	2.06
Religious Activity	68.3	2.05
Volunteer	40.0	1.43
Other	10.0	0.45

In terms of Papanicolau smear and breast self-examination behavior, seventy-five percent of the women reported having had a PAP smear at some time; of those, sixty-nine percent had it within the last year. However, almost half reported irregular frequency in having the exam, with only twenty-eight percent indicating yearly performance of the test. Twenty percent reported a Class II, or atypical result on their last exam.

Regarding breast self-examination, thirty-nine percent of the sampled women did not examine their breasts at all. Of the sixty-one percent who did, nearly half of them had no particular routine for doing so. Seventy-three percent performed this exam any time during the month, without regard to menstrual cycle.

Role Identities, Role Involvement and Health Behaviors

Most of the statistical analyses which follow are based on use of the one-way analysis of variance procedure or the Pearson product-moment correlation coefficient. The critical level of significance for all tests of association was .05, but as Reid (1983) cautions, repeated comparisons of means using data from the same sample increases exponentially the probability of committing Type I errors. The level of significance must be decreased in order to protect the analyses from misinterpretation. Insofar as the present study is concerned, virtually no associations of significance would be found using the required alpha of .001; moreover, since one aim of this work is to suggest areas for further research, correlations "significant" at the $p < .05$ level are reported with the foregoing caveat. The implications of this approach are discussed in the final chapter.

Considering the health behaviors of PAP and BSE and their relationship to number of role identities, one-way analysis of variance revealed a significant difference between women who had received Papanicolau smears and those who had not. The PAP group reported a mean of eight role identities, while the mean for the group who had never had the examination was 6.8. This difference was statistically significant at the $p < .05$ level. No difference was found in number of role identities between women who did or did not practice breast self examination.

A one-way analysis of variance was then employed to test differences in degree of role involvement between women who practiced Papanicolau smear and breast self examination and those who did not engage in these behaviors. First, degree of individual role involvement was compared between groups who did and did not perform the examinations. Degree of involvement as an employee was the only "significant" difference found in the PAP smear groups, $F(1,56)=5.02$, $p=.029$, while degree of volunteer involvement proved different between the BSE groups, $F(1,21)=6.23$, $p=.021$.

Aggregate degree of role involvement was then examined to test differences between entire sample group mean scores according to health behaviors. For the women who had PAP smears, differences were found in degree of involvement as spouse [$F(1,57)=6.21$, $p=.016$], as mother [$F(1,56)=4.46$, $p=.039$], and as employee [$F(1,58)$, $p=.044$]. Using BSE as the breakdown variable, no significant differences in aggregate degree of role involvements were identified.

Health Perceptions

Two tools measured self-perceptions of health. On one scale, participants rated their overall health on a Cantril ladder ranging from one to ten, with higher scores representing a better health self-appraisal. The group average was 8.2. The second instrument was the Health Perceptions Questionnaire. It yielded subscale scores reflecting current health perceptions, prior health evaluation, future health outlook, health worry, perceived

resistance to disease, and sickness orientation. Average scores for the group were above the midpoints on all scales, indicating positive views of personal health. All variables were measured at the interval level.

A Pearson correlation matrix relating number of role identities and the seven measures of health perceptions was generated to determine if associations among the variables exist. Table 7 displays the correlation matrix, with two-tailed significance levels. The only variable associated at the $p < .05$ level with number of role identities is prior health. The correlation was negative, indicating that women with a greater number of role identities viewed their prior health less favorably.

Pearson correlation coefficients were then computed for the seven variables measuring health perceptions and each role involvement. The category of "other involvement" was omitted from this analysis, since only six women listed it as a role identity. Two-tailed tests of significance showed a number of notable associations among the variables. The correlation matrix is displayed in Table 8. It is worth noting here that the three variables of current health perceptions, resistance to disease, and overall health status were inversely related to degree of religious involvement at the $p < .05$ level and positively related to degree of involvement as an employee, $p < .05$. In addition, involvement in the caregiver role was inversely related to perceived resistance to disease ($p < .001$).

Table 7

Pearson Correlation Coefficients

Number of Role Involvements and Health Perceptions

	SUMROLES	HLTSTAT	PRIHLTH	CURHLTH	HLTHOUT	HLTHWORR	RESIS	SCKORT
SUMROLES	1.000	-.088 p=.504	-.266 p=.040	.016 p=.902	.118 p=.372	.056 p=.674	-.083 p=.526	-.065 p=.620
HLTSTAT		1.000	.330 p=.010	.715 p=.000	.163 p=.214	-.106 p=.424	.357 p=.005	-.240 p=.064
PRIHLTH			1.000	.349 p=.005	.201 p=.124	-.020 p=.880	.217 p=.096	-.200 p=.124
CURHLTH				1.000	.238 p=.070	-.070 p=.601	.439 p=.000	-.412 p=.002
HLTHOUT					1.000	.066 p=.620	.276 p=.034	-.249 p=.054
HLTHWORR						1.000	-.168 p=.204	-.103 p=.438
RESIS							1.000	-.211 p=.104
SCKORT								1.000

Note. P values represent two-tailed significance levels; controlled alpha=.001
Note. SUMROLES=number of role identities, HLTSTAT=health status, PRIHLTH=prior health, CURHLTH=current health, HLTHOUT=health outlook, HLTHWORR=health worry, RESIS=resistance to disease, SCKORT=sickness orientation.

Table 8

Pearson Correlation Coefficients

Degree of Role Involvement and Health Perceptions

	SPOUSI	DAUGHTI	WORKI	STUDI	VOLI	RECI	RELI	DOMESI	SOCI	MOMI	CARI
HLTSTAT	-.066	.151	.338	-.052	.074	-.090	-.393	.081	.084	.067	-.250
	p=.727	p=.307	p=.009	p=.790	p=.731	p=.545	p=.011	p=.560	p=.552	p=.713	p=.125
PRIHLTH	-.182	.250	.167	.123	.463	-.013	.065	.019	.025	.219	-.063
	p=.335	p=.088	p=.212	p=.525	p=.022	p=.928	p=.686	p=.890	p=.862	p=.222	p=.703
CURHLTH	.061	.170	.273	-.029	-.207	-.072	-.399	.167	.088	.113	-.223
	p=.751	p=.249	p=.040	p=.884	p=.330	p=.625	p=.010	p=.232	p=.540	p=.539	p=.172
HLTHOUT	-.307	-.119	-.024	.105	.108	-.103	-.097	-.155	.076	-.046	-.303
	p=.099	p=.421	p=.860	p=.589	p=.615	p=.488	p=.547	p=.264	p=.594	p=.801	p=.060
HLTHWORR	-.067	-.081	.119	.149	.148	.018	-.058	-.055	-.101	-.012	.087
	p=.725	p=.586	p=.380	p=.450	p=.501	p=.904	p=.717	p=.695	p=.481	p=.949	p=.604
RESIS	-.245	.059	.300	.099	-.252	-.172	-.447	.072	.018	.151	-.534
	p=.193	p=.690	p=.022	p=.610	p=.234	p=.243	p=.003	p=.604	p=.898	p=.403	p=.000
SCKORT	.307	-.039	-.047	.239	-.053	-.178	.107	-.050	-.096	-.012	.093
	p=.099	p=.795	p=.725	p=.212	p=.806	p=.226	p=.504	p=.719	p=.497	p=.947	p=.574

Note. P values represent two-tailed significance levels; controlled alpha=.001

Note. Role involvement abbreviations represent involvement as spouse, as daughter, as employee, as student, as volunteer, in recreation, in religion, in domestic activities, in social activities, as mother, and as caregiver, sequentially.

A one-way analysis of variance was used to analyze the differences between PAP smear and BSE and the health perceptions variables. Using a significance level of $p < .05$, no differences were found in the mean health perceptions scores between women who had and those who had not received PAP smears. Similarly, no differences were found between women who performed BSE and those who did not.

Sex Role Orientation

Sex-role orientation was measured using the Index of Sex Role Orientation (ISRO), a 16-item Likert-type questionnaire which asked respondents to register their agreement or disagreement with various statements about women's rights in work, society and childrearing. The total range of possible scores was from 16 to 80, with the higher scores reflecting a more feminist outlook. The average score of this sample was 62, with a standard deviation of 7. This instrument also reduces to three subscales: male-female division of responsibility, child-career conflicts, and sex role issues in the domain of work. All sample means were well above the midpoints on each subscale.

Associations among number of role identities and sex role orientation were tested using Pearson correlation coefficients with two-tailed tests of significance. There were no relationships identified between overall scores on the ISRO and number of role identities, nor among the subscale scores and number of role identities.

Degree of involvement in religious activity was negatively correlated at the $p < .05$ level with scores on the ISRO subscale dealing with the domain of work, according to Pearson correlation coefficients (Table 9).

Overall scores on the ISRO were not correlated with any of the health perceptions variables at the $p < .05$ level. Health outlook was positively correlated with scores on the FACTOR1 and FACTOR3 subscales ($p < .05$). The correlation matrix and two-tailed significance values are displayed in Table 10.

By dichotomizing sex role orientation into scores above and below the mean, associations with performance of PAP smear and BSE were assessed using the chi-square test. Crosstabulation of the variables yielded a chi-square of zero for PAP smear and sex role orientation, and .027 for BSE and sex role orientation. These results indicate that the variables are not associated.

One-way analysis of variance was employed to compare the interval-level ISRO subscale scores and health behavior performance. The single notable finding which emerged from this analysis was between the difference in mean scores on the FACTOR2 subscale and PAP smear behavior, $F(1,58)=4.08$, $p=.048$. Women who had PAP smears were more likely to place their careers above their childrearing duties.

Influence of Demographic Variables

The demographic variables of age, marital status, educational level and family income were examined to

Table 9

Pearson Correlation Coefficients

Sex Role Orientation and Degree of Role Involvement

	SPOUSI	DAUGHTI	WORKI	STUDI	VOLI	RECI	RELI	DOMESI	SOCI	MOMI	CARI
FEMSCORE	.159	-.015	.138	.228	.310	.079	-.296	-.118	.185	-.269	-.188
	p=.102	p=.921	p=.303	p=.235	p=.140	p=.593	p=.060	p=.394	p=.190	p=.130	p=.910
FACTOR1	.202	-.068	.047	.248	.306	.102	-.283	-.101	.224	-.199	-.149
	p=.284	p=.646	p=.726	p=.195	p=.146	p=.489	p=.073	p=.277	p=.110	p=.266	p=.366
FACTOR2	.144	.098	.103	-.108	.196	-.034	-.074	-.024	-.060	-.223	.107
	p=.449	p=.506	p=.440	p=.956	p=.358	p=.818	p=.644	p=.863	p=.671	p=.213	p=.516
FACTOR3	.042	-.061	.193	.231	.267	.112	-.339	-.095	.268	-.197	.008
	p=.828	p=.683	p=.147	p=.229	p=.207	p=.450	p=.030	p=.493	p=.058	p=.271	p=.959

Note. P values represent two-tailed significance levels; controlled alpha=.001

FEMSCORE: Total ISRO score

FACTOR1: Male-female division of responsibility

FACTOR2: Child-career conflicts

FACTOR3: Sex role issues in the domain of work

Table 10

Pearson Correlation Coefficients

Sex Role Orientation and Health Perceptions

	HLTSTAT	PRIHLTH	CURHLTH	HLTHOUT	HLTHWORR	RESIS	SCKORT
FEMSCORE	.252 p=.052	.168 p=.199	.216 p=.100	.235 p=.071	-.119 p=.368	.230 p=.077	.065 p=.621
FACTOR1	.271 p=.036	.168 p=.200	.197 p=.134	.268 p=.039	-.133 p=.317	.189 p=.149	.008 p=.949
FACTOR2	.192 p=.141	.063 p=.631	.167 p=.206	-.031 p=.815	-.112 p=.397	.118 p=.370	.103 p=.435
FACTOR3	.115 p=.383	.163 p=.212	.146 p=.271	.313 p=.015	-.024 p=.855	.242 p=.063	.051 p=.697

Note. P values represent two-tailed significance levels; controlled alpha=.001

FEMSCORE: Total score on ISRO

FACTOR1: Male-female division of responsibility

FACTOR2: Child-career conflicts

FACTOR3: Sex role issues in the domain of work

determine any associations with the foregoing variables. Race and religion were not included because of their low variability in the sample.

Of these four demographic variables, age was the most important. One-way analysis of variance of age by dichotomized ISRO scores indicated that a significant difference existed between the mean age of feminist-thinkers (28) and traditionally-oriented women (33.5), $F(1,57)=10.04$, $p=.0025$. One-way analysis of variance also revealed that the age difference between women who had PAP smears and those who had not was significant. The mean age of women who had the exam was 32 years, while those who had not received a PAP smear averaged 27 years, $F(1,57)=6.39$, $p=.014$. No significant correlations, associations or differences were found with respect to age and breast self-examination behavior.

To facilitate statistical comparison of marital status, measures of health perception, and ISRO scores, the categories were collapsed into partnered and non-partnered women. The partnered group included women who were either married or living in a conjugal relationship, while the non-partnered group encompassed single, divorced, separated and widowed respondents. One-way analysis of variance demonstrated only one important difference of means among the health perceptions variables; scores on the prior health assessment subscale tended to be higher for non-partnered women [$F(1,58)=4.44$, $p=.039$]. No other significant

relationships between marital status and health perceptions, sex role orientation, or health behaviors were discovered.

Educational levels and family income were not associated with any of the study variables. Relationships were tested using chi-square, T-test and one-way analysis of variance, all of which failed to produce evidence of association or correlation.

Chapter 5: Discussion

The findings reported herein demonstrate that the performance of selected health behaviors in a sample of middle-class Brazilian women bears some relationship to factors such as number of role identities, degree of role involvement, and sex role orientation. In addition, relationships among measures of health perceptions, degree and numbers of role involvements and sex role orientation were also identified. However, as discussed earlier, the tests of statistical signficance used here are not good indicators of the strength of these relationships. Still, important trends and patterns of associations may be used to guid further research. Discussion of the importance of these interrelationships and their effect on performance of selected health behaviors will precede the discussion of broader implications of the study.

Roles and Health

Involvement in the employee role was associated with a positive assessment of overall health status, current health, and resistance to disease (Figure 1). Indeed, these relationsips were more strongly related statistically. If the concept of health can be extended to infer general well-being, then employment, for these women, seems to promote mental and physical wellness.

Religious involvement, on the other hand, was negatively associated with assessment of current health,

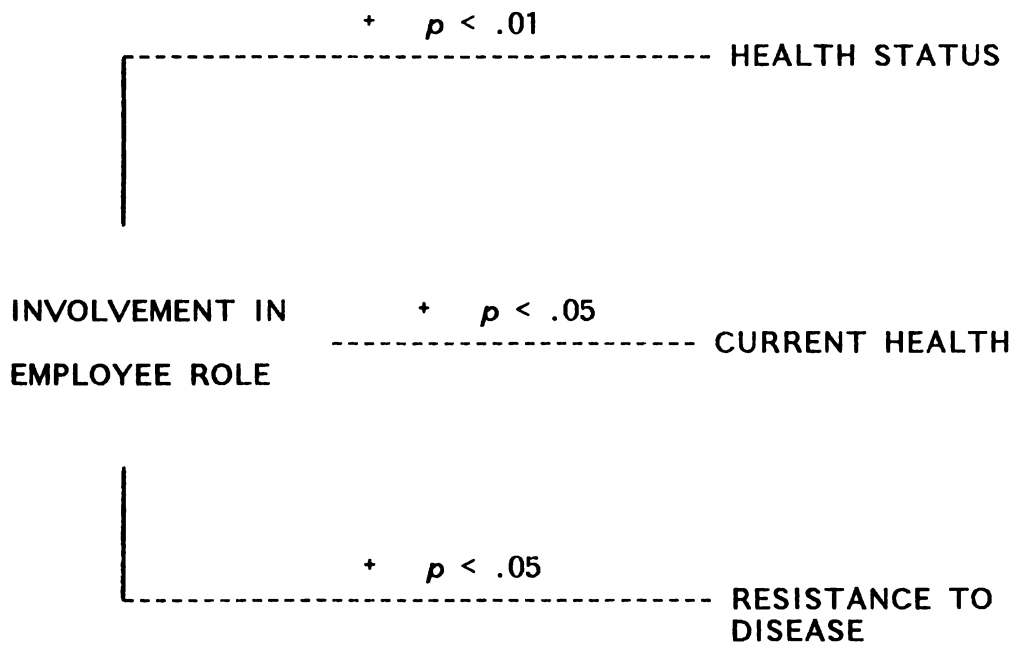


Figure 1. Associations with employee involvement.

resistance to disease, overall health status, and sex role issues in the domain of work (Figure 2). Since the majority of sampled women professed Roman Catholicism, this finding indicates the need for further examination of the influence of the Church on individual self-concept. Some Brazilian authors (Barroso, 1982; Cardoso, 1980) have examined how Church doctrines buttress social and political discrimination against women, but none have explored the direct effects of acceptance of religious dogma on health perceptions.

Degree of involvement in the caregiver role was inversely related to perceived resistance to disease. This association stood the rigorous test of statisitical significance at the $p < .001$ level. This may reflect the influence of the added burden of caring for an older or ill family member on self-assessment of one's own destiny regarding future health needs. It may also reflect the physical and emotional demands, such as loss of freedom and privacy, required of the woman involved in the caregiver role (Archbold, 1980).

Sex role orientation was only associated with age. Younger women were more often feminist thinkers, a findin which may reflect the impact of the greater attention given recently to women's issues worldwide. Women more involved in the religious role were more traditionally-oriented on sex role issues those involving division of responsibility between men and women at work. These findings are congruent

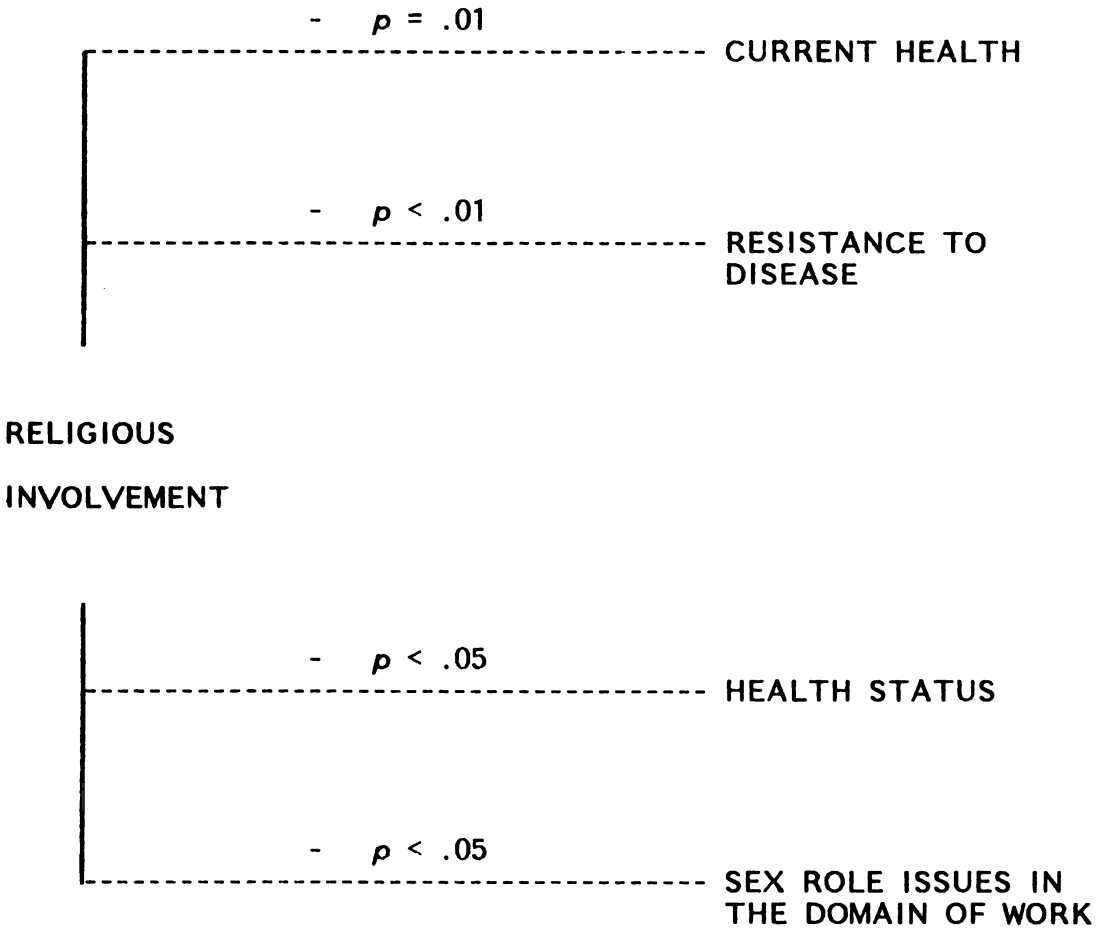


Figure 2. Associations with religious involvement.

with the ideas of Suplicy (1984), who argues that feminism can help raise the courage and self-esteem of women through struggle toward common goals.

Health perceptions had no direct relationship with performance of Papanicolau smear or breast self-examination. This suggests that these behavioral choices are influenced by factors other than self-assessment of health status. In her study of cancer attitudes among Brazilian working women in Florianópolis, Neves (1986) found that the majority of women who did not have Papanicolau smears or who did not perform breast self-examination simply expressed no interest in doing so. Further exploration of specific health knowledge and performance of these examinations would help clarify the relationships among health perceptions, health knowledge, and health behavior.

Performance of Papanicolau smear by women in the present study was directly associated with age, number of role involvements, degree of involvement as an employee, and child-career conflicts (Figure 3). Older women who claimed a variety of role identities, were greatly involved in their work, and who felt that careers should come before childrearing duties were more likely to have had a Papanicolau smear. These findings may represent a type of self-care behavior engaged in by self-reliant, career-oriented women. Since a high degree of involvement in the employee role was also associated with a positive health self-appraisal, this interpretation is plausible.

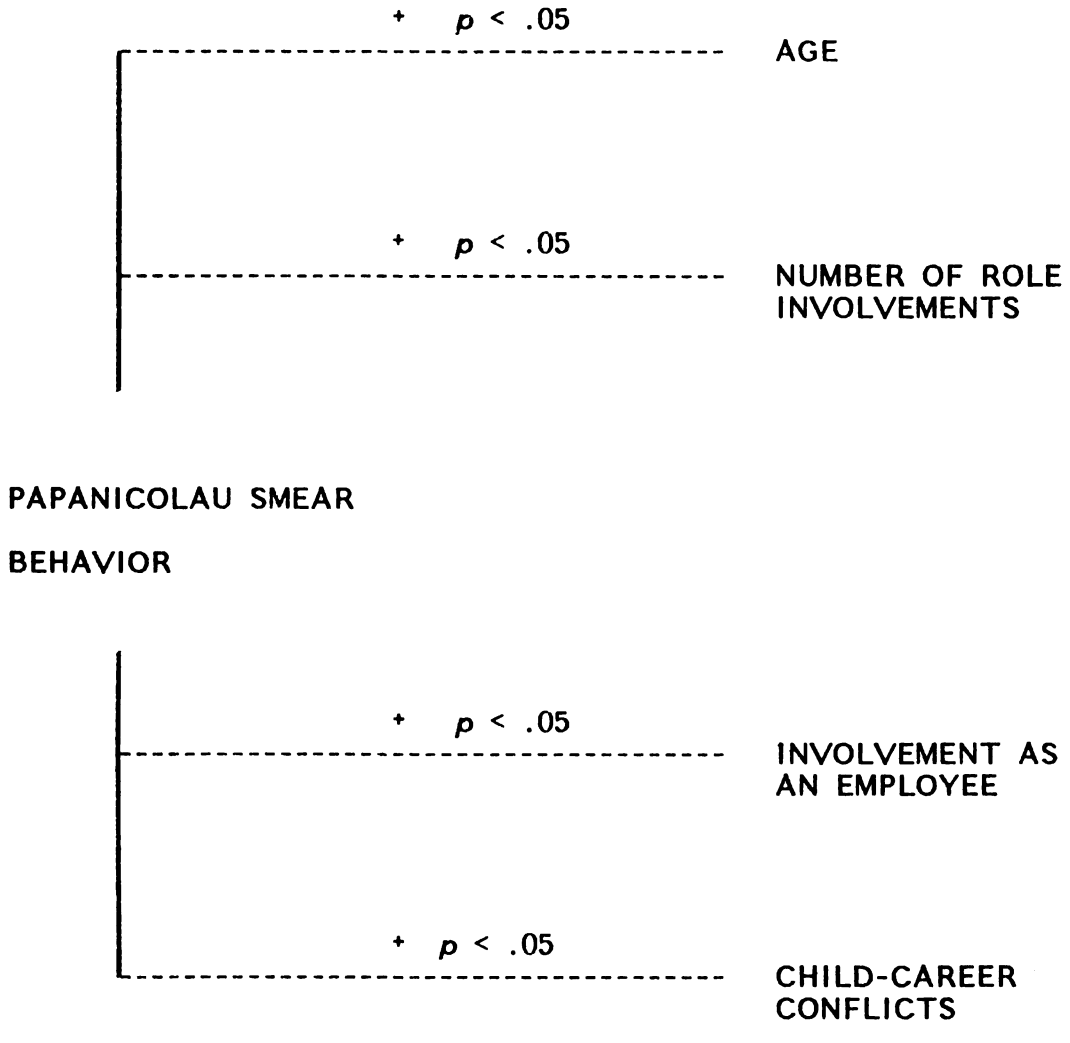


Figure 3. Associations with Papanicolau smear behavior.

Analysis of breast self-examination behavior proved more elusive. Performance of breast self-examination was related to only one factor, involvement as volunteer. Since the women were not asked about the nature of their volunteer work, no inferences about type of exposure to possible factors influencing this behavior may be drawn. The failure to identify relationships with any of the other variables also points to the personal and individual character of the examination. While Papanicolau smear requires the assistance of a health care professional and also produces a tangible outcome in the form of a laboratory result, breast self-examination is entirely dependent upon the woman herself for initiation, interpretation and action, if required. Further studies aimed at clarifying the factors involved in reaching a decision to perform this simple but potentially lifesaving examination are sorely needed.

Analyzing these findings within the above-described theoretical framework, then, commitment, as measured by number of role involvements, bore a statistically significant relationship to the health behavior of Papanicolau smear performance. Individual identity salience, measured by degree of involvement in each role identity, was associated with the health behaviors of both Pap smear and breast self-examination in the role identities of employee and volunteer. The effect of commitment on identity salience was not tested in this study, nor was it assumed that the measured health behaviors were

role-related. Behavioral choices, however, as part of the constellation of women's life involvements, mus crystallize as roles in themselves. Therefore, the discovery of associations among some of the variables, particularly those involving the employee and the religious roles, forms the basis for further exploration with an eye toward theoretical clarification of the hypothesized relationships.

In addition, the findings relating to the influence of sex role orientation and health perceptions on health behavior, while not part of the original model, highlight the importance of sociocultural and individual factors in the analysis of personal behavioral actions. Sex role orientation in particular bears closer examination in future work to interpret more clearly the effects of ideology on health-related behavior.

Finally, an ideal study would have made greater use of key informants to clarify the issues important to Brazilian women. A verbal interview format would likewise have been preferable to the self-administered written questionnaire, but time and language constraints rendered this impossible for the present work. Future research efforts abroad may benefit from this hindsight.

Limitations of the Study

These data represent the responses of a random sample of employed clerical workers at a public institution in Brazil, but they also reflect the historical conditions of society at the time they were collected. While the findings

may be generalizable to other populations of women public employees in Brazil, they will remain firmly imbued with the social coloring of *abertura*, the process of re-democratization occurring in mid-1980's Brazil.

The study is also limited by structural factors. While every attempt was made to ensure an accurate translation of the original English questionnaire into Portuguese through the use of back-translation and consultation with bilingual experts, some questions were inevitably misunderstood by respondents. For example, one question asking "how many people do you work for?" was frequently taken to mean "how many people benefit from your salary?" Although none were germane to the present analysis, it is nevertheless difficult to determine the extent to which responses reflect a full understanding of the intent of some questions.

Further, the issue of treatment options for women with cancer in Brazil was not included as a possible confounding variable in the study. Reluctance to undergo surgery radiation or chemotherapy for a tumor could have a considerable effect on a woman's decision to have a test for cancer, particularly if she demonstrated no other signs of the disease. Exploration of attitudes toward cancer treatment would illuminate this aspect of influences on health behavior.

Implications for Nursing

Nurses are increasingly involved in the primary health care activities of prevention and early detection of disease

processes. This study offers insight into the factors influencing certain preventive health behaviors in a sample of Brazilian women. Knowledge of these factors can provide nurses with information necessary to facilitate the performance of Papanicolau smear and breast self-examination. The findings indicate that health perceptions, levels of education, and family income bear little relationship to performance of these behaviors, while number and degree of involvement in certain role identities are positively associated with performance. Nurses, often the first health care professionals encountered by the client in a primary care setting, can determine how best to influence health behavior by an inquiry into the client's role involvements and sex role orientation in addition to asking standard questions about past medical history. Such an approach enriches the nursing assessment and allows for development of a plan of care which is at once meaningful, client-centered, sensitive, and more likely to prove effective.

In sum, increased knowledge of women's role obligations and their influence on health and health behaviors can guide nurses in their role supplementation interventions (Meleis, 1975). These nursing activities are aimed at assisting clients to traverse difficult life situations, or transitions, through an understanding of the client's unique needs and available support systems. The present study offers a beginning analysis of the interactions among

quantity and quality of role obligations, other cultural, social and ideological factors, and health behaviors. Supported by research-based findings, nurses can plan more effectively, implement more sensitively, and evaluate more fully strategies for caregiving which take into account the totality of the woman client's life experiences.

Appendices

Appendix A

Hello. I am Amy Marie Beckman, a nurse enrolled in the Master of Science in Nursing program at the University of California, San Francisco. I am here to conduct a study to learn more about the relationships between women's work, their duties and responsibilities, and their health.

I would like to invite you to participate in this study. If you agree, I will ask you to complete six questionnaires. Some of the parts ask you to circle a number which best describes your feelings; others require you to answer in your own words. The entire process will take about 45 minutes.

There are no physical risks involved. You may find some of the questions personal or sensitive, but you are not obligated to answer any question if you do not want to. You may refuse to participate or you may stop at any time without harming your relationship with me or with your job. If you have any questions at a later time, you may call me at 22-3880.

If you agree to participate, please sign the attached form, or give me your verbal consent. Thank you for helping me learn more about women's lives, work and health.

Amy Marie Beckman
Researcher

I have read a description of the study proposed by Amy Marie Beckman and I agree to participate in same.

_____ _____

Date Signature

Oí. Sou Amy Marie Beckman, enfermeira cursando no Mestrado da Ciências de Enfermagem no Universidade da Califórnia, San Francisco, EUA. Estou aqui para realizar pesquisa com a finalidade de saber mais sobre os relações entre o trabalho, as tarefas e as responsabilidades das mulheres e sua saúde.

Gostaría de convidar você para responder a cinco questionários. Em algums basta assinalar com um círculo o número que melhor descreve seus sentimentos; outros requerem redação própria. Tudo levará aproximademente 45 minutos.

Nâo há riscos físicos envolvendo neste trabalho. Você poderá achar que algumas questões são de carater pessoal ou particular, mas você não é obrigada a responder a questão que não desejar. Você pode recusar a participação ou pode ainda parar en qualquer ponto sem dano no relacionamento comigo ou com seu trabalho. Se você tiver alguma dúvida, pode chamar-me pelo telefone 22-3880.

Se você concordar em participar, queira assinar o consentimento em anexo, ou manifestar-se verbalmente.

Grata por sua cooperação em levar-me a saber mais sobre a vida, o trabalho e a saúde das mulheres.

Amy Marie Beckman
Pesquisadora

Após ter lido a descrição da pesquisa proposta por Amy Marie Beckman, concordo em participar da mesma.

_____ _____

Data Assinatura

Appendix B

Questionário de Atividade

1. As mulheres desenvolvem atividades diferentes em suas vidas diárias. Qual é a extensão do seu envolvimento em cada uma das atividades abaixo?

		Nao Aplicavel	Nao ha Envolvimento	Pouco Envolvimento	Algum Envolvimento	Envolvimento Moderado	Envolvimento em Grande Quantidade
a.	companheira/esposa.....	0	1	2	3	4	5
b.	mãe.....	0	1	2	3	4	5
c.	filha.....	0	1	2	3	4	5
d.	atenção e ajuda..... a um parente	0	1	2	3	4	5
e.	trabalhadora voluntária..	0	1	2	3	4	5
f.	atividades no emprêgo....	0	1	2	3	4	5
g.	estudante.....	0	1	2	3	4	5
h.	atividades domésticas....	0	1	2	3	4	5
i.	atividades sociais.....	0	1	2	3	4	5
j.	atividades religiosas....	0	1	2	3	4	5
k.	atividades recreativas...	0	1	2	3	4	5
l.	outras_____	0	1	2	3	4	5

2. Você tem outras responsabilidades que nós não lhe perguntamos?_____

_____

_____

_____

3. Que grau de satisfação lhe traz cada uma das atividades abaixo?

		Nao Aplicavel	Nao ha Satisfacao	Pouco Satisfacao	Alguma Satisfacao	Satisfacao Moderada	Satisfacao em Grande Quantidade
a.	companheira/esposa.....	0	1	2	3	4	5
b.	mãe.....	0	1	2	3	4	5
c.	filha.....	0	1	2	3	4	5
d.	atenção e ajuda..... a um parente	0	1	2	3	4	5
e.	trabalhadora voluntária..	0	1	2	3	4	5
f.	atividades no emprêgo....	0	1	2	3	4	5
g.	estudante.....	0	1	2	3	4	5
h.	atividades domésticas....	0	1	2	3	4	5
i.	atividades sociais.....	0	1	2	3	4	5
j.	atividades religiosas....	0	1	2	3	4	5
k.	atividades recreativas...	0	1	2	3	4	5
l.	outras_____	0	1	2	3	4	5

4. Ocupação (seja específica): tempo integral_____

Principal_____

tempo parcial_____

tempo integral_____

Secundária_____

tempo parcial_____

5. Número de horas que você trabalha por semana:_____

6. Turno: dia____ noite_____ madrugada_____ variado_____

7. Ocupação do marido ou companheiro (seja específica):

tempo integral_____

Principal_____

tempo parcial_____

tempo integral_____

Secundária_____

tempo parcial

8. O que você gosta no seu trabalho?

9. O que você não gosta no seu trabalho?

10.

a. Que tal o espaço físico no seu trabalho? Como ele é? Como ele lhe afeta?

b. Para quantas pessoas você trabalha? Como você se sente com esta situação?

c. Você trabalha em grupo ou você trabalha sempre sozinho? Como você se sente com esta situação?

d. De que maneira você participa nas decisões relacionadas com seu trabalho? As pessoas pedem sua opinião sobre a melhor maneira de providenciar uma tarefa?

e. Como é sua carga de trabalho?

f. Você tem alguma interrupção (perturbação) em seu trabalho? De que tipo?

g. Qual é a distância da sua casa ao trabalho? Que tipo de transporte você usa, como funciona isto para você?

h. Como você se sente sobre a quantidade de desafios no seu trabalho?

i. Há alguma coisa no seu serviço que afeta sua saúde ou conforto? De que maneira?

PARA PESSOAS QUE SÃO CASADAS OU VIVEM MARITALMENTE COM OUTRA PESSOA: Se você é solteira ou não tem companheiro, vá para a questão 14.

11. Quais são as coisas que mais lhe satisfazem como esposa ou companheira?

12. Quais são as coisas que a incomodam como esposa ou companheira?

13.

a. O que seu marido/companheiro acha de você trabalhar?

b. Que tipo de ajuda você tem nas tarefas domésticas? (Especifique quem ajuda)

c. O quanto pode contar com a ajuda do seu companheiro?

d. O quanto você se sente estimada por seu companheiro? De que maneiras?

PARA PESSOAS QUE TEM FILHOS OU FILHOS ADOTIVOS: Se você não tem filhos, vá para a questão 19.

14.

a. Quantos filhos você tem?_____

b. Homem(s)_____ mulher(es)_____

c. Suas idades: 1.___ 2.___ 3.___ 4.___ 5.___ 6.___ 7.___

d. Quantos filhos moram em casa?___

e. Quantos filhos moram fora mas que ainda dependem de você?___

f. De que maneira eles dependem de você?_____

_____

15. Quais são as coisas que mais que lhe satisfazem como mãe?

16. Quais são as coisas que a preocupam como mãe?

17.

a. Quem cuida de suas crianças? (Especifique: em casa, na creche, ou na escola maternal): Você está satisfeita com este tipo de cuidado?

b. Como você se arranja no trabalho quando tem um filho doente?

c. Como você consegue levar seu filho/filhos ao médico ou outras atividades?

d. De que maneira o seu nível de energia é afetado pelo fato de ser mãe?

e. Quem mais vive em sua casa além de você e seus filhos?

19. Quais são as coisas que mais a ajudam a contrabalançar suas atividades?

    a.

    b.

    c.

20. Quais são as coisas que menos a ajudam a contrabalançar suas atividades?

    a.

    b.

    c.

21. Para cada afirmação abaixo, circule o número que melhor describe seus sentimentos:

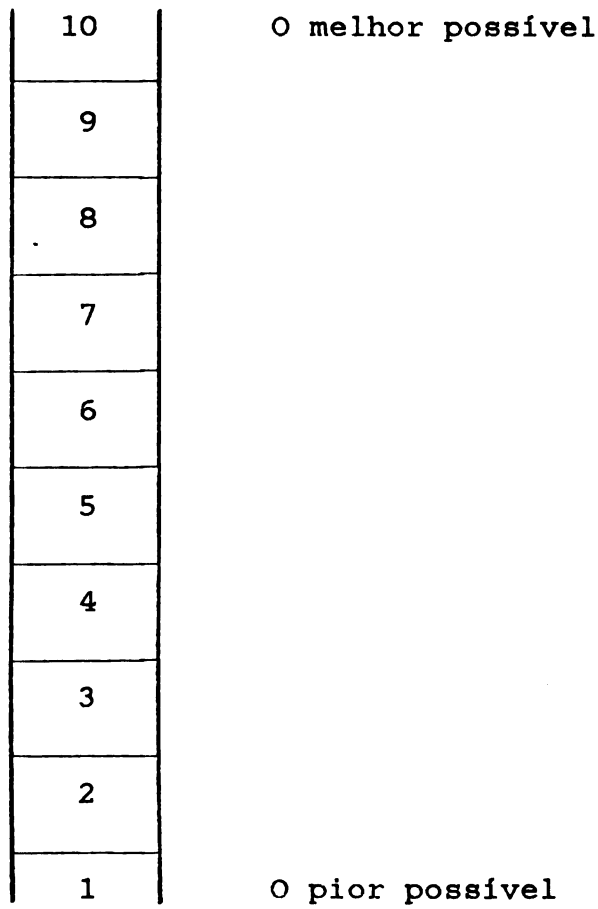
	Nao Completamente				Uma Grande Quantidade
a. De um modo geral, eu sinto que minha vida agora é bastante satisfatória	1	2	3	4	5
b. De um modo geral, eu tenho tempo suficiente para desempenhar todas as minhas responsabilidades	1	2	3	4	5
c. De um modo geral, eu sinto que eu pósso contrabalançar minhas responsabilidades satisfatoriamente	1	2	3	4	5

Estado de Saúde

Este seção faz perguntas sobre sua saúde e quão saudável você se considera.

Este é o desenho de uma escada. Suponha que o topo da escada representa o melhor grau de saúde e a parte de baixo representa o pior grau de saúde.

Onde você colocaria sua saúde nesta escada? Circule o número que está mais de acordo com sua estado de saúde.



Comportamentos de Saúde

Esta parte faz perguntas sobre os cuidados que você tem com sua saúde pessoal. Não há respostas certas ou erradas. Por favor escreva o que você realmente faz, não o que você pensa que você faria. Dê respostas bem completas.

1. Você tem alguma clínica, médico, enfermeira, farmacêutico ou outra pessoa a quem você recorre regularmente para manter sua saúde?
   Sim_____ Explique:

   Não_____
2. Quando você procura alguma assistência de saúde?
   Quando tenho algum problema (físico ou emocional) _____
   Para revisão periódica: anual_____
   a cada dois anos_____

   Outro_____
   Não vou_____Explique_____
3. Quando você procura o dentista?
   Quando tenho algum problema_____
   Para revisão periódica: anual_____
   a cada dois anos_____

   Outro_____
   Não vou_____Explique_____
4. Durante os últimos doze meses você procurou a emergência do hospital?
   Não_____ Se a resposta for negativa vá para a questão 5.
   Sim_____
   Quantas vezes você esteve lá neste período_____
   Porquê você esteve lá?

5. Você já se submeteu a exame do colo do utero (Papanicolau)?
   Não_____ Se a resposta for negativa vá para a questão 6.
   Sim_____
   Qual foi a última vez?_____
   Quem o fez? _____Médico
   _____Enfermeira
   _____Ginecologista
   _____Outro (especifcar)_____
   Qual foi o último resultado?_____
   Com que frequência você faz este exame?_____
6. Você alguma vez se submeteu ao exames das mamas?
   Não_____ Se a resposta for negativa vá para a questão 7.
   Sim_____
   Quem as examinou? _____Médico
   _____Enfermeira
   _____Ginecologista
   _____Outro (especificar)_____
7. Você mesma examina suas mamas?
   Não_____ Se a resposta for negativa vá para a questã 8.
   Sim_____
   Com que frequência você o faz?_____
   Que época do mês você o faz?
   _____ 1 semana antes da menstruação
   _____ 1 semana após o primeiro dia da menstruação
   _____ Qualquer época do més
8. O que você faz para proteger de doenças?

9. Que tipo de doença você o qualquer membro de sua família que mora com você teve durante os últimos doze meses?

10. O que você fez a respeito disso? (Da questão 9). Por favor inclua remédios caseiros ou remédios recomendados por outras pessoas.

Pesquisa de Opinião

O próximo grupo de perguntas pede sua opinião sobre o lugar da mulher na sociedade. Por favor responda como você se sente e não como você pensa que você sentiria. Seja sincera.

		Concordo Plenamente	Concordo	Neutra ou Sem Opinião	Discordo	Discordo Plenamente
1.	As mulheres deveriam administrar... suas casas e deixar a direção do país para os homens.	1	2	3	4	5
2.	A maioria das mulheres que querem.. seguir uma carreira não deveriam ter filhos.	1	2	3	4	5
3.	Uma criança em idade pré-escolar... está sujeita a sofrer se sua mãe trabalhar fora.	1	2	3	4	5
4.	Ter uma emprego significa ter uma.. uma vida própria.	1	2	3	4	5
5.	Uma mulher não deveria permitir.... que gestação e educação de crianças interferissem em uma carreira se ela a desejar.	1	2	3	4	5
6.	Exceto em casos especiais, a ..... mulher deveria cozinhar e limpar a casa e o marido prover o sustento da família.	1	2	3	4	5
7.	Uma garota prova que é mulher ..... quando tem um filho.	1	2	3	4	5
8.	Uma mulher deveria ter exatamente.. as mesmas oportunidades de emprego que um homem.	1	2	3	4	5
9.	As mulheres são mais felizes..... quando estão em casa tomando conta dos filhos.	1	2	3	4	5

		Concordo Plenamente	Concordo	Neutra ou Sem Opinião	Discordo	Discordo Plenamente
10.	Uma mãe que trabalha pode..... estabelecer uma relação tão afetiva e segura com seus filhos quanto uma mãe que não trabalha.	1	2	3	4	5
11.	As mulheres deveriam preocupar-se.. com suas obrigações de gravaidez e tarefas domésticas as invés de com suas carreiras.	1	2	3	4	5
12.	Apesar das mulheres terem muitos... empregos importantes, o lugar mais apropriado para elas é em casa.	1	2	3	4	5
13.	Eu aprovo que uma mulher sustente.. a família enquanto o marido faz as tarefas domésticas.	1	2	3	4	5
14.	Eu não respeitaria um homem que.... dicidisse ficar em casa tomando conta das crianças enquanto sua mulher trabalhasse fora.	1	2	3	4	5
15.	Uma mulher deveria compreender..... que assim como ela não tem condições de realizar trabalhos físicos pesados, há também outras tarefas que a mulher não tem condições de realizar por causa de sua natureza emocional e mental.	1	2	3	4	5
16.	Homens e mulheres deveriam ..... receber o mesmo salário se eles fizessem o mesmo trabalho.	1	2	3	4	5

Questionário Geral de Saúde

Classifique as afimações abaixo de acordo com seu próprio estado de saúde. Por favor circule o número que melhor expressa o quanto você pessoalmente concorda ou discorda. Por favor, lembre-se que nás queremos sua opinião. Não há respostas certas ou erradas.

	Definitivamente Verdadeiro	Quase Verdadeiro	Eu nao sei	Quase Falso	Definitivamente Falso
1. De acordo com os médicos que eu vi, minha saúde é excelente.	1	2	3	4	5
2. Eu tento evitar que doença interfira em minha vida.	1	2	3	4	5
3. Eu pareço ficar doente um pouco fácil que os outros.	1	2	3	4	5
4. Eu me sinto melhor agora do que eu já me sinti antes.	1	2	3	4	5
5. Eu provavelmente ficarei doente muitas vezes no futuro.	1	2	3	4	5
6. Eu nunca me preocupo com a minha saúde.	1	2	3	4	5
7. A maioria das pessoas ficam doentes com mais facilidade do que eu.	1	2	3	4	5
8. Eu não gosto de ir ao médico	1	2	3	4	5
9. Eu estou um pouco doente	1	2	3	4	5
10. Eu espero ter melhor saúde no futuro, do que outras pessoas que eu conheço.	1	2	3	4	5

		Definitivamente Verdadeiro	Quase Verdadeiro	Eu Nao Sei	Quase Falso	Definitivamente Falso
11.	Eu estive tão doente uma vez que eu pensava que ia morrer.	1	2	3	4	5
12.	Eu não estou tão saudável agora como eu costumava ser.	1	2	3	4	5
13.	Eu me preocupo com a minha saúde mais do que outras pessoas se preocupam com a delas.	1	2	3	4	5
14.	Quando eu estou doente eu tento me comportar normalmente.	1	2	3	4	5
15.	Meu corpo parece resistir muito bem a doença.	1	2	3	4	5
16.	Já estou acostumada a ficar doente de vez em quando.	1	2	3	4	5
17.	Eu sou tão saudável como qualquer pessoa que eu conheço.	1	2	3	4	5
18.	Eu acho que minha saúde ficará pior no futuro do que agora.	1	2	3	4	5
19.	Eu nunca tive uma doença que durasse muito tempo.	1	2	3	4	5
20.	Outras pessoas parecem mais preocupdas com sua saúde do que eu com a minha.	1	2	3	4	5
21.	Quando eu estou doente eu tento manter isto para mim mesmo.	1	2	3	4	5
22.	Minha saúde é excelente	1	2	3	4	5
23.	Eu espero ter uma vida muito saudável.	1	2	3	4	5
24.	Minha saúde é uma preocupação em minha vida.	1	2	3	4	5

		Definitivamente Verdadeiro	Quase Verdadeiro	Eu nao sei	Quase Falso	Definitivamente Falso
25.	Eu aceito que algumas vezes eu.... ficar doente.	1	2	3	4	5
26.	Eu tenho me sentido mal..... ultimamente.	1	2	3	4	5
27.	Eu não me incomodo de ir ao..... médico.	1	2	3	4	5
28.	Eu nunca estive seriamente doente.	1	2	3	4	5
29.	Quando existe alguma doença por... perto eu geralmente a pego.	1	2	3	4	5
30.	Os médicos dizem que agora eu..... estou com má saúde.	1	2	3	4	5
31.	Quando eu acho que eu vou ficar... doente ue luto contra ela.	1	2	3	4	5
32.	Eu me sinto tão bem agora como.... nunca estive.	1	2	3	4	5

Questionário Demográfico

A fim de comparar os resultados desto estudo com pessoas de grupos e situações diferentes, nós gostaríamos de alguma informação adicional sobre suas experiências. Por favor complete os seguintes items.

1. Sua idade_____
2. Estado Civil (assinale um):
   a. Solteira, nunca casou....._____
   b. Casada....._____
   c. Divorciada ou separada....._____
   d. Viúva....._____
   e. Vive maritalmente mais de 5 anos....._____
3. Nível escolar (assinale o maior nível escolar):
   a. 1° grau incompleto....._____
   b. 1° grau completo....._____
   c. 2° grau incompleto....._____
   d. 2° grau completo....._____
   e. curso universitário incompleto....._____
   f. curso universitário completo....._____
   g. curso completo de especialização.(360 h)_____
   h. Pós-graudação: mestrado....._____
      doutorado....._____
4. Renda familiar mensal:
   a. abaixo de Cz$ 2.500....._____
   b. de Cz$ 2.501 à Cz$ 5.000....._____
   c. de Cz$ 5.001 à Cz$ 10.000....._____
   d. acima de Cz$ 10.001....._____
5. Religião:
   a. Católico....._____
   b. Protestante....._____
   c. Judaica....._____
   d. Espirita kardecista....._____
   e. Sem religião....._____
   f. Outro....._____

6. Recursos econômicos (assinale um):
   a. não é suficiente para as necessidades..._____
      da família
   b. apenas o suficiente para a família....._____
   c. salário adequado....._____
   d. salário mais do que adequado....._____
7. História étnico/racial (assinale um):
   a. Japonês....._____
   b. Chinês....._____
   c. Preto....._____
   d. Mulato ou Mestiço....._____
   e. Português (incluindo o brasileiro....._____
   f. Latino americano (de fala espanhola)...._____
   g. Germanico....._____
   h. Italiano....._____
   i. Grego....._____
   j. Outro....._____
8. Residência (assinale um):
   a. Zona urbana....._____
   b. Subúrbio (bairros)....._____
   c. Zona rural....._____
9. Se seus pais não nasceram no Brasil, onde eles nasceram?
   Mãe_____
   Pai_____

Appendix C

Activity Questionnaire

1. Women carry out different activities in their daily lives. What is the extent of your involvement in each of the activities below?

		Not Applicable	No Involvement	A Little Involvement	Some Involvement	Moderate Involvement	A Great Deal of Involvement
a.	partner/wife.....	0	1	2	3	4	5
b.	mother.....	0	1	2	3	4	5
c.	daughter.....	0	1	2	3	4	5
d.	caregiver to a relative..	0	1	2	3	4	5
e.	volunteer worker.....	0	1	2	3	4	5
f.	employee.....	0	1	2	3	4	5
g.	student.....	0	1	2	3	4	5
h.	domestic activities.....	0	1	2	3	4	5
i.	social activities.....	0	1	2	3	4	5
j.	religious activities.....	0	1	2	3	4	5
k.	recreational activities..	0	1	2	3	4	5
l.	others_____	0	1	2	3	4	5

2. Do you have other responsibilities that we haven't asked you about?_____

_____

_____

_____

3. How satisfying is each of the activities below?

		Not Applicable	No Satisfaction	A Little Satisfaction	Some Satisfaction	Moderate Satisfaction	A Great Deal of Satisfaction
a.	partner/wife.....	0	1	2	3	4	5
b.	mother.....	0	1	2	3	4	5
c.	daughter.....	0	1	2	3	4	5
d.	caregiver to a relative..	0	1	2	3	4	5
e.	volunteer worker.....	0	1	2	3	4	5
f.	employee.....	0	1	2	3	4	5
g.	student.....	0	1	2	3	4	5
h.	domestic activities.....	0	1	2	3	4	5
i.	social activities.....	0	1	2	3	4	5
j.	religious activities.....	0	1	2	3	4	5
k.	recreational activities..	0	1	2	3	4	5
l.	others_____	0	1	2	3	4	5

4. Occupation (be specific) : full-time_____

Primary_____

part-time_____

full-time_____

Secondary_____

part-time_____

5. Number of hours you work per week:_____

6. Shift: day____ evening_____ night_____ variable____

7. Occupation of partner or husband (be specific):

full-time_____

Primary_____

part-time_____

full-time_____

Secondary_____

part-time_____

8. What do you like about your work?

9. What don't you like about your work?

10.

a. What about your work space? What is it like? How does it affect you?

b. How many people are you assigned to work for? How does that work out for you?

c. Do you work as a team with others (co-workers) or are you always on your own? How does that work out?

d. In what way do you participate in decisions related to your work? Do people ask your opinion about the best way to go about an assignment?

e. What is your workload like?

f. Do you have any interruptions in your work? What kind?

g. How far do you live from work? What about transportation to work--how is that for you?

h. How do you feel about the amount of challenge in your work?

i. Is there anything about your work that affects your health or comfort? in what way?

FOR PERSONS WHO ARE MARRIED OR LIVE WITH AN INTIMATE PARTNER:

11. What are the things that are most satisfying about being a wife or partner?

12. What are the things that bother you about being a wife or partner?

13.

a. What does your husband/partner think about your working?

b. Who helps you with household tasks?

c. How much can you count on your partner for help?

d. How much do you feel appreciated by your partner? In what ways?

FOR PERSONS WHO HAVE CHILDREN OR STEP-CHILDREN:

14.

a. How many children do you have?_____

b. Male(s)_____ Female(s)_____

c. Their ages are: 1.___ 2.___ 3.___ 4.___ 5.___ 6.___ 7.___

d. How many children live at home?___

e. How many children live away who still depend on you?____

f. In what way are they dependent on you?_____

_____

15. What are the things that are most satisfying to you about being a mother?

16. What are the things that concern you about being a mother?

17.

a. What about child care? (Specify: in the home, day care center) How satisfied are you with these child care arrangements?

b. What do you do about work when you have a sick child?

c. How do you handle getting your child/children to their doctor´s appointments or other activities?

d. How does being a parent affect your energy level?

e. Who else lives in your home besides you and your children?

19. What are the things that are most helpful in balancing your activities?

    a.

    b.

    c.

20. What are the things that are least helpful in balancing your activities?

    a.

    b.

    c.

21. For each statement below, circle the number that best describes your feelings:

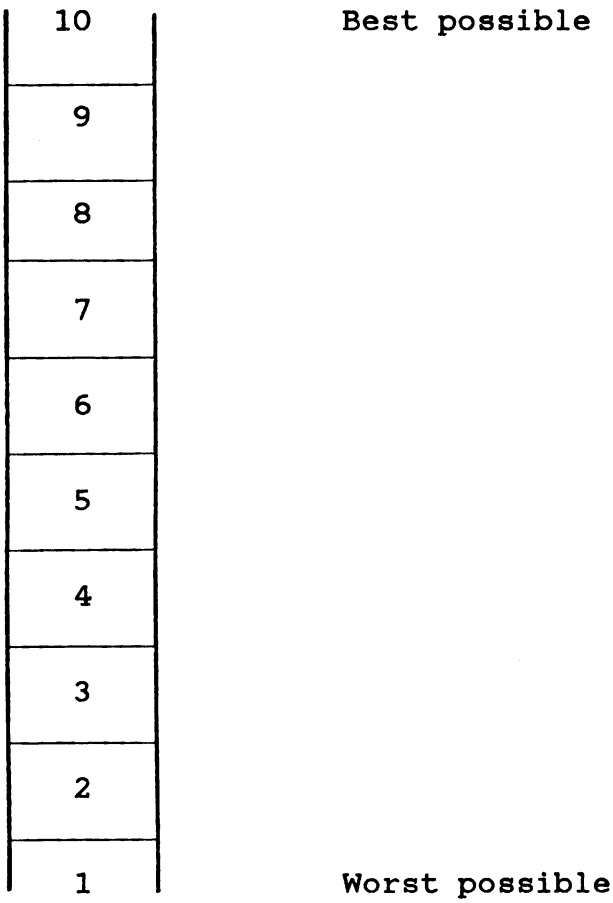
		Not at all				A great deal
a.	On the whole, I feel that my life now is very satisfying	1	2	3	4	5
b.	On the whole, I have enough time to handle all of my responsibilities	1	2	3	4	5
c.	On the whole, I feel I can balance my responsibilities satisfactorily	1	2	3	4	5

Health Status

This section asks questions about your health and how healthy you consider yourself to be.

This is a picture of a ladder. Suppose that the top of the ladder represents the best possible health you can think of and the bottom represents the worst possible health you can think of.

Where would you place your own overall health on the ladder? Circle the number which comes closest to where your own health is.



Health Behaviors

This part asks questions about your personal health activities. There are no right or wrong answers. Please write what you actually do, not what you think you should do. Be complete.

1. Do you have any doctor, clinic, nurse or pharmacist or other person that you would call your regular health care provider?
   Yes_____ Explain:

   No_____
2. When do you see a health care provider?
   When I have a problem (physical or emotional) _____
   For regular checkups: annual_____
   every two years_____
   other_____
   I don't go_____Explain_____
3. When do you go to the dentist?
   When I have a problem_____
   For regular checkups: annual_____
   every two years_____
   other_____
   I don't go_____Explain_____
4. During the last twelve months, have you visited an emergency room of a hospital?
   No_____ If no, skip to question 5.
   Yes_____
   How many separate times did you visit?_____
   For what reasons did you visit?

5. Have you ever had an examination of the cervix of your uterus (Pap smear)?

   No_____ If no, skip to question 6.

   Yes_____

   When was the last time?_____

   Who performed it? _____Doctor

   _____Nurse

   _____Gynecologist

   _____Other (specify)_____

   What was the last result?_____

   How often do you have this examination?_____

6. Have you ever had your breasts examined?

   No_____ If no, skip to question 7.

   Yes_____

   Who examined them? _____Doctor

   _____Nurse

   _____Gynecologist

   _____Other (specify)_____

7. Do you examine your breasts yourself?

   No_____ If no, skip to question 8.

   Yes_____

   How often do you do it?_____

   At what time of the month do you do it?

   _____ 1 week before menstruation

   _____ 1 week after first day of menstruation

   _____ Anytime during the month

8. What do you do to protect yourself from getting sick?

9. What common illnesses did you or a family member living with you have during the last twelve months?

10. What did you do for each illness? Please include any home remedies or family remedies.

Opinion Survey

The next set of questions asks for your opinions about a woman's place in society. Please answer in whatever way you personally feel and not how you think you should feel. Be sincere.

		Strongly Agree	Agree Somewhat	Neutral or No Opinion	Disagree Somewhat	Strongly Disagree
1.	Women should take care of running.. their homes and leave running the country to men.	1	2	3	4	5
2.	Most women who want a career..... should not have children.	1	2	3	4	5
3.	A preschool child is likely to..... suffer if his mother works.	1	2	3	4	5
4.	Having a job means having a life... of your own.	1	2	3	4	5
5.	A woman should not let bearing and. rearing children stand in the way of a career if she wants it.	1	2	3	4	5
6.	Except in special cases, the wife.. should do the cooking and house cleaning and the husband should provide the family with money.	1	2	3	4	5
7.	A girl proves she is a woman by.... having a baby.	1	2	3	4	5
8.	A woman should have exactly the.... same job opportunities as a man.	1	2	3	4	5
9.	Women are much happier if they..... stay at home and take care of their children.	1	2	3	4	5

	Strongly Agree	Agree Somewhat	Neutral or No Opinion	Disagree Somewhat	Strongly Disagree
10. A working mother can establish..... just as warm and secure a relationship with her children as a mother who doesn't work.	1	2	3	4	5
11. Women should be concerned with..... their duties of childbearing and house tending rather than with their careers.	1	2	3	4	5
12. Although women hold many important. jobs, their proper place is in the home.	1	2	3	4	5
13. I approve of a woman providing .... the financial support of the family while the husband does the household chores.	1	2	3	4	5
14. I could not respect a man if he.... decided to stay at home and take care of his children while his wife worked.	1	2	3	4	5
15. A wife should realize that just as. a woman is not suited for heavy physical work, there are also other chores she is not suited for because of her mental and emotional nature.	1	2	3	4	5
16. Men and women should be paid the... same money if they do the same work.	1	2	3	4	5

General Health Questionnaire

Rate the statements below according to your own state of health. Please circle the number that best expresses how much you personally agree or disagree. Please remember that we want your opinion. There are no right or wrong answers.

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
1.	According to the doctors I've seen, my health is excellent.	1	2	3	4	5
2.	I try to avoid letting illness interfere with my life.	1	2	3	4	5
3.	I seem to get sick a little easier than other people.	1	2	3	4	5
4.	I feel better now than I ever have before.	1	2	3	4	5
5.	I will probably be sick a lot in the future.	1	2	3	4	5
6.	I never worry about my health.	1	2	3	4	5
7.	Most people get sick a little easier than I do.	1	2	3	4	5
8.	I don't like to go to the doctor.	1	2	3	4	5
9.	I am somewhat ill.	1	2	3	4	5
10.	In the future, I expect to have better health than other people I know.	1	2	3	4	5

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
11. I was so sick once I thought I..... might die.	1	2	3	4	5
12. I'm not as healthy now as I used... to be.	1	2	3	4	5
13. I worry about my health more than.. other people worry about their health.	1	2	3	4	5
14. When I'm sick I try to just keep... going as usual.	1	2	3	4	5
15. My body seems to resist illness.... very well.	1	2	3	4	5
16. Getting sick once in a while is.... part of my life.	1	2	3	4	5
17. I'm as healthy as anybody I know...	1	2	3	4	5
18. I think my health will be worse.... in the future than it is now.	1	2	3	4	5
19. I've never had an illness that..... lasted a long period of time.	1	2	3	4	5
20. Others seem more concerned about... their health than I am about mine.	1	2	3	4	5
21. When I'm sick I try to keep it..... to myself.	1	2	3	4	5
22. My health is excellent.....	1	2	3	4	5
23. I expect to have a very healthy.... life.	1	2	3	4	5
24. My health is a concern in my..... life.	1	2	3	4	5

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
25.	I accept that sometimes I'm just going to get sick.	1	2	3	4	5
26.	I have been feeling bad lately.	1	2	3	4	5
27.	It doesn't bother me to go to the doctor.	1	2	3	4	5
28.	I have never been seriously ill.	1	2	3	4	5
29.	When there is something going around I usually catch it.	1	2	3	4	5
30.	Doctors say that I am now in poor health.	1	2	3	4	5
31.	When I think I am getting sick, I fight it.	1	2	3	4	5
32.	I feel about as good now as I ever have.	1	2	3	4	5

Demographic Questionnaire

In order to compare the results of this study with people from different groups and situations, we would like some additional information about your background. Please complete the following items.

1. Your age _____
2. Marital status:
   a. Single, never married....._____
   b. Married....._____
   c. Divorced or separated....._____
   d. Widowed....._____
   e. Living maritally for more than 5 years.._____
3. Educational level (check highest level obtained):
   a. Primary grade incomplete....._____
   b. Primary grade complete....._____
   c. Secondary grade incomplete....._____
   d. Secondary grade complete....._____
   e. University incomplete....._____
   f. University complete....._____
   g. Specialization course (min. 360 h)....._____
   h. Graduate: Master´s....._____
      Doctorate....._____
4. Monthly family income:
   a. Less than Cz$ 2.500....._____
   b. Cz$ 2.501 to Cz$ 5.000....._____
   c. Cz$ 5.001 to Cz$ 10.000....._____
   d. Above Cz$ 10.001....._____
5. Religion:
   a. Catholic....._____
   b. Protestant....._____
   c. Jewish....._____
   d. Espirita kardecista....._____
   e. None....._____
   f. Other....._____

6. Economic resources (check one):
   a. Insufficient for family needs....._____
   b. Barely sufficient for family needs....._____
   c. Salary adequate....._____
   d. Salary more than adequate....._____
7. Ethnic/racial background (check one):
   a. Japanese....._____
   b. Chinese....._____
   c. Black....._____
   d. Mulatto or Mestizo....._____
   e. Portuguese (including Brazilian)....._____
   f. Latin American (Spanish speaking)....._____
   g. German....._____
   h. Italian....._____
   i. Greek....._____
   j. Other....._____
8. Residence (check one):
   a. Urban....._____
   b. Suburban....._____
   c. Rural....._____
9. If your parents were not born in Brazil, where were they born?
   Mother_____
   Father_____

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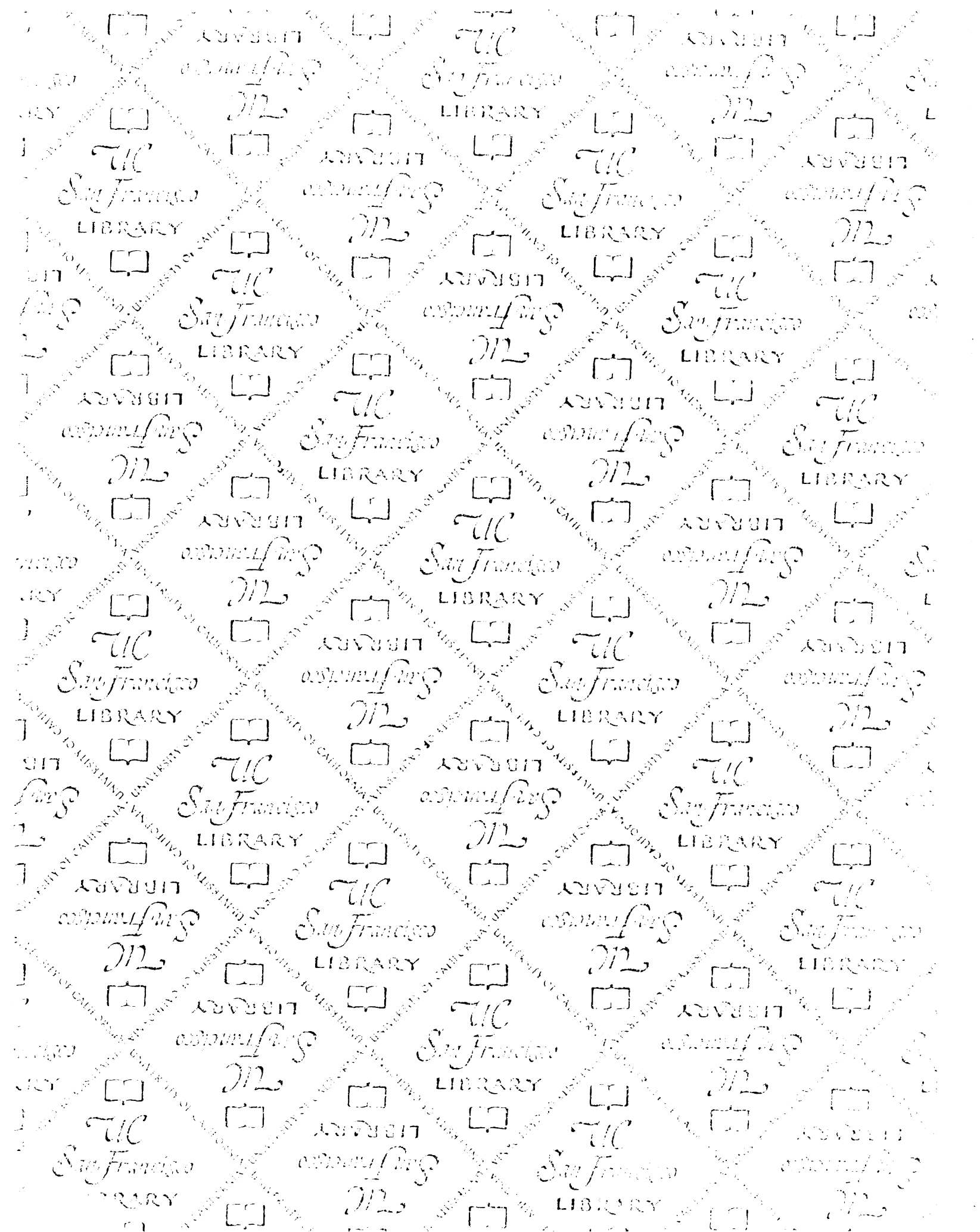
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