FAMILY HEALTH STRATEGY AND OLDER WOMEN: REVEALING INFORMAL CARE PRACTICES

ABSTRACT

Objective: describing the informal/complementary care practices used by elderly women to health care.

Method: study of a qualitative approach using oral history described by Bom Meihy. The collaborative network was composed of six elderly women linked to a FHS in a neighborhood of the city of Joao Pessoa, PB. Data were analyzed from the thematic content analysis technique. Results: from the empirical material emerged the main theme: The main informal/complementary care practices used by older women in caring for health: A path to empowerment. Conclusion: the study shows the difficulty by the FHS professionals combining popular knowledge and scientific knowledge, which leads them to not include informal care practices in the strengthening of relations between those who care and those who are cared. Descriptors: Aging; Care; Public Health.

RESUMO

Objetivo: revelar as práticas de cuidado informais/complementares utilizadas por mulheres idosas para cuidar da saúde. Método: estudo de abordagem qualitativa utilizando a história oral descrita por Bom Meihy. A rede de colaboradoras foi composta por seis idosas vinculadas a uma ESF de um bairro da cidade de João Pessoa, PB. Os dados foram analisados a partir da técnica de análise de conteúdo temática. Resultados: do material empírico emergiu o eixo temático: As principais práticas de cuidado informais/complementares utilizadas pelas mulheres idosas no cuidado com a saúde: Um caminho para o empoderamento. Conclusão: o estudo mostra a dificuldade por parte dos profissionais da ESF em aliar o saber popular e o conhecimento científico, o que os leva a não incluir as práticas de cuidado informais no fortalecimento das relações entre quem cuida e quem é cuidado. Descritores: Envelhecimento; Cuidado; Saúde Pública.

RESUMEN

Objetivo: revelar las prácticas de cuidado informales/complementarias utilizadas por las mujeres de edad para el cuidado de la salud. Método: estudio de enfoque cualitativo utilizando la historia oral descrita por Bom Meihy. La red de las colaboradoras se compone de seis personas de edad avanzada vinculadas a una ESF en un barrio de la ciudad de Joao Pessoa, PB. Los datos fueron analizados por la técnica de análisis de contenido temático. Resultados: del material empírico emergió el tema principal: Las principales prácticas de cuidado informales/complementares utilizadas por las mujeres de más edad en el cuidado de la salud: Un camino para el empoderamiento. Conclusión: el estudio muestra la dificultad por parte de los profesionales de la ESF en combinar el conocimiento popular y el conocimiento científico, lo que les lleva a no incluyeren las prácticas informales de cuidado en el fortalecimiento de las relaciones entre aquellos que asisten y los que son asistidos. Descritores: Envejecimiento; Cuidado; Salud Pública.
INTRODUCTION

Care practices have always been associated with the figure of the woman. Such representations have on their principles direct relationship with the natural ability of biological reproduction and responsibilities in caring for household chores and family. The knowledge needed to practice these care was acquired in the family, it had no scientific basis or was made Herculean great need for it to be done, and thus free of prestige and social power.¹

Revisiting history, we find that, with regard to the social position of women, there is a myth defined by concepts that refer to an essential condition of inferiority attributed to their approach to nature. In the family, the woman is the recipient of traditional knowledge passed on between generations, dominating the list of complaints and healing practices, manipulating and preserving medicinal plants, producing teas, ointments and syrups for the most different diseases, including discomforts in the body and soul, becoming thus a reference in family care and community.² So it started to realize the close relationship between women and informal care practices, because its use was the main therapeutic resource used to treat people's health and their families, and at the same time, the segregation of this knowledge, viewed as simple for a society that worships time, the segregation of this knowledge, influencing her community in a positive way.³

In Brazil, aging is growing. With the increase of the population over 60 years of age there was also considerable change in the number of elderly women. The current elderly population consists of 20,590,599 people over 60 years of age, and of these 9,156,112 are men and 11,434,487 are women. These data demonstrate the high prevalence of elderly women in the country, showing that aging is also a gender issue, considering that 55% of the elderly population are women.⁴ The complexity of the problems related to the impact caused by the increase in life expectancy of people associated with a low improvement in quality of life and the lack of efficient public policies, culminating in a range of problems affecting this group, which needs more attention function of functional decline, configuring itself as a political, social and economic challenge.⁵

The natural process of aging experienced by women may limit due to the installation of chronic diseases and disabling physical decline, and often intellectual. These limitations bring different impact on social, economic and family spheres, so there is a need to know in depth the phenomenon of aging, prioritizing these efforts in maintaining independence and autonomy of the woman.⁶

In care spaces to women's health, gender issues show the complexity of life in the exclusivity of each. The multidisciplinary teams, facing the implementation of public health policies, now build spaces for social transformation; now maintain the institutional order, reproducing class and gender inequalities in the professional-client relationship.⁷

In light of this discussion, healthy aging involves not only the possibility of the elderly woman to have care for the most common health problems in this stage of life, but also in recognition of their possibilities and needs.⁸ In addition to physical health we must respect, and the ability to feel active in her community with the opportunity to express herself freely. In this context, the practice of informal/complementary care is an alternative to bypass physical diseases, and it is a significant value creation opportunity, as the woman goes on to recognize the holder of knowledge, influencing her community in a positive way.⁹

It is considered that even though an informal practice, care based in popular knowledge must be valued by the health professional given that the traditional knowledge of health care is culturally transmitted by people very close and based on trust and affection and thus formulate a significant basis for women.¹⁰

In this scenario, it is observed that the model of care focused on the individual and curative care and, more than that, with absolute emphasis on hospital care, does not solve the health problems, nor satisfy the demands of the clientele. For this reason, the question that guides this study converges to the following inquiry: “What informal care practices/complementary older women use for health care?”

Based on these, there is a need to highlight the informal care practices used by older women served by the FHS for health care, as well as to identify the importance of these practices for the empowerment of women. It is therefore important to consider the importance of promoting an inclusive community model, which articulates the scientific knowledge and popular knowledge, supporting people sharing knowledge, respecting them, and empowering them. The impact that this study can provide is awakening to new practices and care strategies. Thus, this research aims to:
• Revealing informal/complementary care practices used by elderly women to health care.

**METHOD**

This research is part of the research project **Care practices in formal and informal health system**, of a descriptive character with a qualitative approach, using the method of oral history, aimed at revealing care practices used by elderly women to health care, and identifying the importance of these practices for the empowerment of women.

To complete the objective of this investigation, it was decided as a methodological strategy, specifically the thematic oral history, which is a methodology focused on the living experience of that which tells, or in search of factual information. For Bom Meihy, work on oral history should follow a few steps and principles, such as the choice of the colony, the target community, network training, and the definition of collaborators. In this case, it was established as colony older women over 60 years old attending the health unit.10

Once characterized the colony, it is understood that there are several members who make up the network, ie, the colony specification. A network could reach all women over sixty who attend the health unit; however, the terms, the key interviewee, Lavender, this indicated women over sixty years old that would have widespread availability to contribute to the research, and who used informal care practices, thus closing our network. These six women who constituted answered a very important question in oral history, the community of destiny, which is the argumentative organization of a problem given to the colony interviewed.

The choice of network, according to Bom Meihy, functions as indicative of how the interviews should be articulated. Therefore, the network was composed of elderly women attending the health service at least once a month, which showed interest and will to participate in the study, and who used alternative/complementary care practices throughout their care history and health.

Verified their correspondence to network criteria and colony, we were facing the collaborators. The term “collaborator” defines the relationship between researcher and respondent at the interview work is something that requires “two personal sides and humans”, there is a compromise between the parties. Directed the production of empirical material, after clarification of the goals of the study and signing the informed consent term, the interviews were conducted.10

The entire interview process was guided by three stages: the pre-interview, where the research was presented, and scheduled interviews according to the availability of women; the interview itself, performed in the unit, and the home of one of the collaborators; and the post-interview time to strengthen and keep the link with assisting to the conference of the material produced. In addition to the actual interviews, Bom Meihy says the field book is an important tool to be used in research, it comments from interviews are recorded, the impressions of the researcher, in short, data that will serve as a reference for the work. I recorded a lot of information in the notebook, from the talks on time, the expression, or body language of some interviewees.

Participated in this study six women between 60 and 79 years old. To obtain the reports, they used cutting questions that are not used strictly in order to avoid the restriction of the reports, but in order to “follow an order of importance of placing the main topics for examination of a witness.”10

From there coherent and certain approach to the study setting and the theoretical narratives were constructed.

The study setting was the Grotão Integrated Health Unit, located in the neighborhood of Grotão, city of João Pessoa, Paraíba, neighborhood famous for its street market, rich in Mangaïans, where they sell potions, herbs, and liquor. Where houses still have green areas, gardens, barns, low-income people who, to gain access to the facility, facing slopes of steep streets, unpaved. Children mix with breeding stock, and the use of informal/complementary care practices is common, either by the difficulty of access to services, or the need to follow a tradition as something that is part of a popular culture.

The empirical data were obtained through interviews that were based on questions, cutting questions that permeated all the interviews and were related to the target community, group identity constituents, and the object of study.10 These were: “What has the lady made for aging well?”,” What do you have about complementary practices used to take care of yourself?”, “What side used by the lady were or have become a family tradition?”

The empirical material was worked according to the steps of the oral history process: transcription, implies listening to all the recorded material, and its transcription...
carried out faithfully the events, including cutting questions; textualization is the next step, in which the questions are deleted, giving the text a narrative character, is at this stage that identifies the vital tone of the interview.

The vital tone is the theme with expressive force to guide the reader and represents its moral synthesis, being placed in the form of heading in each narrative; and finally, transcreation, which is the stage at which occurs the recreation of text in its total, ie whether it operates on broadly deposition, ordering paragraphs, removing or adding words and phrases in accordance with the observation and the notes field notebook.¹¹

The texts have been redone with the participation of the collaborators, bringing the narrative, information, insights, shared between researcher and developer. This is the time that the researcher must be prepared for possible negotiations, in which the basic principle is flexibility, so that there is an understanding between the parties on the importance or or else of cuts or limits for public use of the document.¹¹

The material was subjected to repeated readings to identify the most significant points directly related to the care of experiences developed by women, involving informal practices, which generated the central themes of the study. Strong expressions were used for the construction of vital tone of interviews; it was considered the guiding principle of reading and understanding informal care practices used by women.

After working the text, the author brings the version of respondents to be authorized, providing reliable research.¹⁰ In this way, the material was taken by every collaborator to conference and elaboration of issues of interest to the study. In this study, this time occurred in the Integrated FHU; appointments of great satisfaction, especially according to the participants, the sense of feeling valued, recognized and heard.

The narrative of the interviews was received with great attention, and approved all the stories, with confirmation looks beyond the repetition of what was heard, as if listening to their stories by their own mouths, they gained an irrefutable truth. There was no negotiation and the text was accepted in full.

In order to ensure anonymity, the names chosen were medicinal herbs, for each collaborator. This choice was attended's own collaborators, who have chosen to call as well, since all made use of these plants with children, grandchildren, with themselves and with the community, or bringing the memory use by their mothers, grandmothers, and other female figures that permeated their care memories.

**RESULTS AND DISCUSSION**

The discussion of the produced empirical material was guided by the vital tone of the narrative and by identifying a main theme, which translated the meaning of the experiences of each one of the collaborators; the main informal/complementary care practices used by older women in caring for Health: A path to empowerment.

There is also the predominance of the traditional view of women linked to maternity status as one of their main social roles to be taken to the community. This maternal role refers to caring for others, taking responsibility for each other. This reinforces the cultural construction, which leads in turn to the award of care to the female figure, being careful a function or responsibility considered by all as innate and natural woman.

Still making a historical review, the use of herbal remedies goes back to primitive tribes where women were in charge of the plant extract the active ingredients to use them in the cure of diseases. So we can say that there is an association between woman, care, and nature.

Although this association is being useless, because of the woman, increasingly accumulate social responsibilities that did not conferred, such as several hours of paid work, we often find, especially among older women, this triad: woman, care, and family, very latent. Caution attribute to women is built and is built from the socio-cultural references that give meaning to what a woman is.⁸ In the words of the collaborators, it is insistent the presence of caring for the son, the grandson of maternal care, veiled, which extends to the community, as can be shown in the following lines:

If the boy's with full chest, I do licking white chives, or give Coronopus with cow's milk; it's good for bronchitis, dragging everything. (Mastic)

The bath of mastic heals any wound, when I was a boy, was sitz bath, never had anything to this day my parts are well clean... Today I do for those who ask me, these girls here are same as my daughters. (Fennel)

My mother was like that, for every pain, tea ... In my house has fennel, lemon balm, lemongrass, this coconut oil that're trendy, we already used to cure scabies, virgin coconut oil drawn in wood stove with mutton tallow … (Barbatimao)
If we use such tea for this disease for over thirty years and it works, then it is good. I will rely more on whom? On my mother who raised 12 children, or a doctor who does not even know of life? (Lavender)

When sick, the individual tends to appeal to someone close, in the family or in the community, in this case, the woman, therefore the need for the Family Health Strategy refocus on its care model, in search of a terminating care, bringing these female characters for assistance, seeing them as allies.

Medicinal plants are one of the oldest instruments used by humans to treat illnesses of all types. The use of plants to prevent and/or cure of diseases is a habit that has always existed in human history, mainly used by low-income people, because it is an efficient alternative, cheap and culturally widespread.12

The World Health Organization (WHO) has encouraged the use of traditional medicine/Complementary Medicine/Alternative in health systems so that integrates the techniques of modern Western medicine. In 2006 there was implanted in Brazil the National Policy on Integrative and Complementary Practices (PNPIC) in the Unified Health System (SUS), which aims to stimulate natural prevention of health disorders mechanisms through effective and safe technologies.13

The National Policy of Medicinal Plants and Herbal Medicines (PNPMF), 2006, is a way that aims to ensure the Brazilian population safe access and rational use of medicinal and herbal plants, promoting the sustainable use of biodiversity, the development of the supply chain and the domestic industry.14

Rather than discard the popular knowledge brought by these women, it is necessary to enhance this knowledge, use up health education not only to enforce health regulations, but to add knowledge. Discussing traditional health practices and historically entered into regarding the use of medicinal plants, so that thus can act effectively and efficiently in solving real health problems, combining folk knowledge to scientific knowledge.12

In the study conducted, there was a plethora of therapeutic recipes; the most cited was the tea, especially peppermint, touted as excellent dewormer, the balm and lemongrass, considered digestive, and the “eye cherry”, or guava, cited as antidiarrheal.

The raw material to make these teas is still purchased at fairs, living pharmacies, or in the community, in backyards and in their own homes, largely shared culture, as noted in the speech of the collaborator:

Always I give a twig to anyone who asks me, so I never miss, nearly everyone here has a foot balm or small mint… (Anise)

The use of tea is a health care practice that has strong cultural brands and describes often a family history of users of health services. With this appointment we see the need to recognize the popular wisdom and value it in different situations, possible care to be constructed via health education alternatives.

Science seeks the production of truths, and if the theory in question is confirmed in accordance with the relevant procedures to scientific knowledge, such a theory is taken as a fact. Already popular knowledge, empiricism, being a working knowledge produced in our daily lives, in spite of representing reality in which we operate, to be a fertile knowledge, representing the concerns of the subject, is considered by health professionals, illusory, false, it is considered a common knowledge based on “guesswork”.

These empirical experiences are accumulated through experience, the grandmothers’ advice, they are careful to representations that have worked. Reject these representations can mean the failure of a therapeutic, the abandonment of treatment. Respect the truths brought by speech user, valuing the subject are essential to quality care.

As women age, their quality of life is seen determined largely by their ability to keep autonomy and independence, these may come with the appreciation of knowledge acquired through life experience. The old brings a whole experience in care practice, they are learned with the mother, grandparents, or experienced.9

This knowledge is shared with the community, which gives this old the role of caregiver of all, a kind of leader who will heal, which takes care of those around you. Developing this caring role ends up being more a practice of informal care, as this enhancement brings the elderly well-being, vitality, strength.8 By the previous collaborative reveals that make use of alternative treatments, in the search for better feel and aid in healing and rehabilitation not only of their illnesses, but the community’s disease, as suggested by the following quote:

Only on my street I took care to tell the truth, everyone. It is earache, diarrhea. I put rue ear, i cherry eye tea, mothers all
thank me. He fells ill, so they say, call Mrs. Lavender. Even when the doctor passes the remedy they seek me because most rely on my experience. I have taken care of many young. I saw die of brokenness, already prayed, everybody knows me, respects me. (Lavender)

The collaborators also reported feeling valued and autonomy in decision-making by being required to exercise such care as expressed in the words of the collaborators below.

The whole life I brought life to this world, I want to bring more. I can no longer birth, but I can take care, pray, do shower ... And the mothers come to me more than the doctors, they trust me. Because I’m here. (Aloe vera)

All I need are here in my backyard, I have so much to give to the neighbors take to nurse ... She knows I understand that, my father and my mother, God keeps them in good stead, they taught me a lot. I am proud to know to do my medicine, tinkering in my little land. I take acerola, mango, told her to take the juice of acerola strong, with honey, fasting. (Anise)

The attitude of this nurse contributes to the formation and strengthening of ties, it reveals an attitude of respect to learn from each other, and this other woman/caregiver in a user. However, this is not a general practice of the relations established between the team and community. However, the FHS vocational misses the opportunity to exchange knowledge with the community.

She said that any day I called to make my recipes over to the filling station. This is the only way for me to go there, my health is very good, I only use natural thing. (Barbatimao)

Elements such as the appreciation of the moment of meeting, welcoming, listening and respecting for knowledge can only be achieved, in fact, from a true understanding of this other, the user.9

It is necessary to emphasize the need for a joint effort of information and user awareness of the effects and needs medical treatment for improving the health condition of the individual, even if you do use parallel complementary care alternatives, as the use of teas mentioned by the collaborators.

A condition for successful treatment, that chronic ingestion of a drug makes up a sense for the individual to fulfill the prescription. Understanding the drug as symbolic goods, such sense can be expressed as a necessity that the medicine goods must meet.11 The use of the medicament is the use of a health representation and experimentation in practice, promises rooted in this representation.

Care is a practice that occurs in social relations and thus constitutes the approach movements of popular knowledge with the scientific. There is need for coexistence between conventional care practices (formal) and unconventional complementary care practices (informal).15

Care practices brought by these women should be strengthened by the professional, both in an attempt to strengthen ties, as the credibility that this knowledge is acquired before the community.

The biomedical model has meant that the individual was seen in parts, changes in care concept brought to the fore the need to see the individual as mind, body, behavior, and environment in this context informal care practices, and empowerment of knowledge of these practices are able to provide the elderly woman a considerable improvement in her health, and, in general, the standard of living.16

Popular knowledge, even though little valued, coupled with scientific knowledge, has been shown in research to be able to generate excellent results, which reinforces the need to value this bias care.17 The manipulation of plants by women is not by chance, without having been someone indication, trial, or improvement of a particular symptom. The interviewees reported feeling valued, and autonomous decision-making by being asked to exercise such care as expressed in the speech of the collaborator.

The nurse tells me to make that sucking, I know, before passing syrup, she knows that is really good, I just like to be answered by her. (Aloe Vera)

There is a symbolic meaning behind the care of informal practices, it is the knowledge of a valued community, it is the ability to play an active role, recognized in the community. At the same time, informal practices do not arise as opposed to formal practices, they embrace each other, are unified from the moment the individual, in this case the elderly, is perceived in its entirety.16

Thus, knowledge of folk medicine, from the moment that is recognized and valued, shall not constitute a fragmented set of healing practices, becoming a complex and articulated system of knowledge. The popular knowledge becomes related to scientific knowledge, taking ownership of its elements and adapting them to the local socio-cultural context.16-17
CONCLUSION

Even using the formal care practices, older women also practice the informal care, either as primary therapy or adjuvant. In addition, the study shows that the use of informal care practices for the elderly is closely related to the difficulty that professionals have in combining beliefs and culture that are true of the elderly woman empowerment tools next to her territory, to her prescriptions.

Among the informal care practices used by women interviewed it was observed using natural teas, such as lemon balm, and lemongrass, as well as ointments and plasters. It was also observed that the knowledge of the elderly is recognized and shared in the community assisting in the healing and rehabilitation not only of their illnesses, but on the other in its territory, and often a hesitancy to adhere to drug treatment prescribed by the health professional, since it does not recognize as his own, leads them to resort ace informal / complementary care practices as first choice.

The results of this study may contribute to the development of new researches that have the research focus on the stories of informal care in health, not only during the aging process, but in all stages of life, providing, thus, consolidating a healthcare in health, not only during the aging process, but in all stages of life, providing, thus, consolidating a healthcare process, but in all stages of life, providing, thus, consolidating a healthcare process, but in all stages of life, providing, thus, consolidating a healthcare.

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