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HEALTH CARE AND SOCIO-CULTURAL PRACTICES FOR ELDERLY PATIENTS IN DIFFERENT ETHNIC GROUPS

Práticas socioculturais e de cuidado à saúde de idosos em diferentes etnias

Practicas socioculturales y de la atención a la salud de personas mayores en diferentes etnias

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ABSTRACT

Objective: To identify the practices elderly people from different ethnic groups adopt for health care and in disease situations. **Methods:** Symbolic Interactionism and Grounded Theory were used as the theoretical-methodological strategy. Data were collected from February to July 2011, involving 33 elderly people from different ethnic groups, at their homes. **Results:** Health care involves physical exercise, food, prayer and work, and only the French showed concerns with this aspect across the lifetime. In illness situations, faith and religiosity guide care among the Lebanese; the use of teas among the Paraguayans; traditional medicine associated with the use of teas among the French, the Chinese and the Brazilian. **Conclusion:** Geriatric nursing needs knowledge about the different care practices, because they approximate professionals to the elderly and their family, allowing them to plan and implement actions appropriate to each specific situation.

Keywords: Aging; Culture; Ethnic Groups; Nursing.

RESUMO

Objetivo: Identificar práticas de cuidado à saúde e em situação de adoecimento adotadas por idosos de diferentes etnias. **Metodos:** O Interacionismo Simbólico e a Teoria Fundamentada nos Dados foram utilizados como estratégia teórico-metodológica. Dados coletados de fevereiro a julho de 2011 entre 33 idosos de cinco etnias diferentes, em seus domicílios. **Resultados:** Os cuidados na saúde envolvem atividade física, alimentação, oração e trabalho, e somente os franceses demonstraram preocupação com isso ao longo da vida. Em situação de adoecimento, a fé e a religiosidade norteiam o cuidado entre os libaneses; a utilização de chás entre os paraguaios; a medicina tradicional associada ao uso de chás entre os franceses, chineses e brasileiros. **Conclusão:** As diferentes práticas de cuidado devem ser conhecidas pela enfermagem gerontológica, pois aproximam o profissional do idoso e sua família, permitindo-lhes planejar e implementar ações adequadas a cada situação específica.

Palavras-chave: Envelhecimento; Cultura; Grupos étnicos; Enfermagem.

RESUMEN

Objetivo: Identificar las prácticas de cuidado de la salud y en situación de enfermedad adoptadas por personas mayores de diferentes etnias. **Métodos:** El Interaccionismo Simbólico y la Teoría Fundamentada fueron utilizadas como estrategia teórico-metodológica. Datos recogidos de febrero a julio de 2011 entre 33 personas mayores de cinco diferentes etnias, en sus domicilios. **Resultados:** Los cuidados en salud envuelven actividad física, alimentación, oración y trabajo, y solamente los franceses demostraron preocupación con eso a lo largo de la vida. En situación de enfermedad la fe y la religiosidad orientan la atención entre los libaneses; el uso de tés entre los paraguayos; la medicina tradicional asociada al uso de tés entre los franceses, los chinos y los brasileños. **Conclusión:** Las diferentes prácticas de atención deben ser utilizadas para la enfermería gerontológica, pues aproximan el profesional de las personas mayores y sus familias, permitiendo el planeamiento y implementación de acciones adecuadas a cada situación específica.

Palavras-clave: Envejecimiento; Cultura; Grupos étnicos; Enfermería.

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INTRODUCTION

The population aging observed nowadays has provoked great changes in the country's social, economic and epidemiological profile, demanding changes in elderly health care and entailing greater interest in research about old age, aging and new alternatives to promote health[1]. Therefore, knowledge is needed about the different aspects of this population, including environmental, psychosocial, cultural and economic problems that directly affect the population.

The formation process of the Brazilian people resulted from the collision among Europeans, wild and city Indians and African Americans. This mixture of races gave origin to the triangulation in the Brazilian society: a people established by the "collision among three races", permitting countless genetic crossings. This immigration, which is still present nowadays, represented a threat to transfigure the pre-existing Brazilian population, affecting the destiny of a society that assimilated that whole migratory mass, transforming the newly-arrived more than those who already lived here[2]. The contact among different peoples from several countries, however, who are socialized in one culture and will then live in another, involves a concept defined as acculturation, which takes place in the group as well as in the individual context[3].

Therefore, man should be considered as the result of a culture, transmitted from one generation to the other and defined as a web of meanings woven by individuals, capable of proposing cultural changes, as they incorporate characteristics of the group they live in and gain a basic personality[4]. Thus, the cultural and anthropological aspects are important to understand the disease experiences and health practices of individuals and their families, in which a society's cultural elements influence the worldview related to habits and customs and alter people's behavior with regard to health demands[5].

In this context, health practices vary from individual to individual[6], and knowledge about them is vital to consider them in health programs, as these depend on the population's acceptance and effective participation to achieve their objectives. In addition, they represent an important tool for health professionals like nurses, helping them to face difficulties and to make the target public of these programs acquire healthy behaviors, compatible with their beliefs and values.

That is particularly important for the people who immigrated, due to the barrier imposed by the language, habits and customs. How can one attend to an elderly person at a health service without understanding his/her values and beliefs? It is difficult to make oneself understood when one does not understand either. These situations should be considered, mainly because the elderly, due to their characteristic of established life habits, no longer makes much effort to change certain daily situations.

In that context, and considering that knowing how the elderly perceive their health problems and attempt to solve them is very useful for nursing care planning, the aim in this study was to identify health and disease care practices adopted by elderly people from different ethnic groups.

METHOD

In this study, the premises of the Grounded Theory (GT) and Symbolic Interactionism (SI) were adopted as the theoretical-methodological reference framework, which permits articulating their guidelines with the research and understanding the health care practices in this migration context.

The aim of GT is to understand social phenomena based on the experiences of social actors and their significant aspects. The perspective of SI, on the other hand, is centered on human interaction, as it attempts to understand the symbolic characteristics of social life and reality through knowledge about how people perceive - or signify - a certain context or object[7].

The research was undertaken in Foz do Iguaçu, Paraná, involving 33 elderly people from five ethnic groups (Lebanese, Paraguayan, Chinese, French and Brazilian). The capitation of the participants was based on the indication of friends, at a community center for the elderly, health services and a French language school. The data were collected between February and August 2011, through previously scheduled interviews held at the elderly's homes. They interviews were guided by a semistructured script, recorded, and then fully transcribed. In the composition of the groups, sampling and theoretical saturation criteria were complied with. Hence, the size and composition of the groups were determined during the data collection process, and theoretical saturation was verified when neither new nor additional data were found in a given group[7].

The inclusion criteria to establish the groups were as follows: being 60 years of age or older; having the nationality of the ethnic groups and being capable of answering the research questions. To reduce the influence of other cultures, it was determined that the participants from the Brazilian group should be children of Brazilian citizens. Individuals with great difficulty to express themselves in Portuguese or without a translator were excluded.

Data were analyzed through open, axial and selective coding. In open coding, the data were analyzed line by line and similarities and differences were compared, followed by the conceptual development. In the axial coding, the data divided in the previous phase were regrouped and the relation between categories and subcategories was established. In the selective coding, the categories were integrated and refined to give the research results the form of a theory, when one can reach a central category to express the research theme, with a view to more consistent data and theoretical validation[7].

Approval for the research project was obtained from the Permanent Ethics Committee for Research Involving Human Beings at *Universidade Estadual de Maringá* (opinion 739/2010). All participants signed two copies of the Informed Consent Form and their reports are identified using the first letter of the corresponding ethnic group, followed by a number indicating the order in which the interviews were held in the sample group, besides the letters M and F to indicate the gender and another number to indicate the age.

This paper presents part of a study that was focused on the conception of old age and care practices in different ethnic groups. The central category "Having to get old: sociocultural and care practices guiding aging in different ethnic groups" is accompanied by various interrelated categories, one of which, "Culture influencing habits and customs in health care" will be presented next.

RESULTS

Thirty-three elderly people (17 men and 16 women) were interviewed, between 60 and 96 years of age, which constituted five sample groups, including seven Lebanese, ten Brazilians, five Paraguayans, seven French and four Chinese. Their reports about care practice in different ethnic groups permitted the identification of two subcategories.

The central category and subcategories were constructed in line with the theoretical framework - SI - in which individual and collective actions are constructed based on the interaction among people who, defining situations, act in the social context they belong to. The way the people define events or situations and how they act with regard to their beliefs supported the analysis and interpretation of the data.

Health and care for aging

It was verified that, for the elderly, health has different meanings, such as eating well, sleeping well and drinking, concepts through which they translated the perception of a longer life, as evidenced in the following statement:

> *A friend of mine said: my mother is 103 years old and she doesn't stop at all. She hears well, sees well, does embroidery the whole day. That's being healthy! What kills is the stomach. If she does not eat, does not drink, does not sleep well, she would not live. She would not be that healthy (L1, M, 72 years).*

It is observed that the elderly's health is perceived by changes that happen over the years:

> *As age advances, we get less of everything, less health, it's not like before (L1, M, 72 years).*

And some concepts were reported as playing a determinant role in health maintenance:

> *We cannot do much, because young people between 40 and 50 years of age are very different and, as from the age of 60, it's something different. I felt that in the physical part, I lost strength completely, I want to, but I'm unable to do it like I did before, I feel pain here, pain there... but I haven't stopped working, it's just that everything takes more time; I can't do it the same way, just slowly, if you want to do it quickly it doesn't work (P1, M, 74 years).*

It is also observed that the elderly gradually feel the changes that happen as age advances and that, although these changes can reduce some possibilities of professional activities, for example, they gradually adapt themselves to new activities. Many keep up their housework and adapt to the new rhythm to accomplish it.

They are also able to perceive that some individual personality characteristics contribute to the emergence of diseases, like stress for example.

> *...stress is the principle of all diseases. So we cannot live under stress (L6, M, 72 years).*

> *People who talk do not get health problems (L7, M, 60 years).*

Care was mentioned as being accomplished when getting old and also in the course of life, mainly among the French, who are in better health conditions.

> *Life is less of a rush today. We do periodical health tests, for prevention... but nothing that has greatly changed over the years (F3, F, 62 years).*

> *My diet has always been healthy, so there aren't any big differences, besides the physiotherapy I started to improve my back (F5, F, 69 years).*

Brazilian elderly, then, are ill more frequently, despite mentioning the search for health care, with different manifestations in the five ethnic groups.

> *You shouldn't stay still, you should keep on moving, whether by working, doing stuff, walking. The mind should be exercised as well. Because people who just lie down get ill and get older faster (B1, M, 74 years).*

In view of different cultural concepts related to health, nurses should construct hybrid, mixed and compound conceptions of different socio-historical and cultural situations, which should support their care practice so as to

cover the different population contexts.

Concern with the appearance of illnesses in old age directing care practices

Concerns were perceived with food issues, which revealed a close relation with health. Thus, changes in dietary habits and physical exercise where considered as health care.

> *[...] I take care of what I eat for more than ten years. At breakfast I eat apple, yoghurt, full-wheat toast, scrambled egg and green tea. Two years ago, I included red pepper and a spoon of linseeds with curd. Before lunch I eat fruit and a piece of sweet potato. At lunch I eat salad, beans and rice. And, at five o'clock, green tea and white cheese (L6, M, 72 years).*

Among the five groups, the Brazilians and Paraguayans revealed more similarities, which may be related to their lower income.

> *I take better care of my health now because, in Paraguay, I didn't even have shoes, I walked barefoot in the frost. I take better care of my food, I eat everything, just not too much fat (P2, F, 74 years).*

> *The only thing I take care of is my food because, when I was young, I didn't have any of this, my health was excellent (B5, F, 90 years).*

According to the Chinese, food was very meaningful, considering the whole process of preparation, care and handling that symbolizes not only the satiation of hunger, but also care for the body and mind.

> *Chinese people love pepper, it's very good for your health. I eat it when it's cold in the morning and ginger at lunch, not at night, because it's like poison. It's the best natural remedy, it helps to release salt (C2, M, 70 years).*

> *I eat less salt, I don't eat a lot of fried foods, to keep my mind healthy and so as not to bother too much and be always joyful (C3, M, 70 years).*

Concerning physical exercise, the five groups revealed it as health care, mainly considering the benefits for the body and the mind.

> *[...] I always exercise and give a lot of classes too, which allows me to keep my mind healthy (F2, M, 65 years).*

> *Every afternoon I go for a walk, the maid takes me. It seems like I'm 15 [laughs..]. Walking and visiting my children's house makes me feel better (P4, F, 85 years).*

Another form of health care they mentioned was the consumption of teas, common among Brazilians, Paraguayans and Chinese.

> *[...] we use a lot of herb in the chimarrão, I don't drink it without herbs, I put in mallow, just that the name of the herb is different here. It's good for a lot of things (P2, F, 74 years).*

> *I drink tea from fennel, dill, verbena, which is called capim santo up North. Orange leaves are good to sleep, it calms down (B2, F, 74 years).*

> *Tea is good to eliminate fat. Black tea, green tea, you have to drink tea after lunch to eliminate all of the fat that's left inside of you (C2, M, 70 years).*

Prayer and religion were also revealed as health care practices. The Lebanese elderly stand out in this respect, with their Muslim religion, which rules its followers' conduct of social and family life.

> *Hygiene is part of our culture and religion. Before people can pray, they need to wash their arms, some body parts and the genitals. You have to be purified to talk to God. And that's health care too (L4, M, 60 years).*

For the other groups, prayer is not only a habit that makes them feel healthier, but also considered as care in disease situations: they believe in God as a form of treatment in situations of illness.

> *My leg seems like torn bone, it can't be operated on. I take medicine and it's no use. I live my life according to God, I've got hope, I pray a lot (B9, F, 90 years).*

Sleep and rest habits, protection against cold and rain, besides using a cap in the coldest seasons were also revealed as self-care in old age.

> *I sleep eight hours per night. I get up early and in the afternoon I sleep until three, and that makes me feel good (L6, M, 72 years).*

> *I started to shelter myself more; with age, we get more sensitive to colds (B10, F, 74 years).*

I go to bed like the Brazilians, after the soap, and wake up at 6:30, and I feel good like that (C1, F, 60 years).

I don't catch any cold wind or I catch a flue easily. If there's mild rain, I immediately get my umbrella, otherwise I don't go out. When I take a bath I don't go out either and I don't put on the ventilator with the wind straight at me, that does me great harm (B2, F, 74 years).

I use a cap because I'm bald now, I feel colder and protect myself (P1, M, 74 years).

As opposed to these statements, other elderly declared they are not concerned with their health, neither in the course of life nor in old age.

I've never done anything. I do not usually eat vegetables, I wasn't concerned with held, I didn't remember that it existed. Then, the first time I went to the doctor I had diabetes, anemia, rheumatism and cholesterol. Now my blood pressure is always high, that's why I had a stroke, I used to eat a lot of salt, now I make my food kind of tasteless (B8, F, 86 years).

I don't take much care no, I don't take it very seriously (C4, M, 63 years).

In some situations, the perception of being sick was only manifested when the disease caused some physical limitation or degree of dependence. Elderly people with hypertension or diabetes only report these conditions when they caused some limitation in their daily life; if not, they were perceived as a consequence of age.

My health has always been very good, the only problem is my worn out knee and, as I got older, I gained a lot of weight (B7, F, 75 years).

This elderly woman experienced limitations to walk as a result of different diseases like diabetes and hypertension, treated and controlled through drug therapy. As they did not change her routine, not even her diet, they were not considered as illness.

In those cases when the disease provokes changes in the routine and triggers important changes in the elderly's life, care and treatment are accomplished to reduce or eliminate the discomfort. Except for the French, the other elderly only turn to medical care in case of illness. The use of traditional medicine was predominant and most elderly mentioned it. In combination with medical treatment, however, other practices were indicated, revealing the cultural influence of each group.

I always drink a lot of tea made of nutmeg, clove and canella and senna if my stomach is upset. I used to visit the faith healer all the time, took my kids and for myself as well. After I came to Paraná I couldn't find any faith healer around here (B6, F, 96 years).

The Paraguayan elderly manifested their belief in faith healers, although they reported that they do not use these for themselves, but only for their grandchildren and great-grandchildren. In Paraguay, this practice is widely used, independently of age, due to the population's low economic level and the high cost of health services.

The French demonstrated great skepticism towards health care alternatives. They do seem susceptible to adopt these when they migrated at a young age, when they became more permeable to the belief in alternative care.

Definitely traditional medicine, although I have already tried homeopathy and acupuncture in the past (F3, F, 62 years).

If it's a cold or even a flue I solve it with tea, honey, gargles and antipyretic medicine, if necessary; I've never needed more than that. If it's something else, like a virus, if it doesn't get better and I feel very bad, I go to a doctor (F5, M, 80 years).

The data demonstrate that, independently of the ethnic origin, the elderly tend to associate medical treatment with the use of teas and herbs, which they do in situations they consider less severe. Only one Chinese participant mentioned acupuncture, demonstrating the cultural adaptation this elderly ethnic group has gone through in Brazil, as this practice is common in oriental medicine and traditionally used and acknowledged as effective in eastern countries.

DISCUSSION

Acknowledging popular health care practices is important to preserve this wisdom and interact between scientific and popular knowledge, considering cultural diversity in the context we live in. Care, commonly present in all cultures, varies in its forms of expression[8], as cultural standards determine how individuals understand and lead their own life.

In some countries, like France, Germany and the Netherlands, health care is offered through a social insurance. In Brazil, on the other hand, this access is universal, as one of the only countries to offer it to the population.

May factors interfere in a population getting ill, and the socioeconomic, historical and cultural conditions, which reveal opportunities to get access to better schools and information, figure among the factors that favor quality of life and, consequently, health conditions. Among the French elderly, their better health condition is due to the combination between these factors and self-care across the lifetime.

In France, the low incidence of cardiovascular illnesses is due to red wine consumption, which compensates for the negative effect of high saturated fat intake. It can also be related to behavioral factors and to the high consumption levels of vegetables and fruits[9], as identified among the French study participants.

As regards the study population, the Brazilian and Paraguayan participants showed the lowest income levels, making them more vulnerable to illnesses. Both Brazil and Paraguay have been historically marked by strong social inequalities in terms of housing, education, food, health and safety, problems whose solution still demands attention[10].

Dietary habits are an essential element in identity construction[11], as well as language, and that is why habits and customs cultivated in childhood do not get lost. Instead, adaptations take place in function of the foods offered, in view of the climate conditions in each region. As a result of globalization, however, it is easy to purchase Chinese or French food items on Brazilian territory.

Physical exercise as health care is important to prevent illnesses, improve mobility, functional ability and quality of life in the aging process. Therefore, it is important to emphasize that actions focused on an active lifestyle are part of healthy and high-quality aging[12], necessary for physical and mental wellbeing.

Faith and religiosity, a marking factor for Muslim participants, entail a profound and comprehensive influence that directs attitudes and conducts, as all acts necessary for human life involve a religious sense and meaning, determined by the *chari'a,* a set of standards that establishes rules for: religious practices, the family and marriages, social conduct, food intake and personal cleanliness[13].

Religious medicine is part of a historical process and is able to survive, despite current technological innovations, as it is inserted in a sociocultural context and influenced by relatives or social groups. Independently of age, prayer is considered as popular care, used in the belief that it can prevent health problems and grant protection in case of illness[14].

Elderly people attribute their own meanings to life habits they develop in a culture of self-care, including: food, hygiene, comfort, leisure, spirituality and rest. In old age, habits become more evident and are crystallized in daily reality as a significant part of life.

Concerning the use of teas, its knowledge is disseminated in popular culture through family practices and the advice of older to younger people. It is important to observe that, among the participants, no concern exists with the scientific endorsement of their use for disease treatment. It is important that they respond to their needs and are considered effective. Based on these data, it is inferred that health care practices and actions start at the encounter among subjective aspects, socially determined and culturally supported. Nowadays, evidence exists for professionals and health users' changed paradigms, making them take interest in new treatment and cure methods[15].

One of the findings in this study was the invisibility of nursing professionals for the elderly of different ethnic origins under analysis here, perhaps because of their undistinguished action, marked by tasks in which interactions and changes are not processed in the contact with other human beings and their multiple dimensions and complexities.

The need to consider cultural differences in each region, state or city when putting in practice public policies, also in educational programs for health and gerontology professionals, has been identified in other studies that involved elderly people from different ethnic origins[8]. The lack of policies that consider the social, economic and cultural development of a population is a reality. Interprofessional care, however, should be sensitive to these differences and diversities, as people experience aging in different ways and health services need to pay sufficient attention to identify this fact, respecting diversity in terms of gender, ethnic origin, culture, housing, education level, marital status, sexual orientation and religion[16].

Thus, although there is no intent on generalization, further research is suggested, involving health professionals who deal with aging-related issues in their daily work, besides other social sectors, with a view to strengthening the coherence of public policies and facilitating health interventions.

According to the premises of SI, the description of human behavior should be based on social acts, assessed based on manifest activity - observable behavior - and covered activity, manifested based on the individual's internal experience. Therefore, human conduct should be understood in social terms, and not as simply deriving from external influence on the individual[7].

Thus, individual interaction is considered as a process and as changing social actors, in a constant "*state of becoming*", socialized in interactive processes across the lifetime. In this context, nurses' willingness to deal with different publics and in multiple scenarios, their training and knowledge about the clients are fundamental to deliver more effective care to the people who receive it.

Respect for the premises of cultural care, including values, beliefs and standardized expressions, which help and train the individual or group to preserve their wellbeing, to improve a condition or human life and to cope with death and impairments, represent an important means to develop gerontological nursing care, as it directs and supports interaction with elderly people, their relatives and other individuals involved in the care process[17].

Therefore, knowledge about the multiple dimensions of elderly people's experience allows nurses to achieve holistic care, which demands critical-reflexive cross-sectorial

attitudes, capable of rescuing the human aspects involved in this practice, as a form of ethical commitment and social accountability. Respect for the interpersonality of care agents and receivers guarantees a better quality of life[18] and gerontological care in accordance with its premises.

FINAL CONSIDERATIONS

The themes highlighted addressed care across the lifetime, including physical exercise, good dietary habits, praying and keeping oneself occupied, which demonstrates the urgent need to change the profile of health professionals involved in direct and indirect care delivery to this population, who should know and consider these aspects in their daily practice.

For care in disease situations, the search for medicine happens in combination with the use of teas and cottage measures, proving that sociocultural practices are used to complement medical treatment and, therefore, cannot be ignored, but integrated in care.

The different forms of care, whether to promote health or in situations of disease in the different ethnic groups, demonstrated faith and religiosity as care guides in the Lebanese group; belief and the use of teas among Paraguayans; belief in conventional medicine among the French; and tea and traditional medicine among the Brazilians.

The different ethnic groups under analysis contributed to the formation of the Brazilian people, considering not only their bio-typological aspect. Until today, the cultural traits of these immigrants continue in their descendants, who cultivate the traditions, customs and beliefs of their origins and, although they consider themselves Brazilians, this cultural heritage they carry should receive special attention from health care professionals.

Developing gerontological nursing care, based on sociocultural practices, can approximate the elderly and their family to the professionals, permitting actions that were planned based on individual experiences, in view of an identifiable and positive relation in the way people from different cultures define, interpret and know care. Care that is only based on disease does neither contribute to the evolution of health care, nor to the valuation of each being's individuality.

As natural study limitations, the impossibility to expand the sample groups can be highlighted, due to the limited time to finish the Master's program, besides the researcher's lean experience in qualitative data collection and interpretation techniques, compensated for through dedication, involvement and effort; besides the qualitative nature of the research, whose results cannot be generalized. The researcher believe, however, that these results can arouse professionals to the importance of the aspects identified here.

Finally, aware of the value of this type of study for nursing science, further research with the same focus is suggested in other scenarios and involving other ethnic groups, which will certainly provide important findings for gerontological nursing. In addition, the interaction among professionals, clients and families, based on the premises of SI as a reflection point, encourages new interactive care possibilities, against the background of social reality. Enhancing welcoming at health service, as well as the ability to listen, provide orientations and deal with different concepts about aging, health and care, can promote elderly people's autonomy and improve their quality of life.

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