ORIGINAL RESEARCH

Therapeutic practices of housewives of a population in Valdivia,Chile: A contribution to the rescue of knowledge in domestic medicine

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Abstract

Introduction. Different medical systems coexist within therapeutic itineraries; one of these is domestic medicine, in which women play a predominant role. Different visions propose the need for integration between systems. *Objective.* To describe the perceptions about domestic medicine practices and the value given to these practices by housewives of a population in Valdivia. *Methods.* A study was conducted under the tradition of Participatory Action Research, between 2019-2020. The pre-reflective and diagnostic phases are presented. Convenience sampling was used with members of a women's group in Valdivia, Chile. Group and individual interviews and a thematic analysis of the data were conducted. *Results.* A syncretic set of knowledges is observed, transmitted between women within the families, that uses practices from different traditions. There is a perception of ignorance and a rejection from physicians towards domestic medicine, as well as a need for dialogue between systems. *Discussion.* This experience makes it possible to rescue women's own knowledge, empowering them as valid interlocutors in a dialogue between medical systems. It is necessary to make advances towards integrative experiences that incorporate the vision of other actors in the future. **Key words:** Traditional Medicine, Self-care, Community Participation.

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Introduction

Throughout history there have been different traditions designed to face the processes of health and disease. Constituted as a set of shared knowledges, they have ultimately given rise to Medical Systems, i.e., "a more or less organized, coherent and stratified set of therapeutic agents, explanatory models of health-disease, practices and technologies at the service of individual and collective health" (1). With the advance of the natural sciences, scientific medicine gained ground until it became the hegemonic medical model, i.e., "the only way of treating disease legitimized both by scientific criteria and by the State" (2). However, despite the hegemony of scientific medicine, there are visions that show the persistence of multiple Medical Systems, one of them being Domestic or Home Medicine (3). Domestic medicine (also called Popular, Folk or Home Medicine) is understood as "the set of knowledges, resources and therapeutic actions present in the home, which do not transcend this sphere in terms of being offered as a service" (4). The content of this medical system will come from synthetic processes (4), resulting from the interaction with health services, the transmission of knowledges, traditional medicine, experiences acquired in the domestic sphere and

the influence of external agents such as the media and pharmacies (5).

Under a multiple systems approach, Pasarín (6) proposes that "most of the population resorts to different health care strategies, not only for different problems, but for the same health problem". This implies making use of the multiple systems that coexist, in a transit called Therapeutic Itineraries, i.e., the "sequence of activities that are undertaken in the process of seeking resolution of the condition by the social actors themselves, constituting an indicator of the resources used" (7). In this context, Home medicine constitutes the first approach of individuals to the experience of being ill, being inevitably the starting point of their therapeutic itineraries (6). Domestic medicine thus configures the "first real level of care" (8). Different perspectives propose that no medical system is able to solve all the health needs of communities and that it is the validation that each village gives to a medical system that determines the multiple therapeutic itineraries, whether simultaneous or sequential, that will be presented. The understanding of the choice of these itineraries as an act markedly influenced by culture leads to integrative strategies that respect the coexistence and interrelation between different medical systems; in this way, the contribution of collective health in Latin America stands out (3, 9).

As a central element in the domestic medicine system, women are found to be the main agents of self-care in families, in which they occupy the role of "specialists" in home medicine (3). Not in vain Menéndez (10) describes it as the "model of self-care that has the woman at its center". The construction of this feminine knowledge will be determined by a socialization process, of which the first scenario is the family of origin, where mothers and grandmothers play a key role in the transmission and perpetuation of knowledge in home medicine (4). The great current challenge in this sense is the risk of the medicalization of life and the risk that women assume a passive role in the universe of health care, in which they are central (5).

From this perspective, this research attempts to answer the question: How are women's knowledges and practices in domestic medicine perceived and what value is given to them by the housewives of a Valdivian population? The general objective will be to describe the perceptions about domestic medicine practices and the value given to these practices by women housewives of a population of Valdivia. The specific objectives will be to identify the knowledges and practices in domestic medicine of the women housewives of this population, in order to identify the value that the women housewives give to their knowledge in domestic medicine and to describe the perception that these women have of the use of domestic medicine practices.

Methods

Study design

A qualitative approach was used, following the tradition of Participatory Action Research (PAR). This report reflects the first two stages: Pre-reflective (or Pre-research) and Diagnostic.

Context of the research

This experience is rooted in the territory of Población San Pedro, located in the south of the commune of Valdivia, Chile, with origins in the 1990s through the construction of social housing to provide a solution to the needs of the poor and the inhabitants of informal camps (11, 12). This process was aimed at providing the population with minimum conditions of habitability, giving priority to quantity over quality of housing, which resulted in conditions of vulnerability that are still present today. From the perspective of the health sector, the following are attached to the population of the Angachilla Family Health Center (Cesfam Angachilla), a primary care center located in the area. There are also multiple community organizations in the town that are evidence of a rich social fabric; among these is the San Pedro Women's Group, constituted by 20 members, all of them women and mothers, of ages within the mature adult and older adult stages of the life cycle. This group was formed 26 years ago, being the first women's group in the sector. Currently, they meet biweekly, oriented to social sharing, exchange of experiences, knowledge and production of handicrafts for subsequent retail sale.

Pre-reflective stage

The Pre-reflective stage was initiated in the first semester of 2019 through the Health Situation Analysis of Cesfam Angachilla. This process had an initial phase of documentary review and subsequent free individual interviews with neighborhood leaders, as well as a group interview with the San Pedro Women's Group. When we inquired more deeply about the interests of this group, the interest in Domestic Medicine emerged.

Subsequently, once the thematic axis to be worked on was agreed upon, a Research Support Group (GIAP) was formed during the second semester of 2019, made up of two main researchers, the president of the San Pedro Women's Group and an active member of this group.

Participatory Diagnosis Stage

An initial convenience sampling was carried out. The inclusion criteria were: being a woman, belonging to the San Pedro Women's Group and being part of the families using the Angachilla Cesfam. The exclusion criterion was not giving consent to participate in the research.

Data collection was carried out through group interviews and individual interviews. The content of the interviews was audio-recorded and analyzed by means of literal transcriptions. The group interviews were conducted during the month of January 2020 with groups of 10 participants, in the facilities of the La Dehesa neighborhood center. The sessions were moderated by one of the principal investigators, supported by a collaborating researcher from GIAP. The information was simultaneously represented graphically on flip charts to allow visualization of the information by all participants. The first session used a script with two thematic areas to be addressed: knowledge and practices in domestic medicine; and assessment and perception of the use of domestic medicine practices. The second group session used the technique of joint construction of therapeutic itineraries. The individual semi-structured interviews were conducted at the La Dehesa neighborhood headquarters by the principal investigator during the month of January 2020, using a pre-designed interview script.

A thematic analysis of the data obtained was carried out. Data preparation was carried out by two researchers. Triangulation of methods and researchers was carried out in the collection and analysis of the data. The results obtained were presented to the participants in a group workshop to contrast the findings with their opinions.

Ethical considerations

Consent was requested from all the interviewees. A coded transcription system was used to maintain the anonymity of the participants. The audio files with the content of the interviews were only known to the researchers who participated in the analysis of the data and were kept by them.

One of the authors declares the existence of a previous relationship of joint work in the form of workshops with the San Pedro Women's Group, as well as the existence of a previous therapeutic relationship with some of the participants in the interviews or their families.

Results

Knowledge and practices in domestic medicine

The participants highlight their knowledge regarding domestic therapies through the exemplification of practices:

> *"Always when my children were sick we used maqui to lower the fever"; "When there is colitis you take dry maqui and that is good".*

They mainly use medicinal herbs and sometimes other products that can be obtained in natural pharmacies, an arsenal that constitutes what they call home remedies. They are oriented towards symptom relief rather than a specific etiology.

At the same time, they state that they use allopathic pharmaceutical preparations, used without medical indication, according to knowledge acquired in previous experiences with physicians, through recommendations from pharmacy salesmen or influence from internet or media:

> *"I buy collagen, that's good, I found it out on the internet"; "The pharmacy girl helps me, I don't know if she is a pharmacist, but she tells you what to take and when".*

Regarding the use of allopathic preparations, those who use medications for the management of chronic pathologies describe how they adapt their use to the short-term relief of symptoms. At the same time, they describe a certain fear of using them permanently and an attempt to replace some of them with natural products:

> *"They give me a lot of remedies, I bring the whole pharmacy, but I don't take them all, imagine how my stomach would feel"; "I much prefer herbs to these other remedies (...) they are healthier".*

In relation to the origin of their knowledge, a feminine transmission of this knowledge is highlighted: *"With my grandmother, I learned to do the same things she did"*. At the same time, it is described that men in the past possessed more knowledge related to the subject than men "nowadays", however, this appreciation also extends to both genders when referring to the new generations: *"The old person kind of knew, now the young people do not"*.

Assessment and perception of the use of domestic medicine practices

A positive valuation is observed regarding their knowledge of domestic medicine, perceiving it as a parallel system to that of official medicine. Their positioning as connoisseurs of this knowledge is noted: *"I tell my daughter, give her these herbs, they will do her good"*. On the other hand, there is a perception of ignorance on the part of physicians towards this knowledge, which is described as a conflict of beliefs: *"They do not believe in herbs, they believe in the remedies they prescribe"; "The doctor does not know about empacho"*. This means that therapies performed at home are hidden from the therapists of the official system, both because they think they do not understand them and to avoid being victims of ridicule or disqualification: *"One does not tell them, it is better not to tell them"*.

A predilection is expressed for natural therapies, mainly the use of medicinal herbs, with no current use of folk medicine therapists, which did exist in childhood and when the participants had small children: *"It is not used, but it used to be used when we had small children"; "There used to be doctors but not anymore, so one goes straight to the pharmacy"*.

Therapeutic itineraries

The decision about whether or not to seek care from a therapist begins at home, where the woman has the decisive say. The choice to consult a health center immediately depends on the perception of seriousness of the person, information that is obtained through changes in character or mood, decay or presence of fever: *"When a person is sick, his character changes, he declines, he knows he is sick, he knows he has something"*.

If the illnesses are not serious, they are managed at home through the knowledge and the arsenal of home remedies that the woman possesses: *"If it is only a cold, one does not go to the doctor"*. The second moment when it is decided to go to a health center is when the initial remedies tried at home fail, in this sense the non-relief of symptoms weighs more than a certain time window:

> *"I at least think that, after the second day if the issue does not go down, either the fever or the throat or nose is too clogged, I go".*

At the moment of deciding to get help, the first option in case of not perceiving a serious condition are allopathic pharmacies and naturopathic pharmacies, obtaining guidance from their salesmen:

> *"You go to the pharmacy and talk to the pharmacist and he recommends you"; "I always go first to the naturopathic pharmacy, and if it does not work for me I go to the others".*

When this fails or when they do not have the resources to go to buy drugs, they turn to the primary care network. It is said that the difficulty to get an appointment and the administrative barriers of primary care are an obstacle that makes them prefer to go first to the pharmacies:

> *"It is difficult to get an appointment, and on top of that you have to get up so early and when you ask for an appointment there is no appointment".*

Consultation of more complex emergency services is reserved for cases in which a high degree of seriousness or possible vital risk is

perceived: *"To get to the hospital, you have to be on the verge of death"*. This is mainly justified by the waiting time associated with hospital emergency consultations, in addition to not understanding the emergency categorization systems. The use of private medicine in this group is referred to as exceptional and conditioned to the availability of money, where the main motivation to access it is time:

> *"When I am very ill I prefer to go to the clinic, but you still have to wait"; "In the clinic you still wait a lot, but it is for another level, for those whose pockets are heavier"*.

There is an expectation of integration between systems, with a predominance of the idea of an opening of the official system towards practices carried out by the patients in their homes and especially in relation to the use of medicinal herbs: *"If there were herbs in the clinics it would be better, but as long as the doctors know what they are for"*. They see this integration as a task that corresponds to official health services: *"I say that they should also set up an herbal pharmacy in the clinics"*.

Discussion

The diagnostic process carried out reaffirms the role of the woman as a therapeutic agent and as the person in charge of the first decisions regarding the therapeutic itineraries of families, thus reinforcing the idea proposed by several authors of a female-centered medical system (5,10). These results are observed in both individual and group accounts and are similar to findings observed in previous research in the area. Sirguiado (13) in his quali-quantitative characterization of therapeutic itineraries in the pediatric emergency hospital of Valdivia (Chile), reports the role of women as the first medical help and the implementation of knowledge such as the observation of symptoms and their evolution, or the use of traditional drugs. Alarcón and Vidal (14), in their qualitative experience with children's therapeutic itineraries in the Araucanía Region (Chile), also report the main role of women as the first therapeutic resource for their children, and also add the lack of recognition of family health culture as a barrier to receiving care in health centers. This situation is repeated in our study and is reflected in physicians' perceptions of invalid knowledge and in attitudes such as the concealment of home medicine practices from physicians, thus perpetuating the vision of conflicting and incompatible systems. This situation generates dissatisfaction in families and confirms the vision of a system that is not culturally competent (14) and of a hegemonic model that does not integrate with other systems (15).

The need to establish dialogues between the official health services and the mothers/women of the families as a way of resolving this conflict is striking.

The perspective offered by the participants shows the search for multiple resources to be part of the therapeutic itineraries of families. In this sense, the existence of administrative barriers to health center access promotes the adoption of recommendations received in pharmacies as part of the household arsenal, where they become situated next to the practices acquired through the transgenerational transmission of female knowledges, evidencing the syncretic nature of the origin of their knowledges and practices. This reality observed in this study is repeated in other Chilean experiences with rural and indigenous populations (14), as well as in other Latin American countries, such as the experience in Colombia of Ruiz et al (16), which shows the marked cultural component of Latin American countries that exists behind the practices of Domestic Medicine. At the same time, it suggests that the reality in urban communities is not so different, in that sense, from that of rural ones. If the basic cultural elements behind the health-disease models that guide these itineraries have not been lost in urban families, they constitute a potential and valuable resource in this sort of struggle against the medicalization of life derived from Western cultural and biomedical models, while at the same time suggesting that dialogue between systems should be the key to paths oriented towards integration and models more centered on people and their culture, themes suggested by the approaches of Latin American Collective Health (3).

From the perspective of empowerment in the context of PRA, the participants recognize

themselves as holders of valuable knowledge, which does not need to be validated by the official system because they consider that physicians are not a valid source of opinion in this regard; however, this lack of dialogue between systems means that their knowledge in Domestic Medicine remains restricted to the limits of the home, a barrier that ideally should be overcome. In relation to their capacity to generate transformations, the participants still maintain a somewhat passive attitude, perpetuating the view that it is the official system that should promote the rapprochement between systems; however, they are in favor of supporting various initiatives oriented in that direction, either as individuals or as a community group. In the group sessions carried out, a passive posture is initially observed on the part of the participants (in interaction with researchers who are also health professionals), which progressively transitions towards a more horizontal interaction as the topics approach their field of expertise and move away from the vertical interaction experiences of the health centers. Taking into account that the topic of domestic medicine arouses particular interest in this group, it is plausible for GIAP to mobilize them towards more active roles, especially considering the skills and experiences of this group of women in terms of their capacity to organize themselves, generate resources and define future lines of development independently.

As a future task and challenge, the need for concessions on the part of the health team is seen as part of a necessary dialogue of knowledges. This should start by taking charge of the knowledge gaps in this regard and by recognizing the need to incorporate the cultural dimensions and expectations of people into the work of professional health. This genuine act of humbleness is presented masterfully by Dr. Solar in his Manual for Home Medicine (17), when he recognizes and makes explicit the contradiction represented by a physician writing a manual on the subject.[1] At the same time, it is a challenge for GIAP to promote forms of symmetrical interaction, avoiding reiterating formulas of dependency and assistance that are so traditional in the history of the health system, a process described by Comelles (18) as the acculturation of traditional or "folk" practices.

It is still necessary to deepen the understanding of these issues by incorporating the perspectives of other actors left aside by previous experiences, which have concentrated on the vision of patients and, in particular, of pediatric users. The absence of these other perspectives is one of the limitations of the present study. It is necessary to access the perspective of physicians, both from primary care and other levels of care, other members of the health team, health center managers and decision-makers at the local and regional government level.

Finally, it should be pointed out that the approach to this issue through the PRA experience makes it possible to rescue women's own knowledges, empowering them as valid interlocutors in a potential dialogue between medical systems.

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[1] Dr. Solar, in the forward to his manual, addresses the home physician with these words: "Someday, some grandmother will decide to write and tell her experience of taking care of her parents, her husband, her children and grandchildren; also her neighbors. This book will be the real Manual Of Medicine and not like the one you have in your hands; no doubt it will be better".

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