

\* Original Article

## The viewpoint of the Cape Verdean Community in Lisbon regarding health and illness<sup>1</sup>

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### Abstract

This article is based on a study focusing on sociology in health with a particular focus on the health of immigrants in relation to their representations and practices of health and illness. This article was intended to establish a comparative analysis of the data. The study aims to understand how individuals perceive health, both in general and in their particular cases. A comparative analysis was conducted to highlight the similarities and differences in representations of health or illness. The study was conducted with a sample of 40 first generation Cape Verdean residents in the Lisbon area, who were divided into three subgroups by social group, generation, and gender. We chose a qualitative methodology and used semi-structured interviews to collect information. The results suggest that there are differences between social groups relative to their representations of health and illness. The differences were determined more by socioeconomic factors than by cultural aspects or ethnicity. We found that socio-economic status, more than culture or ethnicity, determines the major differences in perspectives and affects health practices and illnesses when examining a group with the same cultural origins. In general, individuals overestimated their common ethnic identity and cultural origin. These differences have been exemplified in two points of view: cosmopolitan, which is more sophisticated regarding the world and ideas expressed by the elite group; and existential, which is more closely linked to the material conditions of existence and corresponding to the representations made by the popular group. Because they belong to different social groups, people with the same cultural origin and ethnic identity have a shared sense of cultural belonging but not identical behavior and practices.

**Palavras-chave:** Health; representations; immigrants; Social groups

### Introduction

Since the beginning of the 1960's, Portugal has accommodated immigrant populations with very diverse cultural characteristics and distinct immigration trajectories. In recent decades, economic globalization, accelerated urbanization processes, and intensified international migrations have accentuated cultural and ethnic plurality in major urban centers. Despite being far from an "optimal" situation when putting legislation into practice, Portugal is, in theory, a European country with a well-designed policy for integrating immigrants, creating, in practice, conditions that have afforded rights and obligations to foreign citizens since the law in force was first established. The relationship between health and immigration has caused significant concern both nationally and internationally as well as from policy makers and scholars that study the process of integrating immigrants into host regions. Several factors, such as low socio-economic status, poor housing conditions, low income, insecure employment, the psychological stress associated with social exclusion, and the lack of support networks, are related to health and contribute to unfavorable situations for the immigrant. These life circumstances are only a portion of the broader framework in which access to health care is hampered by the lack of information about rights and available services or the lack of sensitivity and knowledge within the health organizations and from health care professionals. These health issues also accompany all of the social and economic problems that are attributed to situations of extreme deprivation and social exclusion. Health has served as a mirror for the entire set of complex and entangled processes that are a consequence of the fragile state in which some immigrants exist.

This article aims to analyze the viewpoints and perceptions about health and illness from within the Cape Verdean immigrant community that resides in Metropolitan Lisbon. This research analyzes issues around the health and illness of the immigrants from a sociological perspective, using a methodology for collecting personal reports, within the field of social representations of health.

Immigrant health is part of a particular framework that interacts with ethnic cultural characteristics. However, assessments of health can vary depending on the goals and context of social and economic comparisons. This article aims to illustrate and describe the multiple representations of health that exist in the migratory context. We believe that the immigrants' representations of health are identical to those of the Portuguese of the same socio-economic status (Sundquist, 1995).

### **Looks, Perceptions, and Representations**

Being sick or healthy implies a subjective interpretation of the origin and meaning of this state. In the case of illness, the meaning given to both the symptoms and the pain are chosen responses that are influenced by personal characteristics as well as the cultural, economic, and social contexts in which the symptoms occur. These responses are culturally constructed in how we perceive, experience, and cope, based on our explanation of illness and given our social positions and value systems. The reaction to pain is a significant example of a cultural construction that is linked to illness. One should therefore question whether this reaction varies depending on the culture and the value attributed to the symptoms. These values can vary greatly in importance and significance, depending on the beliefs, prejudices, and knowledge that each culture accepts and transmits (Helman, 1990). Definitions of what constitutes both health and illness vary among individuals, families, and cultural and social groups. However, cultural factors determine which symptoms or signs are perceived as abnormal. "What is an individual's perception of their health and illness? What does this perception depend on?" Flick asks (Flick, 1992). This perception can vary, on the one hand, as a function of an individual's socio-economic characteristics and, on the other hand, as a function of subjective theories regarding health and illness and as a social representation. The subjective theories assume that an individual holds certain hypotheses regarding themselves and the world. Regarding the subjective theories of health, Faltermaier (Faltermaier, 1992) presents an image of the "invisible" health system of everyday life. The invisible system is primarily supported by women who are not only the "experts" in health but who are also the first to specifically help those who are ill, such as care providers, negotiators, and mediators.

Representations of illness and health can be conceived of as a cultural system that passes from generation to generation within social groups and societies. Formerly, illness was related to poverty and religious beliefs, according to which the sick were often considered to be either possessed by evil forces or victims being punished for their sins. Over time, the relationship between illness and religion diverged, separating body from soul. For most people, health is not a unitary concept, but multidimensional; it is possible to have "good" health in one area and "bad" health in another. It is difficult to conceive of a simple dichotomy between having "good health" and being "sick." To be healthy can be expressed only as an absence of illness, but it is also a positive concept with multiple levels. Normal health, and even "good health," can accommodate a number of symptoms or complaints, as well as functional consequences, an important part of the lay definition of health (Blaxter, 1990). The concept of health statements in the study by Milred and Blaxter derived from responses to two questions, the first addressing the concept of another's health<sup>2</sup> the second addressing the concept of one's own health<sup>3</sup>. Other questions in the questionnaire are important, particularly those regarding beliefs, causes of illness, ideas about health and lifestyle, feelings of guilt, responsibility, and control; these are all aspects that reflect how health is perceived<sup>4</sup> and that invite the subject to evaluate his or her own health. How does an individual recognize the experience of health, subjectively? There were several types of responses, including negative responses (health as in not being sick, health as the absence of illness, health despite illness) and more positive responses (health as a reserve, as behavior, as healthy living, good fitness, energy, vitality, health as in social relations, health as good psycho-social well-being). It is also noteworthy that, in the modern world, health still preserves a moral dimension. Health can be considered in terms of power, self-discipline, and self-control (Blaxter, 1983). In industrial societies, illness is, essentially but not only, a subject for the doctor and the medical community. There is a collective interpretation of illness shared by members of the same social group, which is an interpretation, however, that undermines society and speaks of our relationship with social issues. The social dimension of illness lies in the fact that it is significant and supports our relationship with social issues (Augé, 2000).

Williams (Williams, 1996) addresses the lay perspective on medicine, drugs, the risk of using certain medications, and dissatisfaction with modern and scientific medicine. The degree to which modern medicine is accepted differs between social groups. Regarding ethnic minorities, there is an association between their self-identity and their sense of belonging to a community, given their place of origin and the permanent, distinct aspects of their culture in terms of social institutions (religion, family structure, and marriage), social norms, manners, attitudes, ways of thinking, and social behaviors (food, clothing, health practices) (Williams, 1996).

In regard to illness and its classification, a different approach is taken, compared to that for health, because a specific reality is drawn, including types of well-classified illnesses. Illness is translated into two groups: organic realities, such as pain, temperature, and other external symptoms; and specific behaviors such as cures, treatments, medical resources, and reduced activity. Illness often reveals itself, not through a single symptom, but through several that are coordinated, such as inactivity, doctor visits, pain, and psychological alterations. It is necessary to translate these subjective sensations into objective reality. The symptom is an intrinsic value and a criterion for illness. Each symptom is perceived by the individual as a function of his or her value system and the symptom's relationship with the individual's group.

## Methods

Our central hypothesis assumes that immigrants will have distinct profiles with respect to their "representational" analysis of health and illness, according to their social group, generation, and gender. Culture is considered to be one of the most important influences on health-related beliefs and behaviors and the differences in perceptions of health depend on cultural factors.

We selected a purposive sample of 40 Cape Verdean individuals who are so-called "first generation" immigrants and all of whom are residents in the Lisbon region. The sample was divided into two socio-economic groups, named the "*popular group*" and the "*elite group*," divided based on education, occupation, and family income. The "popular" and "elite" definitions were attributed to each group depending on the previously mentioned criteria, and not corresponding to any social stratification system, nor attributing a particular sociological status to one or the other group. "Popular" and "Elite" only refer to characteristic variables (educational level, professional activity, income) without designating any structurally distinct socio-economic status and with no evaluative or normative connotations. These terms were first used in the Rodrigues study, which analyzed the insertion of the Cape Verdean community into the host society, particularly along the dimensions of space appropriation (in terms of habitat space) and the modes of spatial registration of the community, focusing on the city of Lisbon. The author, in addition to distinguishing three dimensions of space appropriation (economic, socio-cultural, and psycho-social), noted the existence of a homology of a dominant appropriation between the majority Cape Verdean community and the Portuguese popular strata. The study only focused on the more "visible" group and the majority Cape Verdean community, concluding that this Cape Verdean group and that of the Portuguese popular strata somehow coexist and interact. From this study, we began to use this nomenclature to denominate one of the groups in our sample, the "popular" group, and from that decision, we searched to find a term to compare and identify the other group. We used the study by Saint-Maurice on Cape Verdeans in Portugal to adopt the term "elite," based on the typology that distinguishes different generations of immigrants with different social insertions, depending on the period when they first arrived in Portugal.

Analyses by generation (younger and older) and gender (male and female) were also conducted. Each of these groups was composed of 20 individuals. The essential criterion for including elements in the sample was the requirement that all were born in Cape Verde and had lived there for 17 years, inclusively. We chose a qualitative methodology by conducting semi-structured interviews to collect information.

The selected methodology consisted of audio recorded semi-structured interviews conducted with all of the individuals in the sample. These interviews were initiated after contact was made with privileged informants: contacts with the associations connected to the Cape Verdean community in Lisbon and with the community associations based in the most populated Cape Verdean neighborhoods.

Data analysis included a thematic content analysis of the interviews and identification of differences and similarities between and within each subgroup. This analysis allowed us to establish "typical" standards for representations according to the target groups. We sought to find thematic categories, trends in the high frequency responses, and response patterns with similarities and differences. We tried to understand to which group the patterns belonged, and we tried to use these patterns to construct a system or a set of relationships between the response classes and the social characteristics, gender, and generation of the respondents.

## Results

Since the time of European colonization, migrations between regions have been associated, as noticed throughout history, with economic factors. The arrival of immigrants in Lisbon began in the 1960s, when the first wave of Cape Verdeans transformed the region into a very diverse population.

The residential patterns of the immigrant groups illustrate the asymmetries of their economic and social status. Often, one has the idea that people who are from the same place have the same identity, culture, and propensity for particular illnesses, assuming an incorrect image of cultural homogeneity through the countries of origin. The identity of the individuals is sometimes perceived as being from one geographic origin, without considering the cultural variability within the same territory. It is wrong to think that all health care users, Guineans, Angolans, and Cape Verdeans, are "Africans," without further considering the following aspects: ethnicity, identity, culture, language, politics, or economics. Cultures are not "static realities", but are the result of a constant negotiation with foreign countries and with different cultural systems. One can maintain a more enclosed cultural system and simultaneously internalize a set of behaviors that facilitate an easier integration into the host society (Machado, 2002.) Integration is a problematic imperative and a long process. Africans are a group that generally faces more difficulties in integration due to their ethnic and cultural origin, which is distinct from the host society and the prototype of Western culture. Aside from their distinct origin, most of them arrive without economic, cultural, or social equity.

For Cape Verdeans, illness is a totality that incorporates the individual as a whole; in their social and cultural experience, the biological, psychological, and emotional elements of illness are based on cultural and social references that give them their cosmological viewpoint as individuals. The literature that addresses folk medicine<sup>5</sup> in Cape Verde provides references on resources including natural and cultural products, such as plants, minerals, or rituals of diagnosis and healing that can be manipulated by the healer or by the given clientele for a domestic healing. Cape Verdean folk medicine is, according to their cultural habits, transmitted through oral tradition and not used individually but as part of a set that is of daily importance to the groups' survival and its physical, spiritual, and social balance (Rodrigues, 1991).

We intended to analyze how individuals perceive health issues in the context of social representations and subjective perceptions, which are named *Viewpoints*. Medicine, health, and illness constitute a privileged field within the study of social representation. The popular and lay perceptions on health and illness can be studied from different perspectives in the field of subjective theories and social representations.

Analysis of the results demonstrates that there are differences between the social groups relative to their representations and their practice of health and illness. Representations were determined more by socio-economic factors than by cultural aspects or ethnicity. Another determining factor that created variations in the immigrants' health beyond socio-economic position is culture (Smaje, 1995), where ethnicity and ethnic origin are inserted. In this case, culture is viewed as a factor that overlaps socio-economic position in the case of differences in health and illness. However, we know that culture cannot be dissociated from socio-economic factors. The cultural and socio-economic factors influence each other and the socio-economic context is also a cultural determinant. There are named class cultures, and sometimes it is difficult to separate socio-economic context from culture.

We found two ways of talking about life that integrate health issues: a way that states that life conditions are currently good, where health is included as something valuable and positive that determines well-being; and the other way in which the reports on life are less positive, where health complaints arise and are negatively associated with the presence of illness. In this latter perspective, Claudine Herzlich combined the personal perception that individuals have regarding their quality of life and well-being and their health and illness (Herzlich, 1996). The different responses are also a good reflection of what has been reported in the literature on the relationship between health and socio-economic conditions (Venema, 1995). We identified a self-positioning of individuals in relation to life and well-being that was directly related to their socio-economic characteristics, including education, occupation, housing, and income. The different discourses are directly related to the individuals' social position and their material conditions of existence. Differences emerged in the comments produced, but we do not know to what extent that these correspond to real differences in health .

*"Education that my parents, especially that my mother gave me, was always in the sense that it was important to address health and those aspects, she read a lot about this and really informed us a lot on the subject, from the most adequate diet regimes to practicing exercises, she always tried to encourage this idea. It is a concern of mine. I think that without health, there is no quality of life, right? It is a fundamental aspect".*  
{ENT 6: H, MV, GE}

*"It is a permanent concern, in the sense... when you talk about doing the exams, the current ones, the HIV exam, or when I feel bad, I go to the doctor to know what I have. One concern, how one thing...such as food. On the positive side, in the sense of*

*worrying about well-being, feel good and do not let things happen. I take exams every six months, or in the maximum, once a year, in a particular doctor or when I go to a consultation, I take advantage and bring the credentials, for me, for my son, and my husband and everything is fine."* {ENT 44: M, MJ, GE}

Regarding representations of health, we wanted to understand what health means, what concerns individuals have, what their opinions are about their state of health, what notions they have about health and illness, and why and how health is important to them.

In terms of the subjective evaluations of health, there are reports of people from the elite group who identified their health as "more or less" or "not as good as they would like" and revealed a belief that their lifestyles were not adequate for "optimal" health and an awareness that certain behaviors should be changed to improve their health. This awareness demonstrates an "outside" model that is used as a reference from the dominant host society. According to Mildred and Blaxter (Mildred & Blaxter, 1990), for the upper classes, health is a positive and expressive concept, whereas for the lower classes, it is a negative and instrumental concept. To Radley (Radley, 1993), middle class people view illness more in mental terms and working-class people view it more in physical terms. According to the ways of defining health presented by Augé and Herzlich (Augé, Herzlich, 2000), an elite group perceives health as a "health-product" and "health-instrument." For the popular group, health is regarded more as "health-illness," meaning that being healthy is not being sick.

When people hear or think about "health," what does it evoke in them? For the popular group, we identified three response types defining what health is. First, health is the absence of illness, not being sick or having illness or problems. Next, health is a self-assessment of individuals' own health, defined in this case as positive or negative and related to their given condition. Finally, health is associated with the presence of something, for example, value, wealth, life, good mood, joy, being and feeling good, and enjoying a sense of well-being. On the one hand, the elite group also uses expressions that are found in the popular group, such as "well-being, joy, good mood, and feeling good," but, on the other hand, they also use "acquiring good practices for health, balance, harmony, being alive, having a good life, having quality of life, being at peace, happiness, and healing."

As in the popular group, for the elite group, health is the absence of illness and not being sick:

*"Well-being is in first place. Health is well-being... it is physical well-being, if a person feels good about their body... for me, health right now is a sign of freedom. When I think of health, I especially think about the concept of freedom."*{Ent 8: M, MV, GE}

*"The absence of illness. As I have already said, I mean, for me, health is generally the absence of illness."*{Ent 13: H, MV, GE}

This representation is not individual, but is largely constructed with "images" from the dominant culture of the society, which, according to some authors, are social representations (Blaxter, 1983; Sontag, 1998; Flick, 1992). "Health-instrument" and "health-product" were also found within the definitions of what health means for individuals (Augé, Herzlich, 2000). Health as a "health-product" appears in the results when respondents were asked to talk about illness, especially in the elite group.

In our understanding, the trend observed in the interviewees' responses above all meet the first type of social representation of illness: «destructive» illness, a punishment for the individual, a loss of autonomy, and a burden to others:

*"You know... Illness makes me think about... about... about the concern that this may represent and in the burden that this can represent for others, that live with me, and makes me think in something else that is the isolation here that votes on us, acts on us, relative to the world around us "* {Ent 13:H, MV, GE}

*"Illness is... limitation. Illness is sickness and suffering, often it needs medical treatment. Above all illness is... a feeling of loss of anything that a person previously had..."* {Ent 8:M, MV, GE}

In the elite group, we found that illness is defined as a consequence of less healthy behaviors that lead to illness; these are individual behaviors related to lifestyles and connected to the model developed by Herzlich through the health-product idea or as a resulting illness (Augé, Herzlich, 2000). In other reports within the elite group, illness is associated with individual attitudes, moods, and the notion of balance. Therefore, in this group, both when referring to health and to illness, there is a more comprehensive, holistic perspective that encompasses physical and mental well-being, as well as the idea of prevention and of quality of life. It should be added that people from the popular

group are more fatalistic and pessimistic than those from the elite group, at least at the level of discourse about the concept of illness. According to D'Houtard (1989), for manual laborers from the popular level and for the elderly, health is more fatalistic than it is for workers from elite groups or for younger people. As Blaxter (1990) and D'Houtard (1989) state, health is measured by the way people define it, and it is different depending on the social group. The working classes convey a more negative -- absence of illness -- and functional -- able to work -- viewpoint. In comparison, people from the upper classes provide a definition that is more positive, linked to well-being, and emotionally related to satisfaction and happiness, which is evident in our results . We found that, although individuals describe particular symptoms, they also say that they do not feel sick. In these cases, they will continue to behave as healthy people; this result was also found by Reijneveld and Gunning-Schepers (Reijneveld SA, Gunning-Schepers LJ, 1995). If we consider Williams' statement that «the more "integration," the more needs and the values are more similar to the host society dominant patterns and the greater is the sense of exclusion » (Williams, 1993), we can see that this transition occurs in some of the studied cases. However, this does not apply to the "health complaints" in the analysis by social group. Most of the complaints stating that health is poor right now or that it is "more or less" came from individuals from the popular group. We believe that, for this group, individuals' health is perceived more in "internal" terms related to their own bodies and is observed as an instrument in terms of their functionality, ability to work, and ability to be active.

As in studies by Claudine Herzlich (Herzlich, 1996), interviewees distinguished between illness -- a negative concept -- and healthy lifestyles and preventive health practices. At the level of high negative/positive dichotomy or the absence/presence of health, negative responses appear -- health as not feeling sick, health as the absence of illness, health despite illness -- and more positive responses, describing health as a reserve, a behavior, a healthy life, fitness, energy, vitality, social relationships, and a condition of physical functionality.

## **Conclusion and Discussion**

Groups with lower socio-economic conditions and, within these, the elderly, face health and illness in a similar fashion to the "biomedical model," while the comments of the upper class group, the "elite," correspond to the "Bio-psycho-social model." According to Nettleton (Nettleton, 1995), in the biomedical model, health is synonymous with the absence of biological dysfunction. This model is rooted in mind/body dualism, in biological reductionism, and in linear causality. Health is observed to be the absence of illness, without considering the symbolic dimension of illness or behavioral differences. The biomedical model was replaced by the bio-psycho-social model and, later, by theories on social inequalities in health. For Lillie-Blanton and Laveist (1996), health and well-being are functions of multiple interrelated factors, including membership within a social group, behaviors associated with lifestyles, and the use of health services. The concept of positive health emerges, including the behavioral changes that lead to the adoption of a healthy lifestyle, enabling people to have more control over their health and their improvement, and giving personal agency back to the individual. The "ethnic" culture has been mentioned as an important factor in determining differences in the health and illness of immigrants and ethnic minorities, and it has become the center of explanations regarding immigrants' health .

A purely "culturalistic" explanation can omit the meaning of alternative factors, such as class, gender, and age, that can be variables as important as culture and ethnicity in the incidence, diagnosis, and treatment of some illnesses. To overcome these problems, the cultural analysis of health and illness must be balanced with the structural analysis (Smaje, 1995).

Another health model, the holistic model, highlights the importance of individual responsibility and personal involvement, in that the patient plays an active role within the health care team. This model already includes the psychosomatic aspects of health and illness and the relationship between body, mind, and spirit in social, psychological, and physical dimensions. Emphasis is given to preventing illness and examining the lifestyles that, in turn, are shaped by consumption and behavioral patterns (Nettleton, 1995). Health is not only the absence of illness but also manifests itself in well-being and functionality, in interdependent mental, social, and physical aspects, configuring a well-being that results from self-assessment and the expression of a personal opinion (positive) about oneself. This perspective is very similar to the notion of "happiness."

The determining variable to distinguish between representations of health and illness, rather than generation and gender, was found to be the "social group" to which the individuals belong. Similarities were observed within the same social group and differences arose when comparing two social groups. Although we found that the variable that determines the most differences is the social group, similarities between the two groups were also demonstrated. In addition to these findings, we can also conclude that some divergences exist inside each social group when analyzed in terms of

generation and gender.

The results reflect two viewpoints; cosmopolitan and existential. The former perspective is more articulated to the world and relates to ideas expressed by the elite group; the latter perspective is more linked to the material conditions of existence and corresponds to the representations made by the popular group.

Representations of health are translated through a record that ranges from organic -- absence of illness -- to social -- being good to others, being efficient at work (Herzlich, 1996), similar to Maslow's pyramid of needs and corresponding first to the popular group and next to the elite group. The elite group views health and illness as phenomena that are more global and external to individuals; the popular group views health and illness as being more restricted to the body, symptoms, and physiological aspects, giving health and illness a more private and inner meaning. These interpretations match the cosmopolitan and existential views. The representation that individuals have of their health is clearly associated with their educational level (Reijneveld, Gunning-Scheppers, 1995) and cultural capital but less with generation and gender.

Despite the heterogeneity observed, particularly when referring to socio-economic factors, we observed that a unifying aspect exists that arises from cultural heritage. The individuals generally overestimated their ethnic identity and common cultural origin. Belonging to different social groups, but having the same culture and identity, gives rise to a shared sense of cultural belonging but not identical behaviors or practices.

Every health system has two interrelated aspects: the cultural aspect and the social aspect. Modern, complex, and industrialized societies have pluralistic health systems, usually simultaneously containing a popular subsystem (non-medical system related to individual options, including self-medication, advice, and family orientation), a traditional subsystem (folk medicine, faith healers), and a professional subsystem (Western health system). The individuals choose one and/or others, depending on the situation (Laplantine, 1992).

For health care professionals, human beings, in all of their dimensions and vulnerability, are the objects of their professional practice. More than their knowledge and know-how, professionals should develop self-knowledge within themselves and towards the users of the public health care system. Some illnesses can only be properly explained and understood if the health technicians understand their social and cultural dimensions. Medical anthropologic studies show that «traditional healers» are primarily concerned with addressing and explaining the human experience of illness, responding to personal, family, and community expectations. Conversely, doctors and other health care professionals are distant and do not offer the sick what they are looking for and what should be mandatory, which is a true and effective aid relationship that supports their emotional needs. Knowledge about the life history of the sick, relative to their illness, can mediate between their culture, beliefs, desires, and hopes. Health professionals can be led towards a holistic view of the ill. An empathic relationship between the health care technician and the user of the public health care system can be created by establishing a relationship of trust and therefore by creating a true and effective therapeutic relationship. This anthropological approach to the care process allows health care professionals to capture the complexity and wealth of interpersonal relationships and, above all, can confront them with the power of the meanings incorporated by the public health care system user. In summary, the particular interpretations of the processes of illness and the respective appreciation for illness in personal and emotional terms can also reveal the meaning of the individuals' situation or problem. Knowledge regarding the social and cultural dimension of illness can help health care professionals understand how culture, beliefs, and values can interfere in the perception and interpretation of symptoms or illness. This knowledge can also help health care professionals better interpret help-seeking behaviors, leading to their resolution, i.e., to understand the processes of self-recognition and subsequent seeking for assistance.

Thus, we can say that health care professionals, for reasons related to their academic and professional training, adopt the "biomedical" paradigm as their priority. This paradigm is important because one should believe that what one studies is fundamental to explaining illness and promoting healing. Therefore, it is natural that health care professionals are less interested in socio-anthropological approaches to health and illness, and clearly despise the practices of other sectors in the «popular medicine» category, i.e., traditional practices and knowledge linked to illness and healing (Bastos C., 1987).

With this study, we intended to contribute to the knowledge regarding immigrants as citizens and to indicate the need to readjust the health care structures to allow for multicultural transformations, which are currently experiencing a rapid change of pace.

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## Notes

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2 "Think of someone that you know that is healthy. Who do you think about? How old are they? What makes them healthy?"



3 "At certain times, are people more healthy than other times? How is it when you are healthy?"

4 "How do you recognize health, objectively?"

5 Popular, here, refers to familiar and home practices exercised by the community.