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The Pragmatic Knowledge of the People and the World of Abstraction. An Opportunity for Dialogue.

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ABSTRACT: In this review, let us explore the historical and philosophical foundations of health and disease, analyzing how these notions have evolved over the centuries. From religious symbolism to the development of rational medicine, humanity has sought to understand and address health challenges. In this context, we highlight the importance of cultural and scientific practices that have shaped perspectives on the human body and the treatment of diseases.

Over the centuries, health and disease have been interpreted in different ways, reflecting the evolution of human beliefs, values, and knowledge. From the confrontation between rationality and the supernatural, to the rise of scientific medicine, humanity's journey reveals a continuous struggle for answers to existential concerns. Ancient debates about the origin of illness, sometimes attributed to human frailty and sometimes to transcendental forces, have shaped not only medical practices, but also the way societies understand the body and the soul. This duality remains alive, albeit in contrast to the technological and scientific advances that characterize modern medicine.

Keywords: health, disease, knowledge and medicine.

I. Introduction

Care... Prevention... These are concepts that run through the entire history of humanity. Going back in time, we see that already in mythology, Asclepius has two daughters: Panacea, who provides assistance and Hygiea, who protects health. Since the beginning of life, there has been care that is indispensable to the perpetuity of every individual. At the same time, since time immemorial, the individual has tried, by all means at his disposal, to detach himself from the illness and suffering that disturb him. For in no society has this fatalism of disease been fully accepted, inasmuch as, from a very early age, individuals began to resort to human, divine means and empirical remedies to combat this curse. This fact justifies that, over time, individuals have learned and accumulated *knowledge, beliefs and experiences* about care and prevention. Depending on the social, economic and cultural environment in which they operate, they have different conceptions of health and disease, using different means that enable cure. Thus, in the face of a situation of illness, medical knowledge is sought, however, when it does not give an immediate answer, witches, straight heads, alternative medicine and saints are resorted to.[1] It should be noted that through information received from previous generations, traditions, personal experiences, information given by health professionals and a collective memory, which has not been erased over the centuries, man accumulates all the *health knowledge* to which he resorts whenever the situation imposes it.

[1] Pierre Adam and Claudine Herzlich, in a 1994 study, state precisely that when faced with a given problem, individuals conceive rituals and address, indistinctly, healers, witches, magicians, priests and saints, whose practices include empirical remedies, magical rituals and religious help.

Traveling back in time, we realized that the practice of this care was built, mainly, around everything that was fertilizable and that gave light. In line with this thought, we mention that it has been up to women, throughout the evolution of the history of humanity, up to the present day, to take care of everything that grows and develops: *taking care of children, the elderly and the sick.* Analyzing the literature, which tells us about this subject, we complete our thought by stating that for centuries, women were *doctors* without a degree, without a course and without access to books. They built a *peculiar knowledge* and transmitted their experience, particularly to their daughters. Looking at the present, we feel the reflection of this cultural past, which currently still elects, within the family, women for health and disease care. Several studies carried out in recent decades at national and international levels (M. Segalen, 1981; F. de Almeida, 1994; G. Cresson, 1995; J. Kaufmann, 1996a; B. Nunes 1997; C. Saraceno, 1997; M. E. Leandro, 2001a; among others) have evidenced, precisely, this peculiar dedication of women to this care. We have always heard about maternal care provided on a daily basis since the beginning of human history. This primordial function, inherent to the survival of every living being, begins at birth in the bosom of the family. Thus, what is constantly evident, from a diachronic perspective, is the fact that in human societies, all individuals need care and protection[2] and these same care and protection are given, at first, at the heart of the family.

Issues involving the health of individuals seen today as a fundamental value of life are currently reaching concerns of inexorable dimension. However, we remind you that this concern for health dates back to time immemorial. According to some authors, such as Armando Sousa (1996), the concern with health is as old as humanity. It is not necessary to reflect deeply to admit that from the most distant times, the individual has tried, by all means at his disposal, to detach himself from the illness and suffering that disturb him.

Through the millennia that Humanity has lived and the documents that have successively accumulated, lost and modified, there have always been concerns, experiences and concepts about health and disease. We will briefly try to establish a schematic line that translates this concern with health since time immemorial.

Going back in time, it is said that Asclepius (in Greek, Asclepius), son of Apollo and a nymph, was interested in the sick and cured them. Asclepius had two daughters who continued his work: Hygiea, from which hygiene was born and who avoided diseases, and Panacea, who cured them. After his death, men recognized him as a god and the priest-physicians consecrated a temple to him. In the fifth century B.C.C., in Greece, the medicine of the Asclepiades is contested by the secular doctors who held philosophical reasoning as a foundation. Pythagoras inspires the Croton school, which criticized the Asclepiades and rejected recourse to the divine in the search for harmony between man and nature. Hippocrates,[3] universally venerated as the *Father of Medicine* in the medical field, personifies this tendency. The essence of Hippocrates' teaching can be summed up in one sentence: *"Diseases have a natural and not a supernatural cause, which we can study and understand."* (M. Tubiana, 2000, 36).

Hippocrates thinks that one can, thanks to reason, construct a logical medicine and give a rational explanation for the symptoms of disease. Thus, he takes the patient's observation as a starting point and states that nothing can replace clinical data. Based on observation, he tried to construct a logical doctrine of disease. It should be noted that the teachings of Hippocrates symbolize a historical milestone in the *operandis way* of dealing with disease.

[2] Remember that there are periods when this care and protection become special, such as in childhood, old age or a period of illness.

[3] Such an honorable qualification does not imply that he invented medicine, but only that he deserved the recognition by doctors of all times, of his originality, independence and elevation of the paths opened by him to medicine. Little biographical data exists about Hippocrates. It is known, however, that he was born on the island of Kos, from a family of ancient medical traditions, the son of a doctor who was his first teacher. The authors agree to fix the date of his birth around the year 460 BC (Sousa, 1996).

Thus, twenty-five centuries ago, the first conflicts already highlighted the sentiments that would oppose each other throughout the history of medicine: rationality against the appeal to the supernatural, prevention against treatment, fear of transgression against the hope of a miracle. Since antiquity, too, two different conceptions have been confronted: the sick person is responsible for his illness or, on the contrary, he is the innocent victim of unfortunate chance. Pythagoras, in *Gorgias*, made Socrates say: Is there a more precious good for man than health? The answer is, indisputably, "*no"*. This explains the place of medicine in all civilizations (M. Tubiana, 2000).

We cannot, however, forget that if, today, scientific medicine prevails over primitive medicine, it was the latter, which until it reached the scientific spirit had a monopoly on the treatment of ailments of the body and soul. Recovering one's health, after an illness and living long, have constituted, since the dawn of humanity, excruciating concerns. But in order to recover this health, man has not always followed a scientific attitude, but has followed the paths of *empiricism*, *religion* and *magic*, doubtless, at first, guided by the impulses of his own nature. Man has always relied on supernatural interventions: amulets, talismans, elixirs, which since the Middle Ages have nourished the illusion of light medicine until the return to nature presented as a panacea.

For example, in primitive civilizations, diseases could be attributed to the *Loss of the soul*, stolen by spirits or sorcerers. The healer sought the soul and reintegrated it into the body of the patient. This ritual was linked to the idea that, during sleep, the soul left the body. Under another theory, the disease was due to the presence in the body of a foreign object that would be introduced by a sorcerer or by accident. Maurice Tubiana (2000, 25), in this regard, states that: *"Over the course of a complex ceremony, which varies from region to region, the shaman extracts the culprit object (often a caterpillar) usually by suction, sometimes by massage, and shows it to the patient, who often declares himself cured."* Another alleged cause of illness in these primitive societies was the appropriation of the patient's body by spirits. Here, the use of magical rituals to expel the demon was imposed.

Another interesting aspect of medicine is the permanence of beliefs, which we find throughout history in various forms. Religious belief is often a mode of explanation. The medicines that preceded the blossoming of true medicine illustrate the existence of close relations between medicine and collective beliefs, in particular, religion. For example, at the time of the great epidemics, characterized by high mortality rates, the need for immediate survival led to a greater relationship between man and the divine, since the knowledge they had did not allow them to understand the causes for the high deaths that occurred. In a mixture of impotence and horror, they were left with confidence in the divine and in its earthly representatives, whether they were priests, magicians, sorcerers or witches.

Punishment[4], the evil eye, the curse, and sorceries were presented as a source of disease. Maurice Tubiana (2000, 27) mentions in this regard: *"Any sorcerer can cast a curse, it is even his main function; but popular*

[4] We will refer to Hippocrates to illustrate this view of disease as a punishment, and particularly as a divine punishment, in some peoples. This author (1994, 119-121) tells us: *"(...) among the Scythians there are many impotent men: they condemn themselves to perform the feminine tasks and speak like them. They call them effeminate. The natives attribute the cause of this impotence to the divinity, venerate this kind of men and adore them, each one fearing for himself such affliction (...). That is how, in my opinion, this impotence arises; is due to the fact that the Scythians constantly practice horseback riding, which causes swelling in their joints, since they place their feet next to the horse, which even generates lameness and distension of the hip in those who suffer most severely from the disease. They treat impotence in the following way: when the disease begins, they open the vein located behind each ear. When the blood flows, the weakness leads to sleep and they fall asleep; then they wake up, some cured, others not (...). Once this operation has been performed, when they join a woman and cannot have sex with her, they first worry little and rest. But if two, three or more attempts do not work, they imagine that they have committed some offense against the god to whom they attribute their affliction (...). They*

superstitions attribute this power to many others, for example, to women, whose gaze may, during the menstrual period, harm small children (...)." Mesopotamian medical texts, for example, consider illness to be a punishment that sanctions the conscious or unconscious sins of the patient or a member of his family. "*The gods withdrew their protective hand and allowed the demons to take hold."* (M. Tubiana, 2000). These demons were usually incarnations of the souls of the deceased, who had not been buried according to the rites or to whom the necessary offerings had not been made. An interesting aspect is that in the fourteenth century sorcerers assumed such a place in the collective unconscious that the Inquisition was in charge of their repression.

Subsequently, in the Christian West, the religious conception of evil is that illness is linked to an irremediable destiny: illness is sent by God, by virtue of man's sinful nature and is conceived as an occasion for redemption (P. Adam and C. Herzlich, 1994). In the Holy Bible we find this vision of sickness – punishment: *"The sinful people are likened to the sick"* (Jer 5:3); *"Sickness among the Hebrews was regarded as a punishment for sins"* (Deut 28:27-28); *"Certain diseases had a religious significance"* (2 Kings 5:8). It should be noted, however, that in no society has this fatalism been completely accepted, inasmuch as, from a very early age, individuals began to resort to human, divine means and empirical remedies to combat this curse. Thus, individuals conceive rituals and address, indistinctly, healers, witches, magicians, priests and saints, whose practices encompass empirical remedies, magical rituals and religious help (P. Adam and C. Herzlich, 1994). We cannot forget that, although the Catholic Church is opposed to these beliefs and practices, particularly with regard to magic and witchcraft, it is worth remembering that it has also been creating its set of miraculous saints and/or healers, so we have some saints with names linked to health: Our Lady of Sorrows, Our Lady of Remedies, Our Lady of Health, São Brás, São Gregório (among others).

Be that as it may, the relationship between disease and transcendental forces is still present today, as soon as disease arises and scientific and technological means are unable to provide an immediate and effective response to certain problems related to this issue. According to some authors, such as Geneviève Cresson (1995) and Marcel Drulhe (1996), the coexistence between magic and religion characteristic of ancient medicines, whether of a knowledge and science nature, or popular exists in all cultures and has prevailed to this day, although the technical and scientific intervention of health professionals, both doctors and paramedics and the medicalization of contemporary Western societies are increasingly consistent.

It is pointed out that modern medicine was born when man renounced these mirages. Currently, modern scientific medicine is characterized by the predominance of an empirical orientation, as well as by the constant specialization of health professionals, especially the medical staff, and by the execution of scientific and technological knowledge, which is increasingly subtle. However, it should be remembered that at an empirical level this does not preclude the persistence within Western societies of various elements of a religious, traditional or other alternative and/or complementary means, as well as issues related to health and disease.

After this brief historical review that the health sphere has gone through, we have returned to the idea that, today, health remains as in the past an indispensable value of life.

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declare their impotence. This disease affects (...) not the men of the lower classes, but the rich, the most powerful by nobility and fortune, horseback riding is the cause, and if the disease attacks the poor less, it is because they do not ride horses. And yet, if this disease were more divine than the others, it would not be exclusive to the noblest and richest Scythians, and would affect all in the same way, and preferably those who possess the least and do not offer sacrifices, it being true that the gods are pleased with the homage that men pay them and return favors to them. For the rich can immolate countless victims, present offerings, and use fortune to honour the gods, while the poor cannot do so, owing to their poverty. Thus, the penalty for such offenses should fall on the poor rather than the rich. (...) every thing happens according to the laws of nature, and the disease I refer to comes, in the case of the Scythians, of the cause I have pointed out."

Several studies carried out both nationally and internationally (E. Leandro and M. Pato, 1997; M. Drulhe, 1996) show that health concerns are present in each one of us, regardless of age, gender, profession, resources, political or religious preferences, etc... Just look at how the issue of health has mobilized all electoral campaigns and many political debates in Portugal over the last few years. Health is a matter of concern to public authorities. Health expenses are increasing and people are not satisfied, which worries those who govern us. The rising cost of the health system is not accompanied by a parallel improvement in the health status and entails expenses that are difficult for the nation to bear, as they deprive other sectors (e.g. the education sector) of useful resources. For example, in the health sector there are funds that would probably be more effective if they were earmarked for prevention and/or health education in schools. Nevertheless, health indicators reveal significant changes. Progress can be seen in national coverage and access to medical care. Thus, health is one of the first, if not the first priority of people and governments. It is seen as the key element of well-being and the organizer of other areas of life.

It is also worth noting the important work in terms of health and disease care performed by the profane, especially the family and not always recognized as such (G. Cresson, 1995). We take care of the sick and no one thinks about the family, we think almost exclusively about health institutions. However, we forget that institutions only take care at specific times and the family takes care whenever one of its elements needs it. Health institutions have only a small portion of the population in their care. The sector of assistance in the event of illness remains entrusted to families. Most diseases, obviously, do not pass through the hospital and, sometimes, not even the doctor, they continue to be left to family care (C. Saraceno 1997). A similar opinion is shared by Maria Engrácia Leandro (2001a, 86) when she states: *"In truth, it is verified, as soon as someone needs care that prolongs or secularizes the medical or hospital act, that it is, in the first place, the family that is appealed to carry out this task. In addition, it is through the relationship that is established between the doctor and the family, namely with the woman (wife, mother, grandmother or daughter), that this triangle of mediation is most directly established: doctor – patient – family."*

However, this family management of care, around health and disease, is little studied in sociology. Geneviève Cresson (1995, 110) studied this problem and refers us to this reality, saying that "thefew studies that exist are mainly interested in this work as a complement or a substitute for professional activity, for example, in cases of dehospitalization at home or diagnosed serious pathology."

Thus, from a theoretical-empirical study, whose basic unit of analysis will be the family, we propose to achieve an objective: *to try to understand the ways in which the family invests in health and disease care, with its elements, aiming at preservation or cure when the situation imposes it. We also try to apprehend the knowledge of a family, traditional or medicinal nature, as well as the practices that mobilize families whenever necessary.*

This theme is of due relevance to the researcher who explains and develops it, with the objective of collecting information that allows an appropriate view of the care of families with health and disease. It is also important to try to understand the knowledge and experience reproduced within families, over the generations, such as the knowledge that mothers transmit to their daughters. It is important to study the therapeutic alternatives of families from self-care, advice from neighbors, grandmother, mother, family, the use of magic, religion, saints, straightening, the woman of virtue, witches, herbalists. In other cases, for example, a consultation in the so-called alternative medicines including homeopathy, naturopathy, chiropractic, etc. can be promoted. These medicines, similar to what has been seen in Europe and North America, seem to have a growing popularity in Portugal. When medical science does not give the answer that the profane want, they resort to other agents, who reveal a systematic, ordered knowledge and who have instruments capable of interpreting the disease and acting on it. Individuals, according to the social environment in which they live, with the information they have and the degree of anxiety that a certain disease has triggered in them, resort to various fields of medical knowledge and not only to medical science. Disease is currently in the hands of medicine, but it remains a phenomenon that transcends it everywhere. As stated by Claudine Herzlich (1994), the information given by the doctor and the diagnosis he presents to us and which, in most cases, we accept, are not enough to answer. For this reason, and as we have already had the opportunity to mention, the profane try to respond to the challenge of completing the medical perspective through another one, which seems to them capable of solving the problem that worries them.

Next, we will focus our attention on health and illness inscribed in a family context. We emphasize the essential role *of the family* in issues related to health and disease, as it remains at the core of care, as soon as disease arises and, identically, in its prevention. Ian MacWhinney (1994, 176) referred to the importance of the family in family medicine in these terms*: "The importance of the family is inherent to the paradigm of family medicine. Family medicine does not separate the person's illness or the person from his environment. It recognizes that health and disease are strongly related to personality, way of life, physical environment and human relationships. He understands the strong influence that human relationships have on the outcome of the disease and recognizes the family as the crucible of the person's development."* Surely we remember our grandmother or our mother giving us a macela tea for tummy aches. Possibly, we never asked them, as children, why did they do this? Most likely not. Although no one has established it as a law, we all know, almost by instinct, that our grandmothers and mothers are the ones who take care of the family's health and who take care of the prevention of diseases. Throughout history, care for the health of the family has fallen, particularly, on mothers. This last aspect seems pertinent to us: the *primordial* role of women within the family and their concern with caring for and preventing health and disease, as well as the medicinal, family and traditional knowledge that the mother mobilizes when someone in her care falls ill. Geneviève Cresson (1995) points out that women are the main producers of profane care within the family. Also in this regard, Berta Nunes (1997, 190) states that *"(...) The role of women with regard to family health ranges from daily care that contributes to the maintenance of health and prevention of disease: food, hygiene care, warm clothing, etc., to decisions regarding the treatment of current diseases and serious illnesses."*

Going back in time, as early as 1876, the hygienist Fonssagrives, wrote in the *Dictionary of Health*, declaring himself determined to teach women the art of domestic nurses, aiming to make them the most direct collaborator in the fight against disease and preservation of health. Fonssagrives had the ambition to make women a guardian of disease. However, he stressed that "*the role of mothers and that of doctors is and should be completely different. One prepares and facilitates the other"* (Fonssagrives *in* Donzelot, 1977, 23). The role of the doctor and the mothers, although distinct, complement each other. Thus, *the doctor prescribes and the mother executes.* (J. Donzelot, 1977).

Regarding the action of the medical profession, in the opinion of Jacques Donzelot (1977, 23): *"This organic link between medicine and the family will have a profound impact on family life and will introduce its reorganization in at least three directions: 1. The closing of ranks of the family against the negative influences of the old social educational environment, against domestic methods and prejudices, against all the effects of social promiscuities; 2. A privileged alliance with the mother, leading to the promotion of women by virtue of the recognition of their educational usefulness; 3. The use of the family through the doctor against the old teaching structures, religious discipline and the habit of boarding schools."*

This author alerts us to the fact that, until the middle of the eighteenth century, medicine was not interested in children, nor in adults. Women were seen only as reproducers (J. Donzelot, 1977).

In the course of time, it became apparent that within the bourgeois family, it was the servants who educated the children. They educated spoiled, capricious, sensitive children, particularly susceptible to diseases and difficult to cure, because they did not follow the doctor's treatments. The need arises, then, for an ally for the doctor - the mother - the only one capable of imposing her power on the child. The importance of this alliance emerges from the end of the eighteenth century. The doctor provides a social status to the woman. According to Jacques Donzelot (1977, 25), *"it is this promotion of women as mothers, as educators, as medical assistants, that will serve as a point of support for the feminist principles of the nineteenth century."* In the lower classes, according to the opinion of the same author, the intervention of families in the health issue was different. Illiteracy was felt until the end of the nineteenth century, people did not have the economic means to have a family doctor and the problems they presented were completely different.

In 1865, the first societies for the protection of children appeared in Paris and Lyon. These were intended to ensure the medical inspection of children in the nannies and, together, to assess the education systems, the methods of hygiene and the control of children from the poor classes. (J. Donzelot, 1977).

It is therefore very essential for the mother to participate in the preservation of health within her family. Take, for example, her constant concern about taking care of her children, her husband and family members she may be in charge of. When, for example, it is necessary to follow up with the doctor, the mother is usually always present, we will say that the mother knows when someone needs health care. This care represents a whole set of acts carried out on a daily basis, with the objective and function of maintaining a healthy life for its members and to allow family life to reproduce and perpetuate. It is worth pointing out all the work that the family does to keep all its members in good living conditions: the constant concern with food, clothing, shoes, hygiene, studies, the doctor, medication, in short, with the well-being of all its members. We see, especially, the mother's concern that everyone should dress warmly and eat well, whether it is the children, the husband or some elderly relative who has her care. In case of illness, the first care is usually given at home. The mother measures the fever, makes a tea, gives a suppository, a cold water bath, etc. We observe that basic care in disease issues begins in this *vital cell* of society. However, we must not forget that there are ages in life when this concern is more intense, such as childhood or old age. The sexual division of domestic work thus makes the woman in the home a primary actor in health promotion.

Another aspect to highlight is the mother's educational level. This is closely linked to the economic and cultural level. However, the most important thing is, that it is inseparable from the mother's attitudes, expectations and beliefs, which concern her and her child. It is plausible to think that a family with a high level of education ensures adequate health care for their children. It is admitted that mothers with a high level of education break more spontaneously with tradition, becoming less fatalistic when facing a situation of illness, more capable of receiving attention from health professionals and, at the same time, more aware of their rights and how to use them in favor of the health of their children (T. Rathwell, 1992). These mothers are more persevering in applying medical treatment and are more likely to contact the doctor if the illness persists. This author also mentions that more educated mothers have a greater capacity to play a decision-making role within the family, to contest the opinion of family members, to communicate more openly with their husbands and to provide more means for the survival of a child. Following the same opinion, we highlight Geneviève Cresson (1995) who proves that, regardless of the distinctions arising from gender conditions, it is families with more educational qualifications and a better social condition that are more involved in terms of health. As an example, we mention that these families are more careful with their diet, more concerned with hygiene and more often turn to doctors, following their advice more thoroughly.

After a brief reflection on the essential role of the mother in caring, we can start by asking ourselves what can families do on a daily basis to prevent diseases or take care of the health of their members?

It is known that the key to staying healthy is prevention; However, it is often difficult to know everything that can be done daily to avoid diseases.

The prevention of the disease is intended to avoid certain behaviors that increase the chances of getting sick (C. Paúl, 2001). There are certain risk behaviors that we should avoid, such as being careful with fats, excessive salt, tobacco, alcohol, narcotics, unprotected sex, among others. Mention should also be made of road accidents, often resulting from excessive alcohol and certain risky behaviours. It should be noted, however, that some behaviors and habits (eating, sleeping, sports, etc.) of individuals are influenced by the pressures of the environment, by the society in which they are inserted, by the education they have received, by the socio-professional environment, by family, by friends, by the media (among others). These factors play a vital role in the health of individuals, particularly in adolescence and young adults. Regarding risk behaviors, Maurice Tubiana (2000) points out that about 75% of cancers and more than half of myocardial infarctions are essentially due to the way of life of individuals. He points out as factors responsible for these pathologies, tobacco, alcohol, dietary imbalances, food excesses, sedentary lifestyle and lack of physical exercise. Maurice Tubiana (2000) points out that in 80% of cases road accidents are due to driver failures caused, in more than half of the cases, by excessive alcohol, drugs and tranquilizers. It should be added that these risk behaviors are at the origin of premature deaths

in young adults. This is because the ingestion of licit drugs, such as tobacco or alcohol, or illicit drugs, begin to gain ground in adolescence, [5] a period in which young people go through psychological crises.

Regarding prevention, we cannot fail to focus on a very important aspect: the lack of information about health in our country, especially when it comes to disease prevention, is enormous in some social groups and in some parts of the country. This lack of information prevents us from doing what is necessary to ensure good health; If we don't have good basic information about prevention, we will never know how to put it into practice in our lives. However, we find that there are isolated villages in the interior of the country where the population does not have a family doctor (which means that they are not given information on the prevention of certain diseases) or, if they do, they are countless kilometers away. These populations, with few educational qualifications, are very few sensitive to, for example, being careful with a diet low in animal fats, consuming fruit and vegetables, practicing physical exercise (sports, walking, swimming...) to avoid future health problems, such as obesity, cancer or cardiovascular diseases. Thus, these populations have increased health risks. The same can be said of the disadvantaged classes who, for example, do not have sufficient economic resources for a balanced diet, and have dietary imbalances (we must not forget that certain individuals from the privileged classes also take up risky behaviours, drinking excessively, driving at high speeds, etc...) that put their health at risk. For example, another important aspect is preventive measures during pregnancy, such as prenatal care to detect possible health problems. A question arises, to what extent are families with low economic resources sensitive to this issue?

It is also known that an indispensable aspect in the prevention of diseases is vaccination. Among us, there are few children who are not vaccinated. It is a duty of parents, as this way they preserve the health of their children and prevent the installation of some diseases, which, if not controlled, can become epidemics. Thus, parents should consult with health professionals about what vaccines mean and when and how they should be administered. Parents from disadvantaged classes may show little sensitivity in consulting these professionals. This low sensitivity can cause numerous health problems in children, precisely because they have not been given certain vaccines that are essential for the prevention of certain diseases (such as the vaccine for tuberculosis, hepatitis, rubella, tetanus, measles, mumps, etc.). Another essential aspect to highlight for which parents must be sensitive, attentive and informed, in the twenty-first century, are preventive measures for young people. See, in the interior of the country, the regions where information does not arrive or arrives very late. See, also, parents with little educational qualifications and their little or no knowledge with regard to these preventive measures. Is this not a problem, knowing that among adolescents there is a vulnerable group, which consumes drugs and alcohol, smokes and initiates sexual intercourse at a very early age, and is therefore exposed to suffering from sexually transmitted diseases such as AIDS, syphilis, gonorrhea and many more? We must not forget that there are preventive health programs and services dedicated to young people; At the same time, we must not forget that some sections of our society do not have access to this information. Steps need to be taken to raise awareness of these issues, which are essentially geared towards the socially, culturally and economically disadvantaged classes. We must not forget that although we focus particularly on preventive measures for children and young people, preventive measures for women, men and the elderly are also extremely important.

Another aspect to be highlighted, no less important, is that it is often found that the interest that individuals give to the body increases with their social position. In the popular classes (more disadvantaged) life difficulties may be responsible for the fact that certain conditions are not given importance, for example. Illness is considered by these classes as a sudden and important alteration of their faculties, capable of making it impossible for them to perform their daily activity. In the favored classes, on the contrary, disease is often considered as a progressive alteration of health that can be prevented or cured in all its stages. These classes attach

[5] Adolescence is inevitably distressing because it is located at the hinge between childhood, during which one lives protected in the family cocoon, and adulthood in which one must provide for one's needs and lead a more independent life. This anguish is accentuated when the outside world is felt as hostile or inhospitable (M. Tubiana, 2000).

greater value to prevention, they do not hesitate to go to the doctor for a health problem of no great importance or for the simple act of prevention such as vaccination (A. Béresniak, 1999).

According to the author mentioned above (1999), farmers are a profession that makes little use of doctors and, at the same time, consumes few medicines. In rural regions, there are often geographical difficulties in accessing doctors or pharmacies and very little use of preventive medicine. It is important to note that, on the other hand, their hospitalization rate is higher and they constitute, together with factory workers, the professions with the most serious physical disabilities. On the other hand, the staff consume more expensive care and seek specialists and dentists more frequently. They carry out more laboratory tests for screening or surveillance. It is generally accepted that higher socio-occupational categories are more sensitive to preventive measures. Their education makes them more aware of prevention.

From the perspective of Ali Abdelmalek (1999), members of the popular classes experience the disease, in most cases, under the model of an accident, as confirmed by the expression *falling ill*. In this conception, to be in *good health* would be to forget the body. It should be added that, objectively, the difference in life expectancy according to social classes and professions favors a representation of the disease as an unpredictable and brutal accident. Hence, we can point out another relationship with treatments: if the disease is a sudden accident, the doctor is asked for an energetic remedy with an instantaneous and almost magical effect (note, therefore, the enormous symbolic value of the injections). In the members of the upper classes, accustomed to anticipation, the disease would be apprehended in advance, due to the announcing signs and symptoms. Illness is not seen as a brutal accident, but as a long perversion of health; it is inscribed in time. This explains a more favourable relationship with the principles of prevention: not overeating, playing sports, respecting the diet, having regular preventive check-ups, etc...

Cultural, social and economic factors are thus at the origin of differences in behaviour with the health of individuals, because they translate into different ways of life. It is also these ways of life that give rise to differences in exposure to disease risk factors. Thus, prevention is increasingly indispensable, as it is realized that the behaviors of individuals influence illness. By promoting people's voluntary and early adherence to certain behaviors, we can regulate their health (C. Paúl, 2001).

It should be noted that the prevention of the disease currently occupies a peculiar aspect of the concerns of individuals. According to Constança Paúl (2001), prevention is divided into: *primary prevention*, which aims to promote actions aimed at avoiding the appearance of diseases, we can mention, as an example, vaccination; *secondary prevention*, which aims to intervene as early as possible at the first signs of disease; and, finally, *tertiary prevention*, which aims to prevent disability resulting from a disease.

The prevention model suggests that changes in behavior occur when the individual realizes that his or her behavior may lead to unhealthy or unhealthy conditions and that eliminating this behavior and/or adopting another reduces the likelihood of disease or disability. Here, the emphasis is placed on individual responsibility for health, which is the philosophy underlying most health prevention campaigns. There are several theoretical models of prevention that try to explain and operationalize modes of intervention with communities. Take, for example, the measures that gravitate around the prevention of road accidents, ranging from speed control, to zero tolerance on the roads, to the mandatory use of seat belts and the control of alcohol in the blood. Unfortunately, these measures have not yet produced the desired results. Another example is adolescent prevention programmes in schools which include subjects such as the prevention of drug use, ways to avoid alcohol and tobacco abuse, their consequences and preventive actions to be taken, the risks of sexually transmitted diseases and how to combat these risks, the prevention of teenage pregnancy, and so on...

We have been focusing on some factors, such as economic factors, which influence the explanation of health and disease. Next, it is important to refer particularly to these factors as well as cultural and social factors in the explanation of disease and, equally, of health seen as *the state of complete physical, mental and social well-being, and not only the absence of affections or disease*, as the definition of the World Health Organization in its 1946 Magna Carta refers to.

We find many historical references to the evolution of medicine that relate its progress to the health of populations over time. These references sometimes place more emphasis on the evolution of medical knowledge,

other times they do so in relation to the evolution of the socio-economic conditions of societies taking into account the improvement of health indicators.

The perspective that privileges the improvement of medical discoveries is based on the positivist current, which started with René Descartes and had its development in the eighteenth and nineteenth centuries, particularly from Auguste Comte. Its beginnings are based on an idea of science, which is characterized by the study of facts that, as opposed to beliefs, can be observed empirically, aiming at the knowledge of the universal laws that govern them. It is believed in the possibility of accessing absolute knowledge of the invariant aspects of phenomena, making them predictable. Biomedicine is the maximum expression of Cartesian dualism, in which the mind appears separate from the body and in which the latter is seen as an object of knowledge subject to universal laws (C. Paúl, 2001). Alternatively, critical perspectives emerged that underline the social construction of medicine and valued the historical, social, economic and cultural interpretation of phenomena, calling into question the absolute and universal value of medical knowledge. It is in this perspective that we situate ourselves and it is in this that we will reflect.

Thus, several authors (J. Pereira, 1987; B. Nunes, 1987; A. Enelow, 1999; M. Augé, 1994; C. Herzlich, 1994; M. Quartilho, 2001; among others) have proposed the inclusion of such cultural, economic and social factors in the understanding of disease, and one can speak of a biopsychosocial model of approach to health and disease, as opposed to a biomedical model. The view of biomedicine, centered on an individualistic view of disease and suffering, often ignores the social and cultural environment in explaining the functioning or dysfunction of the body and, consequently, in explaining health and disease. It is the vision of those who only see the disease and devalue the entire surrounding context. The biopsychosocial model is important for understanding the sick person and their disease, the whole context in which they are integrated. Thus, scientific, medical, economic, social, cultural factors, among others, combine and lead medical thought to give increasing attention to these factors, deviating from the classical theoretical framework of biomedicine.

At the end of the twentieth century, health care changed with the development of medical sciences and technology. It is essential that training and medicine do not focus particularly on the biomedical and technological aspects of healthcare, to the detriment of a global view of the patient. Medical training advocates that the doctor listens to his patient's words, the feelings behind them and, simultaneously, the context in which they arise. The sociocultural history that accompanies the biomedical aspects was called *the voice of the living world* (E. Mischler, 1984). This author argues that only the *voice of medicine* is heard, which leads to a reinforcement of the patient's biological symptoms. To understand the disease and the patient who has it, it is essential to listen to both voices, emphasizes the author. In doing so, the physician apprehends the true causes of his patient's visit, as well as his beliefs about health and disease. According to Ali Abdelmalek (1999), it is necessary to listen attentively to the patient, as the patient's experience can become a basic value. In this regard, we emphasize that from what the patient says and feels, the doctor only retains what finds an echo and makes sense in the medical discourse, often skirting the question of what the patient feels. This question is likely to provide valuable information to translate the symptoms into known clinical conditions. It will be from these perspectives, which include these cultural, social and economic factors in the explanation of health and disease, that we will talk about, in the theoretical framework, when we define the two concepts.[6]

In this chapter, we emphasize that the disease emerges as a socially and culturally determined and influenced construction. According to Susana Duarte, (2002, 55), *"the way the individual talks about health problems, how they present the symptoms when and where help is sought and evaluated is influenced by cultural factors."* On the other hand, Ian MacWhinney (1994, 81) states the following: *"One of the most important determinants for the interpretation that a person makes of his disease and the expectations in relation to the doctor is the culture or subculture to which he belongs (...)."* This author, throughout his work, emphasizes culture as something that we should not forget in the field of medicine. José Pereira (1987) states that for the understanding,

[6] The concepts of health and disease (along with the notion of family, gender and domestic health work) are fundamental in our study.

recognition and treatment of patients, as well as for health promotion, it is essential to encompass all the variables involved in both health and disease.

If we attribute relevance to culture, as it appears as a fundamental factor in the beliefs and knowledge of individuals, the same can be said for the social, as it has proved to be important in determining the disease. If the evolution of medical knowledge and techniques makes diagnoses and treatments more and more specific, we cannot ignore the issue of the cultural and social dimensions of health and disease. In fact, lately, we can see that the exclusive use of the treatments intended by the medical model is increasingly called into question. We can only recognize the abundance of so-called alternative medicines: osteopathy, acupuncture, bioenergy (among others), to realize that disease is first and foremost a social fact. "*In all societies, disease can be associated with social factors* (...). *Disease is first and foremost a social fact: its nature and distribution are different according to times, societies and social conditions*." (C. Herzlich, 1994, 189). Marc Augé (1994, 36) emphasizes, *"it is very much the paradox of disease: it is at the same time the most individual and the most social of things (...) because the schemes of thought that allow their recognition, identification and treatment are eminently social; To think about your illness is to make reference to others."* To illustrate this cultural and social aspect of the disease, we consider it pertinent to refer to a study by Marc Augé and Claudine Herzlich (1994). Let's look at the blood sputum, from the outset, we think that it can only be explained by a biomedical cause. However, Marc Augé and Claudine Herzlich demonstrate that it can understand a social and cultural meaning. A tribe of the Ivory Coast, the Alladians, call *Pisa* the disease that contributes to the weakening of men, due to the sputum of blood. This tribe does not attribute this disease to problems related to cancer or tuberculosis, for example, but only to adultery of women. At first, this explanation seems strange to those who do not know the culture of this tribe. It is important to know that by virtue of a symbolic equivalence, the Alladians assimilate blood to sperm. It should be noted that for them there is an incompatibility between hot and *hot*. In symbolic terms, the husband's sperm will mix with the lover's accumulating *hot excess.* Blood, sperm and warmth, in this culture, give us an active reaction. Thus, the deceived husband reacts to adultery by spitting out excess sperm in the form of vomited blood.

It should be noted that some authors defend not only the influence of the social context on the preservation of health or disease, but also the social support available to individuals, which plays a primary role in the health and disease status of individuals. Social support in case of illness is extremely important, because individuals with high levels of social integration and strong social, affective, cognitive, material and normative support are more capable of overcoming it when it arises. It should also be pointed out that the ability to create a consistent social support is related to the characteristics of individuals and, simultaneously, to the social and cultural conditions in which they grew up and developed. It is essential to mention that it is essentially from the family that the different social supports are built and these differ from one social condition to another. However, and looking at the reality that it encompasses, we cannot forget the role of friends, religion, belonging to groups of an associative or similar nature, as they are also very important in a situation of illness.

At the end of the nineteenth century, in 1895, Emile Durkheim, in his work on *The Division of Social Labor* and *Suicide,* stressed the importance of concepts such as social integration and anomie,[7] giving relevance in his studies to social causes.[8] The concern of this eminent sociologist was linked to the cohesion and social

[7] Anomie designates, in the plane of representations, the disaggregation of values and the absence of references. In terms of human relations, it designates the disintegration of the fabric of social relations and, equally, disaffection or lack of adherence to society's values.

[8] For example, Emile Durkheim showed that suicide is an act that has all the characteristics of a social phenomenon. The suicide rate is relatively stable in one country and varies considerably from one country to another. The author warns that suicide varies according to social groups. According to Emile Durkheim's view, suicides decrease when individuals are integrated into social groups and united by strong social ties. The importance of the integration of individuals in reducing the suicide rate should be emphasized. Undoubtedly, the

integration of individuals in society. He expressed this particularly in the two great works mentioned above, where he conceives social integration in terms of social solidarity.[9] Analyzing the thought of Emile Durkheim, we find that at the end of his work The *Division of Social Labor* and *Suicide*, the author, focusing on the problem of integration, indicates that modern societies present as pathological symptoms the insufficient integration of individuals in the collectivity. Thus, it is verified that an individual with a strong affective level of support reveals to be better integrated into society. The same can be said with regard to disease. An individual with a high level of social integration and strong affective support can better overcome the disease. In this regard, Geneviève Cresson (1995, 32) states that "the *presence of others, the integration of the subject within a group or a social network, have an impact on the morbidity and care received by that social subject*." Social support, as well as the family, are very important aspects. It is known that the absence of family and social support can condition both the state of health and the prognosis and complications of diseases.

Finally, we will focus on economic factors and their influence on determining health or disease. Grossman[10] was an author who was essentially concerned with these factors. He considered health as a *stock* that depreciates throughout the individual's life and that, according to adequate *inputs*/investments, can be increased. The level of health is not only an exogenous factor, that is, resulting from biological factors, but depends in part on the resources destined to production (E. Imperatori, 1993).

According to Grossman, health is sought by individuals for two reasons, as a consumer good, insofar as sick days are a form of disutility; and as an investment asset, as it determines the time available for activities, paid or not. An increase in *Stock* reduces the time lost and the economic value of this reduction is an index of the result of investment in health. According to this theory, individuals choose their level of health, just as they decide on the consumption of other goods. Thus, knowing that health capital depreciates over the years, due to the normal aging process and, sometimes, due to the incidence of non-avoidable disease, the process can be accelerated or minimized, through the actions of each one, by investing appropriately in health promotion activities (exercise, seeking medical care, etc.). healthy food and lifestyles etc...) or by increasing the depreciation rate with activities that consume the *Stock* such as smoking, alcoholism or very demanding working conditions.

According to this health model, it is precisely the most disadvantaged who quickly exhaust their health capital and, in fact, they are the ones who show the most fear of becoming dependent on others or of being reduced to inactivity since they do not have the economic means to cope with that situation, such as resorting to homes with good conditions or by paying those who care for them. The most socially disadvantaged individuals make

sociological explanation that the author gave to explain suicide was discussed. However, in a universal way, subsequent studies have confirmed the author's thesis.

[9] The author will speak of a mechanical solidarity characteristic of simple societies, where a strong *Collective consciousness* (the term collective conscience designates the norms and values shared by all members of the community) among its members, a culture that is not very differentiated and where the social division of labor almost does not exist. Here, the social integration of individuals is very strong. In complex societies, according to the author, since the social ties are more stretched, the division of social labor is manifested through the *Organic solidarity*. In contemporary society, which is quite complex, it is this objective and invisible bond that unites men more strongly.

[10] This author was the first to develop the *Investment Model* of the demand for health and health care. The main assumption of this model is based on the fact that unlike what happens with other consumer goods, such as clothing, food, among others, health is a *Economical Well* which is not available on the market. As it is not available on the market, what happens? People feel the need to produce health using health care as well, as others *inputs,* such as: eating healthy, paying attention to alcoholic beverages, not smoking, exercising (etc...).

fewer investments in health. At the same time, their educational level will make them know less about the advantages, for example, of a balanced diet or the importance of prevention. By being endowed with fewer resources, they may be forced to consume their own resources. *Stocks* health more quickly than individuals from a privileged class, since they do not have educational skills; they have only one instrument for the production of wealth - their health capital.

These reflections do not imply, of course, that medical science is called into question, but only to affirm that health problems are not only medical, but also cultural, economic and social[11] and so on... Illness lacks a search for meaning that goes beyond a simple medical reading, which produces diagnostic categories.

This article does not exhaust the topic addressed, and should be understood as a first systematization contribution, to be deepened in future publications.

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[11] Although we focus essentially on cultural, social and economic factors, we are fully aware that there is a panoply of factors that could be pointed out.

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