HEALTH CONCEPTS AND BELIEFS

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AWARENESS LEVELS

There is increasing evidence that in the Caribbean, knowledge and awareness levels about health and appropriate health behaviours are high. In this study,[1] the discussions with children, adolescents and young adults provide further support and reveal high levels of knowledge, awareness and appreciation of health issues in general, and reproductive health issues in particular. Most are reasonably cognisant of what needs to be done for the maintenance of good health, and if the negative health consequences of specific behaviours are to be avoided. Almost all respondents – including the youngest ones - reported awareness of the importance of proper nutrition, hygiene and exercise for the maintenance of good health. With specific reference to reproductive health all know about the threat of AIDS/ STDS, and the methods of protection and prevention; they were also familiar with at least some of the practices necessary for good health. Finally, since for them health was essentially about vitality, there was a strong concern that known external contaminants that could produce disease should be avoided.

The real problem had to do with the apparent gap between these knowledge levels and actual practices. This gap has now appeared with sufficient frequency that it has really become necessary to spend less time on its documentation, and considerably more on the search for some of the possible explanations. Successive reproductive health surveys in Jamaica have, for example, found a persistently high rate of "unwanted" and/or "mistimed" pregnancies in spite of very high levels of awareness of contraceptives, as well as rising levels of contraceptive use (McFarlane *et al* 1994; Reproductive Health Survey 1997). That is, what factors – social or otherwise – could explain the apparent inability and/or reluctance to translate knowledge into practice?

As might be expected the approaches, information, and attitudes that adolescents and young adults bring to discussions about health and good health behaviours will revolve around the kinds of activities, pursuits and problems pertinent to the life situations of that particular phase of the life cycle. In societies with limited resources, high and even rising unemployment levels, increasing poverty, and where, as in the inner-city communities of Jamaica, the levels of violence and conflict are very high, it may be further anticipated that health concepts and values will also come to be coloured and shaped by those realities. In this final paper in this series, we will seek to show how the demands and exigencies of survival in difficult circumstances – many of which were discussed in the preceding papers

– can influence actual health concerns and behaviours. Three examples will be used namely, the social treatment of violence, the orientation to pregnancy and AIDS/STDS, and the preoccupation with psychological health.

The Influence of Situational and Structural Factors

Within a general framework of knowledge and values, it can be argued that the socio-economic differences within the groups will mean that some areas will attract greater attention than others, and some issues assigned different priority status. For example, the older and the more middle class the respondent the greater the level of importance given to preventive health-related behaviours, and the more central were statements such as *"fresh foods and vegetables are to be encouraged and "junk" food avoided"*. Similarly, the higher the status group the more likely was the concern with early pregnancy related to the possible effects on school and career. Age usually also had the predictable effect; for example, the youngest respondents (that is, 8-9 year olds) made very little mention of AIDS/STDS, it was very much part of the social cognition of the 10-12 year olds, and it was of great concern to the 17-19 year olds.

Violence as a Health Problem

Essentially then, central health concerns tended to reflect the ways in which external realities affected individual survival, and individual social identity and well-being. In earlier papers in this series the preoccupation among the groups of lower socio-economic status with the more basic aspects of social and economic existence, namely: pregnancy, hustling for economic sustenance and violence was described. In this environment the treatment of violence as a potential health problem is especially interesting: it will be recalled that violence appears to be a constant and even accepted feature of most personal (sexual or otherwise) relationships. Children are, supposed to be strongly disciplined; boys should be harshly and "roughly" punished, and males would appear to have some "permission" to use violence so as to retain "face" and control in the competitive struggle of everyday life – especially in the inner-city communities. Thus, while the consequences are obviously feared, and there were usually very lengthy discussions of violence in its many forms, participants tended to treat it as a separate matter not intimately related to health concerns. In this regard there were no significant differences between the pre-pubescent children, adolescent and young adults. Even the youngest respondents saw violence as a persistent feature of relationships, but here again there was no conception of violence as a health problem. While it might not be reasonable to expect widespread prevalence of the increasing tendency in some official policy circles to view particular social conditions as issues of public health, it is nonetheless remarkable that an activity which has the kinds of consequences that physical violence obviously has, is so disconnected from other health seeking activities. To the extent that this may imply not merely fatalism, but also some "normalisation " of the phenomenon, it is therefore cause for concern.

Pregnancy and STDs

At this stage of their lives, the establishment and maintenance of satisfactory personal relationships are of critical concern. AIDS and other STDs as well as pregnancy were then the factors that were central in their

conceptions of some of the health consequences of relationships. By age 10-12 years, AIDS in particular, was very much a part of their social cognition. One girl fretted:

Me hear that AIDS travel very fast...

Others observed:

...the people that catching AIDS...it a'int nobody that you a'int know... [it is] people that we used to go out and see; and then you miss the body...next thing you know? AIDS!

The older the respondent the higher the level of exposure to the public messages about the prophylactic and protective benefits of the condom. But here again situational factors frequently determined actual condom use. In the earlier papers in this series it was shown that multiple partnering has come to have a very critical economic and status value for both men and women, and is consequently fairly widespread. Most respondents knew and understood the possible health consequences of multiple partnering or promiscuity. They all recognised that sexual disease transmission was a serious matter. There was in fact in their minds a hierarchy of STDS with some occupying a higher order than others, and with AIDS at the very top. There were two basic methods for dealing with the problem: one was the use of the condom; the other was and, as implied in the above quote, the exercise of great care in the selection of sexual partners. Further,

Before starting a relationship, [you should] go to a doctor to get a blood test and the same for the partner.

Reality seemed to be a different matter. Juggling multiple partnerships was not always a straightforward matter:

You have a different girl and she thinks she is the only one. Meanwhile you have another woman on the side; you tell her she is the only one, and by the time you think she is the only one, she has a different man. She make love to many different men...[then] she come to check you... you get disease...then you can give to your wife...because you not going to want to use rubber[i.e.condom] on you wife....

The imperatives of the moment may also be considered overwhelming:

Most times things just come up in you head, and you just want to do it, and you don't have any protection...you might be out there...,and a little catty can check you and say that she is waiting on a killer..so hear me...it is a long time [since] I have killed nothing.....

I don't use protection when I am doing a fast t'ing...mi family had gone out, and me know that dem [could] come back anytime.. I do a fast t'ing because I don't time to put on protection....

Pregnancy was the other – and perhaps even more critical - central concern. Certainly, all were aware of the dietary and behavioural rules necessary for safe pregnancy and the health of the unborn child.

When a woman is pregnant, she should'nt smoke and drink, nor dance and eat junk food. She must eat healthy food...and she can't smoke weed because that can mek the baby have jaundice....

Many understood the possible physical and psychological consequences of early childbearing; but given the circumstances of their own existence, most individuals appeared to be more bothered by the profound social and economic consequences anticipated. In reality, pregnancy presented different options and/or problems for males as against females. The following quote efficiently summarises a common male worry, and their conception of the "real" health problem:

When dem have too much children and they lose their job, and the pickney (i.e. child) mother come to dem and say [that] dem going to carry dem to Family Court, then the man gets sick. His head start to hurt him, and he does not know what to do....

Since it was perceived and perhaps feared that in response to this potential difficulty men had the option to either disappear or disown the child, for women, becoming pregnant presented an occasion to test the man's "seriousness" or the likelihood of him being willing and/or able to perform the desired provider function. Given the perceived differences in fears, expectations, approaches and attitudes, it is an arena with potential for generating a great deal of stress and conflict.

Stress and Psychological Well-being

The heavy emphasis given by almost all respondents – but especially those in Barbados - to the psychological aspects of health was surprising – although on reflection, not unexpected. There was a very strong sense of the difficulties of individual survival in the wider society, and the weight of the historical baggage as defined and formed by class, colour, or race. The importance given to one or the other factor would depend on the particular country of residence; but in all the discussions on health issues individuals constantly focused on the extent to which they felt threatened and driven to prove themselves, achieve respectability, and acquire personal and social status. A particularly striking manifestation of the impact and burden of this concern surfaced in the reports of involvement in, and management of relationships. It was commonly perceived that powerlessness and participation in relationships of subordination inevitably meant that they were liable to suffer a great deal psychologically at the hands of others. All relationships – personal or otherwise – then came to represent continuing attempts at psychological survival against the competing interests of others. Sensitivity to these kind of currents in the personal relationships around them and the accompanying "seige-orientation" was also found among the young children. Respondents aged 8-11 years frequently reported and commented on the mental disorders which they felt were precipitated by the "pressures" of relationships. Relationships involving children were deemed to be particularly problematic.

Gender Differentials and Health

Health concepts and beliefs were also influenced by the broader notions about the "normal" roles and life-styles of the different genders. Here, the gender role differentiation should be recalled. In this connection, since men function in the "outdoor" arena and are more likely to take risks they will be more susceptible than the domestic and hearth-bound females to injury and accidents. According to a younger respondent:

> *Sometimes dem play in the mud and dirty water, dem walk barefoot in the water and get ringworm.*

Health for the older boys was more closely defined in terms of their physical fitness and vitality – qualities deemed necessary for meeting societal demands and the outdoor life. Consequently, the efficient running of the bodily engine identified a good state of health.

Related to the notion that men are men because they are stronger, and that women are women because they menstruate, get pregnant and have babies, is the belief that the perceived gender health differential is due to these facts of the female condition. In all the countries studied (Barbados, Dominica and Jamaica), there was a general notion that women were more sickly than men, but by and large this was attributed to the defining notion of pregnancy and/or to the structure of femaleness. Women were more susceptible to STDs because of the construction of their reproductive system; and

> *When you are pregnant you get pains, they have to go to the doctor to get check; when you are seeing your period, pains too....*

The Challenge

It is therefore necessary to recognise that while individuals may be aware of and even subscribe to a range and complex of appropriate values, beliefs and practices, their actual application will often vary and depend on the exigencies and constraints of the circumstances in which they find themselves. In this paper, the discussion of the range and types of health concerns reported by the respondents has sought to illustrate how general concepts and beliefs will almost inevitably come to be narrowed, focussed, and even modified. The real importance of this finding has to do with the lessons that need to be drawn about the *targeting* of intervention and/or behaviour modification programmes. In this regard, it is necessary to improve current levels of understanding about the range of factors that determine and influence actual health-related behaviours in different socio-economic settings. The successful receipt and application of messages are more probable when they more accurately and sensitively address the specifics of the situation, and also seek to introduce the desired changes in terms of what is already known, understood and experienced.

End Note

[1]Further details on the methodology of data collection are provided in the Foreword to this volume.

References

McFarlane, Carmen, Jay Friedman, and Leo Morris. 1994. "1993 Jamaica Contraceptive Prevalence Survey Executive Summary." Prepared for the National Family Planning Board. Volumes I – IV.

Reproductive Health Survey. 1997. Jamaica. Draft Final Report. National Family Planning Board, August 1998.