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Discovering the Healthcare Beliefs and Practices of Rural Mestizo Ecuadorians: An Ethnonursing Study

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DISCOVERING THE HEALTHCARE BELIEFS AND PRACTICES OF RURAL MESTIZO ECUADORIANS: AN ETHNONURSING STUDY

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By

Julie Ann Moss

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ABSTRACT

DISCOVERING THE HEALTHCARE BELIEFS AND PRACTICES OF RURAL MESTIZO ECUADORIANS: AN ETHNONURSING STUDY

By

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August 2010

Dissertation supervised by: Dr. Richard Zoucha

Purpose

The purpose of this ethnonursing study was to observe and collect data related to the role of the nurse, healthcare beliefs and practices of rural mestizo Ecuadorians.

Background

The current literature regarding Ecuadorian health practices has been limited to the study of indigenous Americo-Indian groups. No studies have been conducted in the mestizo rural setting. Discovering these beliefs and practices will enable nurses and other healthcare workers to provide care that is acceptable, congruent in culture, and health promoting.

Research Design

An ethnonursing method was used to uncover and discover phenomena of interest to nursing. The research questions related to healthcare beliefs, practices, and what constitutes culturally acceptable care within the context of their culture?

Participants

The researcher interviewed 28 general informants.

Informants

The researcher had contact over the past seven years in Tosagua, Ecuador. The familiarity with the residents, local leadership, and fluency in the Spanish language has promoted her acceptance. After obtaining IRB approval from Duquesne University the initial informants were recruited by the gatekeeper then the snowball method was used to recruit additional informants. Participation was voluntary and they were free to withdraw at any time.

Data Collection and Analysis

The Four Phases of Ethnonursing Qualitative Data Analysis and NVIVO8 software was used to manage data.

Results

Eighteen categories were extracted from the raw data of interviews, observation, and field notes. These categories were the meaning of health *(la salud)*, meaning of illness *(la enfermedad),* folk and common illnesses *(enfermedades común y folklóricos),* folkhealers *(curanderos)* medicinal plants *(plantas naturales),* professional healthcare *(cuidado professional,* spirituality *(la espiritualidad),* environment *(el medioambiente),* meaning of family *(la familia),* nutrition *(nutricion),* exercise *(ejercicio),* education

(educación), health education *(*educa*ción sobre la salud),* role of the nurse *(papel de la enfermera),* politics, and hope for the future *(eperanza por el futuro.*

Phase three of data analysis is the discovery of patterns of data inherent in the categories related to the DOI. The interviews were conducted until data saturation of patterned meaning in context. Six patterns of data inherent in the categories emerged from this phase are a *pattern of belief in God and the power of prayer, valuing self-care and preservation practices, pattern of external factors negatively effecting health, pattern of identified barriers to healthcare, pattern of hope being essential to well-being and health, and pattern of valuing family caring.*

From the patterns four themes were teased out and were discussed. The themes are *spirituality and prayer are necessary for health and well-being, living in a community with like-minded people positively affects health and well-being, incorporation of traditional medicine with modern medicine is essential to health, and environmental context beyond the people's control greatly affects health and well-being.*

Conclusions and Implications

Four substantive themes which were teased out are complex and inter-related. Spirituality and prayer are necessary to maintain health, healing and well-being. Rural mestizo Ecuadorians living in a community with like-minded people positively affects health and well-being. The incorporation of traditional medicine with modern medicine is essential to health. Many external factors beyond the control of the people greatly affect health and well-being. The intertwining thread between all of the themes is hope. The rural mestizo Ecuadorians are buoyed by hope in something better for the future. Their

hope lies in the power of God to change their circumstances and the core value of living in community.

DEDICATION

My heartfelt love, appreciation, and gratitude goes to my husband, Kevin Moss, who has endured hours of listening to me talk about coursework, culture and nursing without as much as a yawn. Thank you for being my steadfast rock when the tempests and I were swaying and raging. Thank you for undeserved grace. I love you.

Thank you to my wonderful children who have supported me with love and encouragement through an educational journey that stretches back to Ecuador. You have been my inspiration and endless source of hugs.

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Chapter 1

1.1 Introduction

Transcultural nursing studies allow nurses to discover and compare nursing practices and other interconnected issues such as values, health, politics, and economics across and within cultures (Leininger, 2002; Leininger & McFarland, 2006). Because each culture views illness and health differently, this research seeks to discover and describe the healthcare beliefs and practices of rural mestizo Ecuadorians and the role of the nurse now and implications for future care. No transcultural studies could be found in nursing or related literature regarding the healthcare beliefs and practices of rural mestizo Ecuadorians. The paucity of literature is evident. The importance of studying Ecuadorian health is not only to discover and describe their beliefs and practices but to assist healthcare providers who are caring for rural mestizo Ecuadorians who have immigrated to other countries. By increasing nursing knowledge regarding rural mestizo Ecuadorians in their own culture, healthcare providers caring for rural mestizo Ecuadorians can apply this knowledge to their own patient interactions.

1.2 Domain of Inquiry

The domain of inquiry (DOI) for this ethnonursing study is the healthcare beliefs and practices of rural mestizo Ecuadorians and the role of the nurse now and implications for the future.

1.3 Purpose and Goal

The purpose of this qualitative ethnonursing study was to discover and understand the healthcare beliefs and practices of mestizo Ecuadorians within rural Ecuador and the role of the nurse now and implications for future care. The phenomena of interest are the

health beliefs and practices of rural mestizo Ecuadorians in the context of their own culture. Discovering these beliefs and practice will enable nurses and other healthcare workers to provide care that is acceptable, culturally congruent and promotes health. Nurses caring for Ecuadorians in and outside of Ecuador can utilize the findings of this study as a basis for guiding their nursing care and actions.

Of international significance, the current rate of immigration of the rural mestizo group out of Ecuador to countries such as the United States, Canada, Spain and Italy is about 30% (Izquierdo, 2003; Jokisch, 2007; Jokisch & Pribilsky, 2002). This unstudied group at some point will require healthcare treat illness or promote health in their destinations of immigration. Healthcare providers may not understand that the beliefs and practices of this group may differ from their own. The result is potentially detrimental to their long term health and detrimental to their psychological well-being as they experience healthcare practices that are not congruent with their own beliefs.

1.4 Rationale

The significance of this study was to understand the cultural health care beliefs of rural mestizo Ecuadorians in the context of their own country so that these findings may be used in Ecuador and in the countries where they have immigrated. The current literature regarding Ecuadorian health practices has been limited to the study of indigenous Americo-Indian groups. The second largest rural group are mestizo or non-indigenous people. The term mestizo refers to people of mixed race; indigenous, European, or African ancestry. Mestizos make up about 40 percent of Ecuador's rural population and are the focus of this investigation (IFAD, 2002). No studies have been identified in the current nursing and related literature in the rural setting among this

specific group. The importance of this study was to document the healthcare beliefs and practices so that nurses caring for Ecuadorians will have an understanding of their cultural care needs.

The mini-study (Moss, 2008) findings revealed what was previously held to be true by the researcher regarding the care given by Ecuadorian nurses to their patients. The nursing care experienced by rural Ecuadorians at the hands of nurses within Ecuador has been reported to be less than caring and not satisfying to the recipients.

1.5 Research Questions

1. What are the healthcare beliefs and practices of rural mestizo Ecuadorians?
2. What constitutes culturally acceptable care within the context of the rural mestizo Ecuadorian culture?
3. What is the role of the nurse in promoting care in rural Ecuador now and the future implications?

1.6 Significance for Nursing

The indigenous people are the largest rural population group in Ecuador. Eleven different people groups make up Ecuador's Indigenous population. The largest of these is the Andean Quichua, who number more than two million. In addition to the Quichua, the Otavalenos, Salasacas, and Saraguros - all modern-day couriers of the ancient tongue of the Incas, live in Ecuador (USDS, 2007). The second largest group is rural mestizo or non-indigenous people. The term mestizo refers to people of mixed race; indigenous, European, or African ancestry. Rural mestizos make up about 40 percent of Ecuador's population and are the focus of this investigation (IFAD, 2002). The majority of rural dwelling mestizos are working as subsistence and landless farmers with incomes that

place them below the extreme poverty line as set by the International Fund for Agricultural Development (IFAD). Poverty is characterized by limited access to basic services such as healthcare, education, and housing. The rural mestizos have incomes that are inadequate to obtain basic food and services for the family.

The economic situation in Ecuador continues to decline. More and more residents of the rural communities continue to seek employment in international settings (Izquierdo, 2003). The resulting immigration places a strain on the healthcare systems in their new country of residence as nurses and other healthcare providers face the challenge of providing care to rural Ecuadorians who have not had their healthcare beliefs explored and do not have research regarding their beliefs available for study or review.

This unstudied group is requiring care to improve or promote health in the destinations of immigration and healthcare providers do not understand that their beliefs and practices may differ from their own. Without this research, they may be receiving care that is not satisfying or culturally appropriate for their needs. The care may also be ineffective in meeting their healthcare needs.

The nursing profession is in an ideal position to conduct needed research in these areas and report the findings within Ecuador and on an international level. The goals of this research were to describe the healthcare beliefs and practices of rural mestizo Ecuadorians, potentially improve the health of people who have limited resources, unrecognized health needs, and to support culturally acceptable care practices in Ecuador and areas where Ecuadorians are living abroad. Another goal was to discover and describe the role and the implications for the future. Nurses and other healthcare providers can use these findings to provide culturally competent and congruent care.

According to the 2001 Ecuadorian national census, the average Ecuadorian family experiences the emmigration of 1.5 family members between the ages of 15-45. The majority emmigrate to the United States, Spain, and Italy. Since 1999, 49% have been emmigrating to Spain (USDS, 2007).

In the United States alone, the Latino population is more than 15% of the total population or 44,000,000. Of this number, 498,000 are Ecuadorian (Kalia, 2008). The number of total Latinos is expected to increase to 24% of the total U.S. population by 2050. The U.S. has the third largest population of Hispanics outside of Mexico and Columbia (Kalia, 2008).

Health beliefs and practices are directly influenced by social, economic, educational, and cultural factors. How an individual views health and practices health behaviors are learned within the realm of culture and many are passed generation to generation (Leininger & McFarland, 2006). Traditional or folk-remedies such as drinking *te de manzanilla* (chamomile tea) for stomach upset and praying for good health are examples of a practice that is accepted within a culture and may be passed from one generation to another (Moss, 2008). Folk healing is different from one culture to another. In Ecuador, such as *pasando un huevo* (passing an egg over the body) is a culturally acceptable way to cure febrile illness in children (Moss, 2008). Each culture has its own specific beliefs and health practices. Within these beliefs regarding health are also beliefs about spirituality, illness, death, and healing (Leininger & McFarland, 2006). The tapestry of these interwoven beliefs is engrained in the culture of the Ecuadorian people. Understanding the health beliefs and health practices of Ecuadorians will assist in understanding culturally acceptable care practices, which may improve client satisfaction,

enhance acceptance of treatment or recommendations, facilitate completion or continuance of therapy, and support confidence in a healthcare system different from their home culture.

1.7 Orientational Definitions

Research in the qualitative ethnonursing methods differs from quantitative research because the qualitative researcher seeks to uncover the new knowledge about the domain of inquiry from the emic view of the people being studied (Leininger & McFarland, 2006; Luna, 1989; Schumacher, 2006). The following definitions from the Culture Care Diversity and Universality theory of Madeline Leininger were used to guide this study:

1. Care: Assistive supportive and enabling actions or ideas towards others with real or perceived needs to improve their condition or eliminate suffering (Leininger & McFarland, 2006).
2. Culture care: The subjectively and objectively learned and transmitted values, beliefs, norms, and lifeways that that assist, support, facilitate, or enable rural mestizo Ecuadorians to maintain well-being and health , and to improve their human condition and lifeway, or to deal with illness, handicap, or death (Leininger & McFarland, 2006).
3. Culture: Means by which a group or individual interacts with self, others, and the environment includes values, beliefs, norms, patterns, and practices that are learned, shared, and transmitted inter-generationally (Leininger & McFarland, 2006).

4. Mestizo: A Spanish term that was used in the Spanish Empire to refer to people of mixed European, and Amerindian ancestry in Latin America. The term continues to be used today in the Americas, the Philippines, and Guam to refer to people of mixed European and other indigenous ancestry. The term is mostly used specifically of those people of the particular racial mixture of European and American Indian who inhabit and comprise much of the population of Latin America (USDS, 2007). Within Ecuador the meaning is congruent with the stated definition. There are no negative connotations associated with the term.
5. Worldview: The way rural mestizo Ecuadorians look at their world and their interpretation of this view related to health and well-being (Leininger & McFarland, 2006).
6. Etic view: Outsider's view of culture (Leininger & McFarland, 2006).
7. Emic view: Local, indigenous, or insider's cultural view of culture (Leininger & McFarland, 2006).
8. Generic care: The learned or transmitted lay, folk, indigenous, and known care values, beliefs, and practices used by mestizo Ecuadorians over time (Leininger & McFarland, 2006).
9. Professional care: The formal and cognitively learned professional care knowledge and practices gained through professional institutions (Leininger & McFarland, 2006).

10. Health: State of well-being or restorative state that is defined, valued, and practiced by individuals or groups within the culture that enables them to function in their daily lives (Leininger & McFarland, 2006).
11. Home/community environmental context: The informants identification with and comfort level regarding climate, culture, food, religion, healthcare, social, economic, and educational aspects and roles (Wehbe-Alamah, 2005).

1.8 Assumptions

Leininger's Culture Care Diversity and Universality has given nursing researchers 11 theoretical assumptions to support her theory. The assumptions are based on the givens that care is the essence of nursing and that care is essential for human growth, well-being, health, and survival. Care also aids people to face disability, death, and other points on the illness-health continuum (Leininger, 2002).

The following assumptions have been adapted from Leininger's assumptive premises of the theory and were used in this study:

1. Care is not only the essence of nursing but of the human experience (Leininger & McFarland, 2006).
2. The Ecuadorian culture, like every human culture, has generic (lay, folk, or indigenous) care knowledge and practices vary transculturally and individually (Leininger & McFarland, 2006).
3. Care that is beneficial, healthy, and culturally satisfying influences the health and well-being of individuals, families, groups, and communities

with the environmental context of Ecuador (Leininger & McFarland, 2006).

4. Culture-care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, education, economic, technological, ethnohistorical, and environmental context of cultures (Leininger & McFarland, 2006).
5. The informants will be truthful in reporting their knowledge of the DOI.
6. The key informants who are most knowledgeable about the DOI will come forth and share detailed accounts of their emic perspective of the phenomena being studied.

1.9 Summary

This qualitative ethnonursing study was conducted to discover and understand the healthcare beliefs and practices of mestizo Ecuadorians within rural Ecuador. The phenomena of interests were the health beliefs and practices of rural mestizo Ecuadorians in the context of their own culture and the role of the nurse. The results of this study will enable nurses and other healthcare workers to provide care that is acceptable, culturally congruent, and promotes health. Discovering the role of the nurse has implications for nursing practice now and in the future.

Chapter 2

Review of the Literature

2.1 Ethnohistory: Ecuador, the Country

The Republic of Ecuador is located on the continent of South America. The small country, about the size of Colorado, has a diversity that encompasses the geography, climate, and inhabitants. The geography of Ecuador has three distinct regions; Andes mountain central highlands (*sierra),* coastal plain *(costa),* and eastern Amazonian jungle *(oriente).* The republic also includes the archipelago of the Galapagos Islands.

The people of Ecuador are very diverse. The inhabitants today reflect a diverse history dating back to 10,000 BC when the coastal area was settled by hunters and gatherers. By 3200 BC, an agricultural area had been established and the trading of food and pottery was active between the pre-Columbians and the Inca nations of Peru, Brazil, and several Amazonian tribes (Factbook-Ecuador, 2008).

In 1460, Ecuador was invaded by the Inca in their attempt to expand their rapidly growing empire. After conquering Ecuador, the Inca indoctrinated the tribes to Quechua, the language of the Incas, which is still widely spoken in Ecuador. The Inca Empire of the ruling chief, Huayna Capac, was divided in 1526 between the chiefs' two sons, Atahualpa and Huascar. The split inheritance was unconventional in the Incan culture and forced the brothers into a civil war to gain full control of the empire. Little did they know that while they were fighting, Francisco Pizarro (1478-1541) was a Spanish conquistador who was traveling through much of the Pacific coast of South America along Peru (Fact-book-Ecuador, 2008).

In 1532, Pizarro landed a second time in Ecuador with a party of 180 well armed men looking for gold. The previous exploration coupled with news of Hernando Cortez conquering the Aztec nation in Mexico fed the Spanish explorer's lust for wealth and power (Factbook-Ecuador, 2008).

The Incan civil war between the brothers had recently ended with Atahualpa emerging the victor. The fledgling united empire was quickly overtaken by Pizarro. Atahualpa was captured, forced to collect a huge ransom of gold, and was then executed. The Spaniards ruled Ecuador until 1822. The colonial era introduced Roman Catholicism, colonial architecture, and today's national language of Spanish. Lamentably, the Spaniards also brought disease, abuse, and slavery. By the end of the century, over 70% of the indigenous population died (Kalia, 2008).

The nation also received a group of African slaves in the mid-16th century when two slave ships wrecked on the shores of the Esmeraldas Province. The maroon society lived relatively independent during the Spanish reign of Ecuador. Currently, the black population, about 3% of Ecuador's total population, continues to reside primarily in the coastal area of Ecuador (Factbook-Ecuador, 2008).

Independence for Ecuador was won on May 24, 1822, when the famed South American liberator Simon Bolivar defeated a Spanish army at the Battle of Pichincha. The Gran Columbia was formed as a state when Bolivar united Ecuador with Colombia and Venezuela. This union lasted eight years, until Ecuador seceded and became an independent republic (Factbook-Ecuador, 2008).

A coastal-based liberal revolution in 1895 under Eloy Alfaro reduced the power of the clergy and opened the way for capitalist development. The end of the cocoa boom

produced renewed political instability and a military coup in 1925. The 1930s and 1940s were marked by populist politicians, such as five-time President Jose Velasco Ibarra. In January 1942, Ecuador signed the Rio Protocol to end a brief war with Peru the year before. Ecuador agreed to a border that conceded to Peru much territory Ecuador had previously claimed in the Amazon region.

After World War II, a recovery in the market for agricultural commodities and the growth of the banana industry helped restore prosperity and political peace. From 1948-60, three presidents--beginning with Galo Plaza--were freely elected and completed their terms. Political turbulence returned in the 1960's, followed by a period of military dictatorship between 1972 and 1979. The 1980's and beginning of the 90's saw a return to democracy, but instability returned by the middle of the decade (Factbook-Ecuador, 2008).

2.2 Political Instability (1997-2007)

Abdala Bucaram, from the Guayaquil-based Ecuadorian Roldosista Party (PRE), won the presidency in 1996 on a platform that promised populist economic and social policies, and challenged what Bucaram termed as the power of the nation's oligarchy. During his short term of office, Bucaram's administration was severely criticized for corruption. Bucaram was deposed by the Congress in February 1997 on grounds of alleged mental incompetence. In his place, Congress named Fabian Alarcon interim president. Alarcon's presidency was endorsed by a May 1997 popular referendum (USDS, 2007).

Quito Mayor Jamil Mahuad of the Popular Democracy party was elected president by a narrow margin In July 1998. Mahuad concluded an historic peace

agreement with Peru on October 26, 1998, but increasing economic, fiscal, and financial difficulties drove his popularity steadily lower. On January 21, 2000, during demonstrations in Quito by indigenous groups, the military and police refused to enforce public order. Demonstrators entered the National Assembly building and declared a three-person "junta" in charge of the country. Field-grade military officers declared their support for the concept. During a night of confusion and negotiations, President Mahuad fled the presidential palace. Vice President Gustavo Noboa took charge and Mahuad went on national television to endorse Noboa as his successor. Congress met in emergency session in Guayaquil the same day, January 22, and ratified Noboa as President of the Republic (USDS, 2007).

Completing Mahuad's term, Noboa restored some stability to Ecuador. He implemented the dollarization of the economy that Mahuad had announced and obtained congressional authorization for the construction of Ecuador's second major oil pipeline, this one financed by a private consortium. Noboa turned over the government on January 15, 2003, to his successor, Lucio Gutierrez, a former army colonel who first came to public attention as a member of the short-lived "junta" of January 21, 2000. Gutierrez' campaign featured an anti-corruption and leftist, populist platform. After taking office, however, Gutierrez adopted relatively conservative fiscal policies and defensive tactics, including replacing the Supreme Court and declaring a state of emergency in the capital to combat mounting opposition. The situation came to a head on April 20, 2005, when political opponents and popular uprisings in Quito prompted Congress to strip Gutierrez of the presidency for allegedly "abandoning his post." When the military withdrew its support, Gutierrez went into temporary exile. Congress declared Vice President Alfredo

Palacio the new president. A semblance of stability returned, but the Palacio administration failed to achieve major reforms (USDS, 2007).

In presidential elections on October 15, 2006, third-time candidate Alvaro Noboa won the first round. However, Rafael Correa, Palacio's former finance minister, running on an anti-establishment reform platform, bested Noboa in the second round presidential runoff on November 26. Election observers characterized the elections as generally free, fair, and transparent. The new Congress took office January 5, 2007 and Correa was sworn in as President on January 15, 2007. In March, 2007, 57 members of Congress were dismissed on the grounds that they violated campaign laws. Following that, the Congress was largely deadlocked and later effectively replaced by a constituent assembly that was voted into power on September 30, 2007. The assembly, which was inaugurated on November 29, 2007, approved a text for a new constitution on July 29, 2008. This constitutional text must be approved in a referendum scheduled for September 28, 2008. If approved, elections for a new Congress and president are expected in January 2009 (USDS, 2007).

2.3 Topography and Health

In addition to the political instability, the natural environment of Ecuador is prone to frequent earthquakes, landslides, flooding, and volcanic activity. Other current issues affecting the environment include deforestation, soil erosion, desertification, water pollution, pollution from oil production wastes in ecologically sensitive areas of the Amazon basin and Galapagos Islands (Factbook-Ecuador, 2008).

Ecuador has three distinct regions: the *sierra* (mountains and plains), *costa* (from the Pacific Ocean and inland about 50 km), *and oriente* (the eastern jungle of the Amazon

basin). Each area has its own health and environmental challenges. The rural mestizo Ecuadorians of this study reside in the *costa* (Factbook-Ecuador, 2008).

Because of the environmental changes, the health of the people is also affected (Luque, Whiteford, & Tobin, 2008). The 2 rainy seasons last from December - May and the people are affected with fungal infections of the skin, mold in their homes, and landslides. June-November is considered the dry season in the *costa* and the mud is replaced by dust. The dust affects the respiratory system and the people experience more acute respiratory infections (ARI), reactive airways, cough, sneeze, sore throat and itchy watery eyes (Luque et al., 2008).

2.4 Foreign Relations and Economics

Ecuador is a member of the United Nations (and most of its specialized agencies), the Organization of American States (OAS), and many regional groups, including the Rio Group, the Latin American Economic System, the Latin American Energy Organization, the Latin American Integration Association, and the Community of Andean Nations. The United Nations High Commission on Refugees (UNHCR) reports that as many as 250,000 Columbians are seeking asylum in Ecuador due to fear from increased violence between warring drug rings in Columbia (Factbook-Ecuador, 2008). Over half of the US-bound cocaine passes through the Pacific waters off of Ecuador. Ecuador has also been lax in pursuing or prosecuting or pursuing drug traffickers who launder money in Ecuador due to the forced dollarization by the IMF (Factbook-Ecuador, 2008).

The ongoing conflict in Colombia and security along the 450-mile-long northern border are important issues in Ecuador's foreign relations with Colombia. The instability of border areas and frequent encroachments of Colombian guerillas into Ecuadorian

territory has led the Ecuadorian army to deploy more troops to the region. Although Ecuadorian officials have stated that Colombian guerrilla activity will not be tolerated on the Ecuadorian side of the border, guerrilla bands have been known to intimidate the local population, demanding extortion payments and practicing vigilante justice.

The Correa administration is pursuing a policy known as Plan Ecuador to develop the northern border region and protect citizens from the drug threat. Ecuador and the U.S. agreed in 1999 to a 10-year arrangement whereby U.S. military surveillance aircraft could use the airbase at Manta, Ecuador as a Forward Operating Location to detect drug trafficking flights through the region. The Ecuadorian government has stated that the lease for the Forward Operating Location will not be renewed due to extreme opposition from the Ecuadorian citizen (Factbook-Ecuador, 2008).

Ecuador is dependent on its petroleum resources for half of the country's earnings. The collapse of the government in 2000, defaulting on external debt, and pressure from the International Monetary Fund (IMF) to dollarize has helped to stabilize the economy. The previous monetary unit, the Sucre, no longer exists but in the markets and public vendors of food still refer to the dollar as the new Sucre (Factbook-Ecuador, 2008).

In addition to petroleum, Ecuador exports cut flowers, bananas, shrimp, cocoa, and coffee. The United States, European Union countries, Columbia, Chile, and Japan are Ecuador's primary trading partners. In 1998, the United States exported USD 1.6 billion worth of goods to Ecuador, or about 30% of Ecuador's total imports, and received nearly 40% of Ecuador's exports, making it the country's leading import and export partner (Factbook-Ecuador, 2008).

2.5 Technology

Of Ecuador's 13 million people, only 2.7 percent have been online, according to the government-owned communications company, Conatel. Internet café's flourish in Ecuador's largest cities, but many are run by educated businessmen with ties to the United States. Thousands of households in Quito (the capital) and Guayaquil (the largest city) have Internet access, but few rural communities have telephone lines. Satellite technology has not yet been introduced to the country for broadband access. In most rural Ecuadorian homes, land line telephones and televisions with rabbit ears are the norm. The country has 7 national television stations and has one cable TV provider. The current government administration has been given monies from Iran and Brazil to build the technology infrastructure to support more computers and technology classes in rural communities. (Konrad, 2003).

2.6 Education

Education is compulsory in Ecuador. Formal education was divided into four cycles: a two year preprimary, six years of primary school, and 6 years of secondary school. Children could begin attending preprimary school at four; primary school begins at age six. Attendance theoretically was compulsory for children from six to fourteen years of age (Group, 2008).

In spite of the compulsory education, illiteracy rates remain high in rural areas. Only 10 % of the rural population attends and achieves graduation. On the other hand, about 76 % of the total number of children in Ecuador completes their study until class six. Most schools in the rural areas are government funded with classrooms filled beyond capacity and under educated teachers teaching (Group, 2008).

2.7 Religion

Catholicism has been the predominant religion in Ecuador. In 1945, a constitutional amendment was added that allows freedom of religion and called for the separation of church and state. The major religion in Ecuador remains Roman Catholic at about 91%. Other religions include Protestant, Jehovah Witness, and Seventh Day Adventist (Factbook-Ecuador, 2008).

2.8 Challenges

Poverty and inequality are Ecuador's main development challenges (IFAD, 2002; Izquierdo, 2003; Jokisch, 2007; Luque et al., 2008; Moss, 2008; Padilla, Gomez, Biggerstaff, & Mehler, 2001; Schoenfeld & Juarbe, 2005; USDS, 2007). Addressing this will require faster, labor-intensive growth, inclusion of the poor (especially women) in the development process, and more effective targeting of social services. According to the World Bank Group, poverty increased from 40 percent in 1990 to 45 percent in 2001, mainly as a consequence of the 1999 monetary collapse. While poverty rates declined in both urban and rural areas, in 2004 rural poverty levels were still more than double those of urban areas. Ecuador also suffers from dramatic inequality: the richest 10 percent of the population receives three times more income than the poorest 50 percent and sixty times more than the poorest 10 percent (Group, 2008).

Many of the homes in the rural areas have dirt floors, open windows and slat wallboard. The homes are elevated on stilts and the family’s animals are kept below. Electricity and running water are beginning to reach the rural areas. Lack of money is one of the main reasons cited for not being able to improve their living conditions (Luque et al., 2008).

2.9 Review of the relevant literature for studies with Ecuadorians

A comprehensive literature review was conducted of the literature using multiple search terms related to healthcare beliefs and practices in Ecuador via OVID, which includes Cumulative Index to Nursing and Allied Health Literature (CINAHL), PUBMED, and MEDLINE, MEDLINE Extra, OLDMEDLINE, and Health and Psychosocial Instruments (HaPI). EBSCO Host, Journals@OVID, ProQuest, and PubMed@Duquesne. The search terms were expanded and researched in all databases again to include health plus one or more of the following search terms: behaviors, South America, Ecuador, Latin America, Latino, attitudes, coping, faith, death, illness, religion, spirituality, perception, rural, Pan America, Andes, Amazon, Amazonia, alternative medicine, complementary medicine, rural medicine, folk medicine, traditional medicine, nursing, nursing care, healing, ethno pharmacy, healing practices, ethno pharmacy, and ethno biology. A search was conducted in Google Español using Spanish terms for the above plus curandero (healer), shaman, shamanistic practices, mestizo (mixed race), pharmacia (pharmacy), and boticero (pharmacist). No limits were utilized for year, discipline, methodology, source, or type of publication.

The search was expanded to include all of Central and South America. The research findings regarding health beliefs and practices of rural Ecuadorians were extrapolated from studies related to health of female Ecuadorians, indigenous Ecuadorians. The available research regarding the health care beliefs and practices of rural mestizo Ecuadorians is very limited. Through this literature review significant gaps in research will be highlighted.

Research in Ecuador has focused primarily on indigenous Indian groups and indigenous women and has predominantly been in the field of anthropology. The anthropology researchers have studied highland indigenous groups and described the natural diseases including tuberculosis, intestinal parasites, diarrheal diseases, whopping cough and measles. Additionally, the culture-specific ailments included witchcraft (brujeria), evil eye (mal de ojo), envy sickness (envidia), evil airs (mal aire), nerves or depression disorder (nervios), magical fright (susto), soul loss (espanto), water fright illness (bao de agua), alcohol abuse, empacho (bowel blockage) and hot and cold syndrome (Finerman, 1989; Price, 1989; Puertas, 2001).

The research of Price (1989) and Finerman (1989) reported a common practice for treatment of disease is home remedy and herbal treatment with medicinal plants. Women are the care providers in the family using these modalities. The practice of self medication for economic, social, and cultural reasons is common in Ecuador. The self medication practice is more prominent in the rural settings due to lack of access to healthcare providers, poor economic resources, and the practice of home gardening of medicinal plants (Finerman, 1989; Price, 1989).

Nursing research related to rural mestizo Ecuadorians is limited to one qualitative study of 19 rural mestizo women and their perceived health needs (Schoenfeld & Juarbe, 2005). The ethnographic study was conducted in the highlands of southern Ecuador and used a feminist approach to describe the health needs and resources available to women. The researchers reported issues related to domestic violence, lack of financial resources and political instability as causes of poor health. “Four specific themes emerged from the analysis of women’s perceptions of their health needs (1) la falta de plata (lack of

money), (2) major estar sola (better to be alone or unmarried), (3) el dolor del cuerpo (body pain), and (4) suffering and self-sacrifice" (Schoenfeld & Juarbe, 2005, p. 965).

The health beliefs and practices of rural mestizo Ecuadorians have not been sufficiently explored. Significant gaps in the knowledge have been identified through this literature review. The rural mestizo population has not been a part of prior research. The healthcare beliefs and practices of rural mestizo Ecuadorians need to be explored and documented to develop a body of nursing knowledge that will contribute to the health and well-being of this population. The lack of research available is significant to the major stakeholders; rural Ecuadorians and those who provide care for them. Without this research, their care and practices related to health remain unknown except unto themselves.

Nursing care has not been studied within the context of rural Ecuador. A significant gap in nursing knowledge is the lack of understanding related to the rural mestizo Ecuadorians experiences with nurses. Zoucha (1998) noted in his research that nurses are involved in caring for patients from a variety of cultural backgrounds. He challenged nurses to gain an understanding of and appreciation for culturally relevant views of health, illness, and the experiences of care. The nurse and patient relationship in Ecuador has not been documented, but is valuable knowledge within Leininger's Culture Care Diversity and Universality that was used to guide this study.

2.10 Theoretical Framework Guiding Study

In qualitative research, the researcher seeks to understand what is known to the informants regarding the phenomena being studied (Leininger, 2002). In rural Ecuador, much is unknown about the healthcare beliefs and practices of this group. After living

and working in Ecuador for seven years, the researcher had assumptions that were explored during a mini-study guided by Leininger's Culture Care Diversity and Universality.

The Leininger's Culture Care Diversity and Universality developed by Leininger is defined as containing the following essential features:

> A substantive area of study and practice focused on comparative culture care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures. Transcultural nursing's goal is to provide culture-specific and universal nursing care practices for the health and well-being of people or to help them face unfavorable human conditions, illness, or death in culturally meaningful ways (Leininger & McFarland, 2002).

Leininger defines culture as a learned set of beliefs, values, norms, and lifeways of a certain group of people that are passed from generation to generation (Leininger, 2002). Culture can be examined by the actions of people including their words, symbols, and actions. Cultural diversity and cultural universality are two key Leininger's Culture Care Diversity and Universality Theory concepts related to culture. Diversity refers to the differences between and among cultures and universality refers to the similarities between and among cultures. Understanding diversity and universality are important goals of Leininger's Culture Care Diversity and Universality Theory.

The proposed study seeks to examine the health care beliefs and practices of the rural mestizo Ecuadorians and the role of the nurse. The data generated will potentially be both subjective and objective in discovery of factors including worldview, technological factors, religious and philosophical factor, kinship and social factors, cultural values,

beliefs and life ways, political and legal factors, economic factors, educational factors, generic (folk) care, and nursing care practices that affect care practices (Leininger & McFarland, 2006).

The understanding of the health and well-being of groups is achieved through understanding two types of care, professional and generic. Professional care is the care given by health care providers and generic care, the care given by the people, usually family members. The generic care is often in the form of folk-remedies and treatments that have been passed down from generation to generation. Many professional nurses do not understand or try to understand these practices. This often leaves large gaps between the people and the nurse. These gaps lead to misunderstandings, resentments, and even litigation. The patterns from the mini-study (Moss, 2008) revealed that interactions between the informants and nurses has been very negative. The informants used words such as rough, uncaring, and lazy to describe interactions with professional nurses.

Leininger suggests cultural-specific care refers to care that would fit the specific care needs and life ways of that culture. Culturally congruent care refers to the cognitively based assistive, supportive, facilitative, or enabling acts or decisions found in the cultural values, beliefs, and practices of an individual or group in order for the nurse to provide meaningful, beneficial, satisfying care that leads to health and well-being (Morgan, 2006).

Use of the Culture Care Diversity and Universality Theory is beneficial to understand “individual cultures, then to group and family, institutional, regional, and community, societal and national, and finally, global human cultures” (Morgan, 2006, p. 146). Research using Leininger’s Culture Care Diversity and Universality theory uses

qualitative methods to answer the research questions as this produces information about the people from the people being studied. This results in information that is accurate, believable, and true. The theory also predicts three kinds of nursing care, decisions, or actions. The predictions are for theory in culture care preservation or maintenance, culture care accommodation or negotiation, and culture care repatterning or restructuring (Morgan, 2006).

2.11 Sunrise Enabler Model

Leininger developed the Sunrise Enabler Model (Appendix A) not as a theory but as a way to visually depict the many components of the theory. The nurse may use the model to move through the 3 layers of the theory with the ultimate goal being to give culturally congruent care. Beginning with worldview, the nurse moves through social dimensions into the environmental, language and ethnohistory layer and finally into the care expressions, patterns and practices that ultimately influence holistic health, illness, and death. Interestingly, the lines showing movement are lateral only in the environmental, language and ethnohistory layer. Otherwise, the arrows depict movement both top to bottom and bottom to top. This would indicate that within the realm of influences for example that death can influence educational factors and educational factors can influence death (top down) and economics (lateral). The rational for using the Sunrise Enabler model is to demonstrate the relationship between the subjective and objective data. The model also demonstrates the fluidity of the relationships.

Researchers who have used this theory and enablers include Zoucha and Schumacher. Zoucha (1998) studied Mexican Americans and their experience receiving professional nursing care. One of the discoveries using Leininger's Culture Care

Diversity and Universality Theory was the concept of *confianza* (confidence) as an expectation of professional nurses. Schumacher (Schumacher, 2006) studied rural Dominicans and discovered the use of folk practices and professional biomedical care is a common practice within this group. Wehbe-Alamah (2006) used the ethnonursing method to discover, describe, and interpret the healthcare beliefs and practices of Lebanese Muslims living in the Midwest. The findings of these international and cross-cultural studies have been reviewed and studied by the researcher and support the use of Leininger's Culture Care Diversity and Universality and its components guided the study.

Leininger's Culture Care Diversity and Universality was used in Tosagua, Ecuador to explore in-depth the healthcare beliefs and practices of rural mestizo Ecuadorians living in this village. The theory guided the researcher when conducting interviews with the informants from this village. The researcher used several of Leininger's enablers including a semi-structured interview guide, and the Sunrise Enabler model. The collected data was analyzed using the Four Phases of Data Analysis. The purpose of this inquiry and method of inquiry was to discover and grasp the world of the informants in the context of their own natural setting within their culture and the role of the nurse. The research Enablers, as part of the ethnonursing study method, allowed the informants to share their ideas and experiences in a natural conversant way. The use of the Enablers allow the researcher to tease out hidden and complex data as it related to the informants and the DOI (Leininger & McFarland, 2006).

2.12 Summary

The history of Ecuador is as diverse as the terrain of the country. From the mountains to the jungle and coast, the people groups maintain their diversity of ethnic

heritage. Across the country, poverty and health disparities remain. Many people living in the rural villages have little or no access to healthcare or modern conveniences such as potable water, electricity, or telephone service. The lack of nursing studies of the rural mestizo Ecuadorian people is one of the reasons to pursue this international nursing study. More nursing studies will expand the knowledge base regarding care meanings, health beliefs, and practices within the context of rural Ecuador. The study can potentially identify what is culturally congruent care and its' meaning to rural Ecuadorians and the role of the nurse in the present context and future implications for the nurse's role in care.

Chapter 3

3.1 Study Design

The ethnonursing method developed by Madeline Leininger was utilized to guide this study. The distinction of using the ethnonursing method is the ability of this method to document, describe, and explain the phenomena of healthcare beliefs and practices of rural mestizo Ecuadorians in their natural setting. Ethnonursing is a qualitative research method using naturalistic, open discovery, and largely inductively derived emic modes and processes with diverse strategies, techniques, and enabling guides to document, describe, understand, and interpret the people's meanings, experiences, symbols, and other related aspects bearing on actual or potential nursing phenomena (Leininger & McFarland, 2006).

3.2 Mini Study Leading to Proposed Study

The author conducted a mini study in rural Ecuador that began the process to document, describe, and explain the phenomena of healthcare beliefs and practices of rural mestizo Ecuadorians in their natural setting of their community, places of work, places of worship, or their homes (Moss, 2008). Through the mini-study, the researcher was able to refine the research questions and the semi-structured interview guide. These modifications were carried over into the maxi study or the larger ethnonursing study.

The mini study was conducted in Tos Agua, Ecuador a small rural community 12 hours by bus from the capital city of Quito and 30 minutes from the main road that leads to the Pacific coast of Ecuador. In the mini study, six key informants and 16 general informants were interviewed by the researcher to identify recurrent patterns related to the

phenomena of interest. The data was collected from interviews, field notes, observation, and review of tape recordings of the interviews (Moss, 2008).

The interviews were analyzed after they were transcribed by the researcher. Data analysis and transcription was aided through the use of a software program for qualitative data analysis, NVIVO8. The recorded interviews were de-identified and stored in individual audio file folders. The audio transcripts were then analyzed and the data assigned to data containers called free nodes within the NVIVO8 software. Initially 52 free nodes were identified. The free nodes were derived from Leininger's Culture Care Diversity and Universality Theory. Examples of these free nodes were health, education, spirituality, care within the home, environmental concerns, and nursing care. The NVIVO8 software allowed the researcher to identify the number of informants and number of responses to each of the free nodes. For example, the response *"health is everything to me"* was coded 21 times out of 22 interviews. Health was then coded as health and value of health. When asked about professional nursing care, 15 out of 22 informants had personal experience with professional nursing care and all 22 knew of at least one person who experienced care from a professional nurse. This was then coded in the free nodes as professional nursing care. Alongside this free node of professional nursing care other nodes were assigned such as lack of empathy, and rough handling of patients.

Identification of many free nodes or data containers from the categories was refined using Leininger's Data Analysis. The free nodes remained in the file but a second file was started with nodes representative of the data from the initial interviews. The secondary file nodes included *automedicarse* (self-medicating with prescription

medication), herbalism, care within the home, the roles of the mother and father in caring for the health of the family, professional nursing care, folk illnesses, folk or traditional healers, religion, and environmental issues. During second interviews these nodes representing the categories were clarified and expanded upon. These categories were refined in the maxi-study. The semi-structured interview guide was also been refined to reflect these categories and will begin to tease out deeper meanings of the Domain of Inquiry (DOI).

3.3 Entry into the Field

The researcher has seven years of experience working in healthcare delivery with rural mestizo Ecuadorians. The researcher lived in Ecuador during these years as a missionary nurse working with community development. The healthcare delivery team consisted of a medical doctor, a dentist, and two nurses. The team traveled to remote areas of Ecuador to deliver care. The team stayed in the villages and provided primary care services including medical exams, free or reduced cost medication, and health teaching for four days. The village provided sleeping quarters, usually a church building or school, for the team to sleep and set up the mobile clinic. The team paid for the food and supplies and the food was prepared by the local women.

One of the provinces frequently visited was the province of Manabí. The village of Tosagua within the province of Manabí was chosen as a village that represents the rural mestizo Ecuadorian life. The village is off the main road, has no hospital, and the researcher has developed relationships with the people within the community. The researcher continues to visit Tosagua at least annually. The informants have been very open to the researcher's visits.

Being fluently bi-lingual in English and Spanish and very familiar with the Ecuadorian culture, the researcher has a distinct advantage for international and transcultural research. Familiarity with the town is also a benefit for movement in and out of the community. Since Tosagua is located 12 hours from the capital city, Quito, the researcher traveled in and out of the community via transnational bus.

3.4 Methodology

This study began after IRB approval was obtained from Duquesne University. Participants were verbally invited by the gatekeeper to participate in this study. The snowball method was used as word of mouth spread through the village regarding the research study being conducted. The study was explained to each potential participant, Appendix C, as above including the risks which are not more than would be present in everyday life. Each potential participant was provided an opportunity to ask questions and seek clarification on an aspect of the study before participating. Though no direct personal benefits may be obtained through this study, the results may result in rural mestizo Ecuadorians receiving more culturally acceptable healthcare.

Participation in the study was voluntary and the participants were free to withdraw from the study at any time. The consent was either presented orally in Spanish or written in Spanish (Appendix D) whichever was the preference of the participant. The consent addressed the purpose of the study, risks/benefits, confidentiality of all data related to the informant, right to withdraw, and that a summary of the data would be provided to the informant upon request. Each participant provided written signature on informed consent form (Appendix D). If the participant did not read or write, the consent would have been presented orally. All participants were able to read and write and the

oral consent was not used. The signed consents were kept under lock and key in the researcher's home with only the researcher having access to the locked file. Collected data were obtained using a semi-structured interview and were tape recorded for future review. The recorded interviews were stored in the password word protected principal researcher's personal computer. The de-identified data was shared with the researcher's dissertation chair and members of the researcher's dissertation committee. At the end of the study, all collected data will be destroyed using the professional data destroying company.

Key and general informants have been used from the beginning of the ethnonursing method. Key informants are the most knowledgeable about the culture and the DOI as evidenced by the depth of their responses and insights into the culture and are thoughtfully chosen through the information revealed during the interview process. They were interviewed two times. The selection criteria for key informants included being age 18 or older, being a member of the culture under study, willingness to participate in the study, agreed to be interviewed twice and observed, and has lived in the community for at least five years (Leininger & McFarland, 2006). General informants were thoughtfully selected, but usually have only general knowledge about the DOI and were able to offer relevant and cultural insights (Leininger & McFarland, 2006). The general informants also met the selection criteria for key informants though their data contribution was more general.

For this qualitative ethnonursing study, ten to twelve key informants were interviewed two to three times for one to two hour long interviews and 20 to 24 general informants were interviewed one to two times for 30 to 45 minutes. These interviews

took place in the homes of the informants or the place of the informant's choosing. The interviews were recorded on audiocassette with the participant's approval and later transcribed verbatim by the primary researcher. Data collection continued until saturation was reached. Saturation is defined by Leininger (2006) as redundancy or duplication of content of information coming from the informants.

The data was concurrently collected and analyzed from the raw data of the general and key informant's interviews. The interviews were transcribed verbatim into the researcher's personal computer, translated from Spanish to English, and checked for consistency and accuracy with the taped interview, coded and analyzed for emerging patterns. Each field of the data was dated, numbered, given an informant code, and a code to identify where the data collection took place. Verbal data, participant observation, and reflections of the researcher were documented. At no time were informants' names used with the transcribed data or any identifying characteristics.

3.5 Method of Data Analysis

The collected data was analyzed using the Four Phases of Ethnonursing Qualitative Data Analysis. The qualitative data software package NVIVO8 was used to facilitate the data coding, processing, and analysis of the data obtained from the informant interviews. Leininger (2002) described the activities of phase one as the collecting, describing, and documenting of raw data from the general and key informants. During Phase One, catergoried began to emerge. In second and third interviews, the information related to the catergories were clarified and the researcher verified the collected data with member checks.

In phase two the collected data was transcribed, translated from Spanish to English, and checked for consistency and accuracy, coded and categories were identified. Verbal data, participant observation, and reflections of the researcher were documented. The researcher used these notes to record any identified personal bias or preconceived ideas from past experiences living in Ecuador. The process of data collection and analysis occurred concurrently. Use of concurrent collection and analysis allowed the researcher to restate and seek clarification. Using the NVIVO8 software package, the interviews were analyzed through the use of coding each interview according to the emerging themes. The software enabled the researcher to view themes across coded interviews to enhance the identification of recurrent patterning.

During phase three, the data were analyzed until saturation of ideas was reached and recurrent patterns related to the DOI identified. Data examination during this phase also showed patterns related to meanings in-context of the DOI. Additionally, the researcher validated and confirmed the findings with the informants. One method of validation is member check of the collected data in subsequent interviews with the key informants.

The fourth and final phase was the synthesis of data from the previous three phases. Inter-phase checks were performed to verify the emic data and findings during each phase and to validate their presence during all phases of data collection and analysis (Leininger & McFarland, 2006). The researcher rechecked the final themes against the collected data to ensure that the themes were supported by the raw data.

The final step was to summarize the data. Results of the data were shared with informants who requested a copy of the findings. The results were presented as part of

completion of the researcher's dissertation process, used for publication submission, and public presentations.

3.6 Summary

The purpose of this qualitative ethnonursing study was to discover and understand the healthcare beliefs and practices of mestizo Ecuadorians within rural Ecuador and the role of the nurse. The phenomena of interest were the health beliefs and practices of rural mestizo Ecuadorians in the context of their own culture and the role of the nurse. A mini-study (Moss, 2008) conducted previously was used to refine the interview guide. The previous mini-study benefited the ongoing data analysis as the researcher continued to tease out the meanings within the DOI. The use of Leininger's Sunrise Model, Semi-Structured Interview Guide, and the Four Phases of Ethnonursing Data Analysis allowed the researcher to manage the large amounts of data that were gathered through the interviews and observations of the informants.

Chapter 4

Results and Findings

4.1 Introduction

The data presented from an ethnonursing study represents the naturalistic, open discovery, and largely inductively derived emic (insider's) view to document, describe, understand, and interpret the people's meanings, experiences, symbols, and other related aspects bearing on actual or potential nursing phenomena (Leininger & McFarland, 2006). The researcher's etic (outsider's) view and the observational data gathered in context of repeated visits to this rural Ecuadorian village. Leininger's Four Phases of ethnonursing data analysis for qualitative data (Appendix E) and computer data management program NVIVO8 were used to manage the data. The data presented will reveal insights into the culture, health beliefs, and care practices of rural mestizo Ecuadorians.

4.2 The Setting

To reach the village, the researcher began her journey in Fort Wayne, IN, flew connecting flights to Miami and then on to Ecuador's capital city, Quito. The researcher boarded a national bus and began the 12 hour journey down from the Ecuadorian mountains to the coastal province of Manabí. The researcher was literally dropped at the edge of the village from the bus with suitcase and computer in hand. The main village road is in such disrepair with huge potholes, no asphalt, and very little stone, that the large interprovincial and national bus lines do not enter the village. The researcher was approached by a local farmer with a truck who offered to drive the *gringita* (little white girl) to the local hotel. The researcher was driven into town and offered to pay the farmer.

He refused payment but wanted to know why I was in the village. He inquired how he could be a part of the study. He was given the name of the gatekeeper and he later came for an interview.

The population of Tosagua is homogeneously mestizo Ecuadorians. The informants when asked how they identify with Tosagua responded affirmatively. General informant J1 states: *"Yo soy cinto por ciento Manabita y vivo en Tos Agua."* (I am 100% from Manabí (the province) and I live in Tos Agua.) The informants, both key and general, reiterated this sentiment always with smiles and a palpable sense of pride. The researcher also observed many of the vehicles in Tosagua carried bumper stickers with the saying, "100% Manabita".

4.3 Entry into the field

The researcher has an ongoing relationship in the province of Manabí. The costal area of Ecuador is accessible and the people very welcoming. The choice of Manabí province and the town of Tosagua were guided by past experiences in these areas and a

desire by the researcher to listen to the voices of this community with the hope of improving their health in the future with the outcomes of this research study.

Tosagua, Ecuador, a small rural community named for its annual flooding. The small village has a population of 15,000 that includes many small outlying communities *(barrios)*. Tosagua is the agricultural center of the Manabí province. Most residents work in corn agriculture as day workers, grainery workers, or in fruit and vegetable farming. The province has a climate that is hot and varies from dry to subtropically humid depending on the season of the year.

Tosagua has been visited by the researcher twice yearly during the seven years the researcher lived in Ecuador. While never living in the village, the researcher visited personally and professionally with a medical mission. The relationships established during the researcher's visits over 7 years were invaluable in allowing for the informants to speak freely. An additional asset is the researcher's fluency in Spanish allowing for the interviews to be conducted in private without use of a translator. The gatekeeper in the village is a local pastor who was invaluable for back translation of interviews and for facilitation of second interviews and member checks. The pastor approached informants in the community for interviews and also guided those who approached in the snowball method to be interviewed. In Tosagua word of mouth spreads quickly and is a culturally acceptable method of communication.

The majority of the interviews were conducted in the homes of the informants. Other interviews were conducted in the office of the gatekeeper. Most interviews lasted one to one and one half hours. Second interviews usually were 30 minutes to one hour. The researcher had a concern that informants from the mini-study would not be found for

additional interview but this was not an issue. The needed second interviews were completed.

Leininger recommended interviews with 12 to 15 key informants and 20 to 25 general informants to reach data saturation (Leininger, 2002). For this maxi study, data saturation was reached after interviewing 28 informants. Of the 28 informants, 10 were deemed key informants for their in-depth knowledge of the DOI and rich description. Eighteen informants were deemed general informants for their verification of information from the key informants. Four people were excluded from the study. Four teenagers under 18 asked to be a part of the study for their own school project. They were respectfully denied but the researcher enjoyed the opportunity to talk with them about the purpose of the study over ice cream.

In Tosagua, 28 informants were interviewed (Appendix F). All identified as being Ecuadorian from the province of Manabí. Twenty six were born in Tosagua and two in small villages within 20 miles of Tosagua. The informant's ages ranged from 22 - 78 with the majority ranging from 25-50. Five informants report themselves as single, one in a civil union, two divorced, and 20 married. The informant's religions reported were two claiming no religious affiliation, 11 Catholic, and 15 Protestant. All of the informants reported some level of formal education. Two reported education at the primary level, 18 have graduated high school, and 8 have completed education at the university level. The gender characteristics were 19 female and 9 male. Most were employed outside the home. Occupations included farmers, teachers, homemakers, unemployed, retired, domestic help, and medical professionals

4.4 Ethical Considerations and Data Collection

After obtaining IRB approval from Duquesne University, data collection was obtained using digital audio recordings, observation, and field notes. After verbally explaining the study, each informant was given a written consent to read and sign. The explanation and consent were presented in Spanish. The signed consents were kept by the researcher is a locked drawer to maintain confidentiality. The recorded interviews were stored on the researcher's password protected computer. All informants reported being able to read and write. No verbal consents were needed. All data will be destroyed at the end of the study. The consent also included permission for the researcher to use de-identified quotes or paraphrases to present the data in the dissertation, publications, and presentations.

4.5 Presentation of the categories

The data collected in phase one through interviews and observations have been further analyzed and the data abstracted. The raw data from phase one was de-identified and each informant was given pseudo initials. The de-identified raw data was then analyzed further. The categories being presented were obtained by using phase two of Leininger's (1991) Ethnonursing Analysis of Qualitative Data. Data analysis has continued from the mini-study through the end of the study. Initially, free nodes were identified from the raw data using the NVIVO8 software. Further analysis of the data allowed the researcher to refine the data to present 18 categories. The categories are the meaning of health *(la salud)*, meaning of illness *(la enfermedad)*, folk and common illnesses *(enfermedades común y folklóricos)*, folkhealers *(curanderos)* medicinal plants *(plantas naturales)*,

professional healthcare *(cuidado professional*, spirituality *(la espiritualidad)*, environment *(el medioambiente)*, meaning of family *(la familia)*, nutrition *(nutrición)*, exercise *(ejercicio)*, education *(educación)*, health education *(educación sobre la salud)*, role of the nurse *(papel de la enfermera)*, politics, and hope for the future *(eperanza por el futuro).* A full description of these categories will now be presented with the supporting data from the informant interviews and the researcher's observational journal.

4.6 Meaning of Health (La Salud)

The first identified category for this study was the meaning of health *(la salud).* An old saying in Ecuador is *"El que tenía salud, tenía esperanza. El que tenía esperanza, tenía todo."* Translated means he who has health has hope. He who has hope has everything. This saying is very much a part of the rural mestizo Ecuadorian life.

Every informant said "My health is everything!"

General informant:

> In my life, my health is everything. Without my health, I cannot work and take care of my family. I need to be able to work everyday. In my work (farm hand), if I do not work, I do not get paid.

Another general informant added:

> I have to work everyday. I have to care for my family. I must stay well to do this.

Key informants reiterated the above and added:

> Here we do not have sick days. Even if you work for the city or in a business, you have to be at work to receive pay. I have been with the city for 10 years. When I am sick, I go to work anyway. Most of us do because we cannot afford to miss a day's wage.

The direct translation of the phrase what does health means to you yielded very general answers as above. The researcher consulted with the gatekeeper who

recommended rephrasing the question to ask “Of what significance is your health?” (Que significa la salud?”)

Key informant:

> For me, my health means everything. It is a gift from God to me. I thank God daily for my health. My health enables me to work, play, and enjoy my family. I also pray that God will protect and keep us healthy also.

Key informant:

> The significance of my health is like asking the significance of being. My health means I am well. I am not sick and I can go to work and care for my family. Some people are not well. They are sick all of the time and their families suffer.
>
> God has blessed me and my family with health. It means that we are healthy in our bodies and in our minds. To be healthy means to have a well balanced life. Our minds and psyche are very much a part of health. If you are suffering in one of these areas, you are not your best.

4.7 Meaning of Illness (La Enfermedad)

The second category presented here is the meaning of illness *(la enfermedad).* Illness in the Ecuadorian culture encompasses several different meanings. One nuance of the Spanish language is the verbs. Verbs have many tenses and are very specific in their meanings. The word “is” in English is translated by two different verbs in Spanish *ser* or *estar.* To be ill has two different translations depending on the type or severity of the illness. An example is a young man the researcher met at a local gas station. He was 13 years old and had the outward features of a child with Down’s syndrome. The researcher smiled and spoke to the boy who was alone at the front counter. He smiled back but did not speak. Soon, the father came around the corner and told the boy to go back to the garage. The father said to the researcher, “Excuse him, ma’am. He is sick.” (*“Perdón, Señora, el es enfermo.”)* The other phrase for “to be sick” is *está enfermo.* While both

phrases mean to be sick, their meanings are very different. *Está enfermo* means to be ill with a temporary condition such as a cold. In contrast, *es enfermo* implies a long term or permanent illness such as cancer, mental retardation, or long term conditions such as hypertension or diabetes.

Key informant using the phrase *está enfermo*:

> Illness here means a lot. If you are sick, you must do what you can do to get better. No one likes to be sick. Sometimes a person is sick *(es enfermo).* This is unfortunate for the person and their family because the family suffers along with the sick person. If a person is bad sick and cannot work, the family must depend on someone else within the family to work and bring home money. The sick person may feel very bad about not supporting his family. Men suffer a lot if they cannot work. Women do too, but not to the same extent.

Key informant:

> When people get sick here, it is a big deal (es enfermo). Many families fall apart because someone cannot work. The wife really suffers as she tries to maintain the family. Some store owners will give some credit so she can buy the necessities. Some family members give them some money too. It is very hard. When it is really bad is when the older children have to quit school to work and support the family. Some families feel shame when they cannot meet their bills.

Key informant:

> Once I was sick and could not work. I prayed and prayed that God would make me well. He did but it was a long trial. The church was so valuable to me during this time. My brothers and sisters in Christ surrounded us with love, prayers, food, a little money, and lots of visits. It is good to know that your family is beside you.

General informant:

> Simple things like coughs and colds are not so bad. mostly inconvenient. You feel bad for a little bit and then you get better. Sometimes people get really sick (used es enfermo) and then you do not get better.

4.8 Folk Illness (Enfermedades Folkloricos)

Folk illness *(enfermedades folkloricos)* are explored and described in this category. Many folk illnesses in rural Ecuador are not known outside of Ecuador. The

illnesses may vary according to the region of the country. In Tosagua, the informants discussed evil eye *(mal de ojo),* separation of body and spirit *(el susto),* and nerves *(los nervios).* The illnesses will be described by the informants now and the cures later in the chapter.

General informant:

> I am very susceptible to mal de ojo. I have a very weak spirit. Even as a child I was always getting sick. Mal de ojo happens when a stronger person stares at a weaker person and robs their spirit. When I am suffering from mal, I just feel bad all over. I am weaker. I may have stomach aches and fever. You feel bad until you get the cure.

General informant:

> I know some people believe in mal de ojo. I do not. People say that they are weak and someone stronger gives them mal. This is just old folk tales.

General informant:

> Mostly children are affected by mal de ojo. If a person looks at them and is envious because they are prettier than their own babies or the person is a very strong person, they can give the baby or child the ojo. Some believe that touching the babies head by the strong person causes ojo too.

Key informant:

> I think if you were to ask around the village about half of the people believe in mal de ojo and half do not. The older people and the people with lower education believe. When I became a believer in Jesus Christ, I gave up my superstitions and put my trust in Jesus. Who can be stronger than Jesus?

Key Informant:

> You have to be very careful with mal de ojo. Some people are known to be evil and cause the mal de ojo. You cannot just tell by looking at someone and no one says, “Hey, I am giving you the mal de ojo!” No, it is very subtle. You never know. To prevent mal de ojo, you have to be healthy. You have to be careful of people you do not know. Strangers who are very forward with our children are not welcome. We may not trust them because they may mean harm.

The Fright (*el susto)* is caused when a person experiences an emotional shock, is frightened by an animal, near drowning, a fall, or an accident and the spirit seperates from the body. The symptoms of susto intensify over time if you do not seek a cure right

away. Symptoms include body aches, insomnia, restlessness, crying, fear of loud noises, thirst, and green diarrhea stools.

Key informant:

> Susto is not as common as mal de ojo but it happens to some adults and children. It is very important to get a cure as soon as susto happens so that you do not continue to get worse.

Nerves *(nervios)* is a condition where the person responds to suffering and family stress with physical and emotional symptoms that do not respond to medical treatment. The symptoms include fear, stomachache, insomnia, anger, and hot or cold sensations. In men, the predominant symptom is extreme anger. The researcher observed in the local market women consulting with the herb vender for herb combinations that would help with this sickness. No informants claimed to be presently affected with this disorder.

General informant:

> Nervios are very common. There really isn't a cure except time. It seems that nerves just come and go. Some people never get over them. Maybe when the suffering is less, you may get better but with family there is always some suffering.

Key informant:

> Nervios are not nervousness. There is a big difference. Nervios happens when you get upset with your family. My daughter moved out and I was so upset. This was nervios. Oh how I suffered. Nothing cures nervios but time. Things got better with my daughter and I started to feel better but it took time.
>
> Some people go to the doctor for nervios because they do not know what else to do. They know this is not the cure but they are seeking relief. Sometimes the doctor recognizes nervios and sends you to the curandero for help

4.9 Common Illnesses (Enfermedades Communes)

In this category common illnesses *(enfermedades communes)* are discussed. Common illnesses are the illnesses that were most frequently reported by the informants.

Generally, these illnesses are self-limiting and do not require outside medical intervention. In rural Ecuador many people report being affected by illnesses of the upper respiratory system such as upper respiratory infections (URI) of viral and bacterial origins. The informants all concurred with this. Other illnesses in Tosagua reported by informants are diarrheal illnesses, food poisoning, dengue fever, malaria, tonsillitis, and pharyngitis. Chronic diseases named by the informants include diabetes, gastritis, hypertension, high cholesterol, and asthma. Diseases such as cancer were rarely mentioned. AIDS as a disease was mentioned only once.

General informant:

> We can become very sick here. Children are very susceptible to illness of the throat and lungs due to the dust. Lots of children have runny noses and coughs year around. Just last winter (rainy season) my son was sick with tonsillitis and had to be on antibiotics.

Another general informant discussed the illnesses of adults:

> In Tosagua, everyone is sick a lot. Children are sick with coughs and cold. Adults are affected by the same plus we have high blood pressure. The high blood pressure is caused by all of the stress. It damages our bodies. You may have high blood pressure if you have a bad headache all of the time. That is how I knew I had it.

Key informant:

> Part of life and sickness here are amoeba and parasites. They are very common. People who are careful can get parasites too. They come in the water and the food. You can get them from eating from the street vendors, drinking unboiled water, and poor food preparation.

A key informant who is a teacher discussed children's illnesses at school:

> Oh, my! Yes, the children suffer here. So much coughing and sniffling! My classroom is awful. The illness time used to be in the winter but now, it seems to be year around. The children suffer with coughs and runny noses. If they are sent to school sick, I have to keep them in the classroom. There is no where to send them, No one checks on them. Some parents are not very careful and send them with fevers. Now that some parents have cell phones, I can call them but most times I just keep them in the classroom.

The informants were very consistent in describing a cold *(gripe).* All 28 described gripe as the most common illness in Tosagua. Each informant stated that gripe is a sore throat, runny nose, and congestion that last seven to eight days. Verbatim, the informants reported this. Causes of gripe varied from dust to bacteria. The most common ways given for treating colds are herbal teas and fruit juice. Herba Luisa was the most common tea preparation cited.

Inadequate data was obtained regarding aging and chronic disease. With the life expectancy increasing in Ecuador, aging and chronic disease will be briefly mentioned here. The average life expectancy in Ecuador is 70 years for men and 75 years for women. The top three causes of death are hear disease, diabetes, and cerebral vascular accidents (Factbook-Ecuador, 2008). An observation by the researcher is that the elderly do not dwell alone in the community. Most of the elderly live with family or on the same grounds with their extended family. Most informants related diabetes and hypertension as the most common chronic diseases in Ecuador. None were able to say with any certainty if the diseases were related to one another or if men or women were equally affected.

A key informant added information regarding chronic illness:

> People here either take care of themselves or they don't. I have high blood pressure. I am in control. I go to the doctor every three months for my check up. The doctor checks my blood pressure, blood, and urine. I do not know what she looks at but I always do what she says. She gives me a prescription that lasts for three months. I cannot afford to buy more than a few days of medicine at a time. But I buy it as I can. I have rarely missed more than one or two days.
>
> My husband is another story! He has diabetes AND high blood pressure. He does not practice control like me. He has many things he is supposed to do. He is supposed to check his blood sugar. He does not do it. He is supposed to take his pills. He does not do it. He is supposed to be seen every three months too, He does not do anything. I thought at least he

> could eat less sweets but he does not. I do not know why. He says he takes his medicine when he feels his sugar is high. I do not think this is correct.

A key informant discussed chronic illness in Ecuador:

> It used to be here in Tosagua that we did not see so much high blood pressure and diabetes. People did not live long enough to get so sick. Also, when people all worked on the farm, people were healthier and getting lots of exercise. A chronic disease then was an aching back. We still have lots of muscle and bone pain in the farm workers but they keep working right through it. Just like any disease some people take care of themselves and some don't, won't, or can't. Don't want to. Won't do it even if they could or can't afford the treatment.

4.10 Folk Healers (Curanderos y Herbalistas)

In this category folk healers *(cuaranderos y herbalistas)* will be discussed. The names *cuarandero and herbalista* are often used interchangeably. Their methods of treatment are very similar. A distinction is that a *curandero* is usually a man working from his home. In contrast, the *herbalista* is a woman and her work may be done from inside the fruit and vegetable market where she also sells fruit and vegetables in addition to herbs.

Folk healers known as curanderos are in all regions of Ecuador. In rural Ecuador, the curandero lives and works within the community. The curandero in Tosagua is available to the entire community. The process for accessing the curandero is to take the patient to his home. After the consult, the diagnosis and treatment are given in the home of the curandero. If a series of treatments are needed, the patient returns the prescribed number of times.

The curandero may be used as a primary, secondary, or tertiary healthcare resource. As a primary measure, some informants discuss use of the curandero because they have a weak "spirit". A weak spirit means you are susceptible to illness either

biological or spiritual. Secondary resource for those affected by an illness, and tertiary as an ongoing source of treatment and prevention.

General informant:

> When I was small, I had the evil eye (*mal de ojo).* My mom took us to the curandero. The curandero would take an egg that my mom brought and rub it all over our bodies from head to toe. The mal went into the egg. Usually one treatment was enough but sometimes we went two or three times.

General informant:

> The curandero can be used to treat other sicknesses too. Some people who do not want to take pills can go to the curandero, be treated with the egg and herbs.

Key informant:

> I was taken as a child to the curandero for mal de ojo. Her house is just up the road. She has people who come and go all day and into the night. She treats all sorts of illnesses. Some are our illnesses, you know, mal de ojo and susto. Some people go to the curandero because the medical doctor has not helped them. Sometimes the medical doctor sends them because the problem is spiritual and not medical. The treatments vary from egg, herbs, or baths with herbs. The person usually gets better over the next few days and then is back to normal.
>
> If the problem is a demonic problem then the person needs to go to the brujo. The brujo uses witchcraft to help the person. I have never been to the brujo but what I hear is that he uses candles and incantations to saints and devils. This scares me. I would never go.

In observation, the curandero after rubbing the egg over the entire body of the patient, the egg is then broken into a glass and the yolk and white are read by the curandero. In the case of mal de ojo the yolk appears to have bubbles forming that look like eyes. In susto, the white appears coagulated and rises up o the glass wall.

Observing in the local market, the researcher noted the herb vender selling herbs and giving advice related to folk illnesses. Customers would come to her stand that was lined with fresh and dried herbs. The customers would tell her they were there for something for nervios or something to rebuild *(reforzar)* their strength after visiting the

curandero or medical doctor. The vender would bundle together two or three different types and verbal instructions on how to prepare the tea. The cost was usually less than one dollar for three or four days of tea. Other examples of herbal medicines will be presented later. Other buyers requested specific herbs by name without specifying their intended use.

Also, the herb vender was noted to put together an herbal collection in the form of a small whisk broom (escoba). The vender wet the herbs with either water or liquor and hits them over the customers back *(una barrida).* No words are used in the process which takes about five -ten minutes. After the barrida, the customer left. No further purchases where made from the herb vender.

Key informant:

> The curanderos use all sorts of herbs, concoctions, smoke, and candles. People chose who they go to. Some go to the curandero and some to the herbalist. A belief is that the herbalist does not use any form of witchcraft so this is more desirable for some.

4.11 Professional Healthcare (Cuidado Profesional)

In Tosagua there is no hospital or medical clinic. Two physicians are in practice who specialize in primary care. Several laboratories draw blood, examine urine, and feces. No x-ray or other imaging is in Tosagua. The nearest point of care for x-ray or ultrasound is 30 minutes away in Calceta. The nearest full service clinic offering emergency care or basic radiologic services is one hour away in Chone. This hospital is a government run entity with 30 beds. It is not staffed 24 hours per day. Two full-service, 24-hour per day staffed hospitals are one and a half hours away in Manta.

General informant:

> Our medical care in Tosagua is very poor. I mean, I like the doctor I go to but if something serious is wrong with me, I have to go to Chone for care and if it is really serious all the way to Manta.

General informant:

> Not only do we not have a hospital here, we do not even have a healthcare center. We are very lucky to have the doctor, but this is not enough.

Key informant:

> Yes, it is true we do not have a place for emergency care or surgery. In the cities, they have ambulances to carry sick people. Here, if you break your leg or need your appendix out, they put you in a car or the back of the truck and take you to Chone or Manta. This is not good. People are miserable en route. If you have an auto or bus accident, it is the same, back of a truck.

Key informant:

> The doctor here manages my high blood pressure very well. She checks me every 3 months. If I get a cold, she sees me in between. She makes me do a mammogram in Chone every year. This is hard to do because I have to not only pay the doctor visit, but I have to pay transport to Chone and back. Then, the cost of the mammogram. Very expensive.

The informants report little satisfaction with the healthcare system in Tosagua. 10 of the 28 informants report seeing one of the two medical doctors. They are satisfied with the care they receive from them but report wanting something more.

Key informant:

> The doctors here help the town but they just are not enough. They help with control of chronic illness but we have to leave for so much. I do like that when I see her; she takes time and explains what is wrong with me. She gives me lab tests to do, I go back with my results and then, she tells me what to do. She gives me a prescription if I need it and tells me what kind of water *(herbal tea)* to take it with. Taking the medication with the right water is important. You want to have the medicine do what it is supposed to do.
>
> Something else I want from my doctor is to be prayed for. I would really appreciate prayer after the visit before I go home. You know God has given us the medicine. I see the doctors as an extension of God.

The researcher has been involved in medical teams that have visited Tosagua on several occasions. The medical team was invited per request of the local church. The

team provided free primary medical care to the local community. The local church was the central location for examining the participants and organized the appointments and follow up care with local physicians as needed.

General informant:

> I remember the medical teams *(caravana medicas or campanas)*. Lots of people got seen and got help. This is very good for the people who do not usually go to the doctor.

Key informant:

> The local churches, the Catholic and Protestant, each have invited medical teams. Each team does about the same thing. Free or very low cost exams and the same with the medicine. Usually these are open to anyone in the community. Occasionally, they have one day reserved just for the church members.

Key informant:

> The caravans are helpful. People come for different reasons. The doctors come because they want to help. The Churches want to help the people who cannot afford medical care. Some of the people come because they are curious, not because they have a need. Some people come because they think American doctors are better than Ecuadorian doctors. Some people will not go because they think that American doctors do not know how to treat our sicknesses.

In observation during previous medical caravans, the researcher noted that several questions were predominant. One question, “With what water should I take the medicine?” Our team members always responded with boiled water. A second question was, “Should I take this medicine all together or take one and when it is finished take another?” This second question was perplexing because many of the patients has multiple issues such as intestinal parasites, anemia, and gastritis. A patient with this diagnosis would have been given a prescription for each condition plus a vitamin that had been donated by a supporting church. On more than one occasion the researcher noted that the medicines were thrown in the trash or sold to someone else.

Key informant:

> Yes, people do not trust lots of new medicines. I think they are scared of medicine because they do not understand it or maybe someone had a bad reaction to some medicine. Whether in a caravan or not some people go to the doctor, get a prescription and take it to the pharmacy. They may buy one days worth. If nothing bad happens, they go back and buy the rest.
>
> A couple of very dangerous things happen too. Sometimes one person in the family is seen for an illness. If anyone else in the family has the same symptoms the father or mother may buy the full prescription and give a little of the medicine to everyone. Not a full dose to the children maybe half a tablet.

Key informant:

> Yes, those things are true. People take each others medicine. This happens a lot. Something else dangerous is self-prescribing medicine *(automedicarse).* Really this has two forms. One form is that the person goes to the pharmacy and asks for a particular medicine. The person may ask for an antibiotic they had before or medicine for high blood pressure without a doctor's prescription.
>
> Secondly, not all of the people who run our pharmacies *(boticeros)* know anything about the medicines they sell. A couple of the *boticeros* are very good. The know how to give a shot or start an intravenous. You can lay in the back of the pharmacy and get intravenous. All of this without seeing a doctor! You just go to the pharmacy, tell your symptoms, and get your treatment.

General informant:

> When I am sick, I go to the *boticero*. I tell him what symptoms I have and I get medicine. Much cheaper than a consult with the doctor. A lot of people do this.

4.12 Medicinal Plants (Plantas Medicinales)

The medicinal plants *(plantas medicinales)* are presented in this category. The plants used in Tosagua are readily available and grown in the region. The use of medicinal plants in Ecuador is a common practice. In rural Ecuador this is no different. Medicinal plants are grown by the some informants on their patios or small garden plots.

Others purchase herbs from the local market, receive some from neighbors, or purchase dried from the pharmacy.

Medicinal plants have a multitude of uses and preparations. Appendix G lists the names, species, forms, preparation, and indications. Medicinal plants are most commonly prepared as teas. The herbal preparations have been reported to protect from disease such as cancer, cure illnesses such as amoebas and parasites, and relieve symptoms such as head, diarrhea, and insomnia.

General informant:

> We grew up to herbal tea *(aguitas).* Mom always had aguitas for us. The aguitas de oregano pr manzanilla was used on a daily basis to keep us well. She used other teas according to our symptoms.

General informant:

> I drink aguitas all of the time. I want my kids to use them too. They are so much better than colas.

Key informant:

> Some may not understand the importance of aguitas. Like you, you ask me what I drink and I say aguita. You think tea like iced tea but it is not. Aguitas are herbs steeped in either hot or cold water depending on what you want it for. These are very important to me. I believe that drinking aguitas keep me healthy. I know that I must take my medicine with either oregano or manzanilla because the doctor told me.

Key informant:

> Aguitas are one way that we can take care of ourselves. This is way to care for the family that really costs very little but has a lot of benefit. We rarely drink plain water. Since the water is so contaminated, we boil everything we drink. It is very easy to add some herbs.

4.13 Spirituality

The category of spirituality is presented here. In Ecuador spirituality is an individual and corporate practice. In rural Ecuador, as in most South American cities, the center of town, (la plaza central) is the geographic and cultural center of town. The local

Catholic Church usually is situated on this plaza. In Tosagua, the Catholic Church was moved from the plaza to a street higher above the city after a devastating flood destroyed the original 100+ year old building. In Tos Agua, there are several churches: Catholic, Protestant, Seventh Day Adventist, and Jehovah Witness. Two informants reported no religious affiliation, and 11 Catholic, and 15 Protestant affiliations.

Church participation varied among informants. The informants who claimed Protestant affiliation reported to regular church attendance, daily prayer, and faith in God. The Protestant churches offer services Sunday morning and evening and Wednesday evening Bible study. The Catholic Church offers daily morning mass, Saturday evening and Sunday morning mass. Catholic informants reported more sporadic mass attendance but reported daily prayer for health.

General informant:

> When we were young, my Mother made us go to mass. We had candles all over the house. I go now once or twice a year. I pray everyday to be healthy and keep my job. My Mother still goes to church every week. She prays for me too.

Female key informant:

> I am a good mother. I know that my children are happy and growing strong. I work very hard to make sure they are clean, fed well, go to school, go to church and that my oldest girl is learning to cook and clean also. Someday she will have her own family to care for. She can cook rice, chicken, and make juices, simple things. But, my most important job as a Christian mother is to teach the children about God. We pray together and I teach them about faith. We all go to every church service together. I can lead them to God but they must make their own relationship with Him.

The churches in Tosaguaalso look after the physical needs of the congregations. The local Catholic Church in years past under the direction of the former priest hosted medical campaigns *(campanas).* The protestant church has also hosted medical teams. In both instances, the medical care was free or very low cost and open to the entire

community. These campaigns were always very well attended and met the needs for many people who could not afford to see the local medical doctors.

In addition to medical campaigns, the local churches are places for health information. Observing in the Catholic Church vestibule, many health related posters were present regarding a number of topics including; vaccines, abortion, exercise, and diabetes. The catechism teacher informed me that in the parochial school the children have a specific health class that is linked to the Biblical teaching that the body is the temple of the Holy Spirit.

Key informant:

> At our church (Protestant) we talk about caring for our bodies and our families as Christ cared for the Church. How can we care for others if we do not care for ourselves? In the church we come together and support one another in prayer. Not only do I pray for my own health but I pray for my brothers and sisters in Christ. I know that in the church, I am safe and I am loved. My children are cared for by the Sunday School teachers also. I do not look at church attendance three times per week as a burden. The church feeds me and my family spiritually.

General informant:

> Last 2 months or so, pastor has a walking session for the men three mornings per
> week. We meet at 5:30 AM and walk several miles. We come back to the church to pray and then we all go home and get ready for work. Pastor has a real heart to keep us united as brothers.

4.14 Natural Environment (Medioambiente)

The category of the natural environment is a difficult translation from the word *medioambiente* in Spanish. *Medioambiente* encompasses not only the air, water, and land but the interaction of the three. Traveling to Tosagua is an adventure for the senses. Leaving Quito on the bus the landscape begins as a metropolitan city with lots of traffic, buildings, and surrounded by mountains. The bus winds its way down the mountainside

through many switchbacks and a relatively well maintained road. At certain spots the road is rough or literally washed away from the mudslides down the steep mountains. The landscape begins to become more green and lush as the bus descends to a subtropical climate and lower elevation. The sight of the llamas in the sierras is replaced with seeing tropical birds in flight and in the trees. The tall pampas grass is now replaced with acres and acres of banana trees, orange groves, and corn fields. The province on Manabí has been called the bread basket of Ecuador because of the amount of crops that are grown here.

In the past, farmers were able to grow enough crops to make a living and feed their families. As the economy has declined over the years, these small farmers were forced to abandon their own farms or sell them to larger land owners or corporations such as Dole, Chiquita, and Del Monte who have converted small farms to large mega farms or plantations of banana, pineapple, and oranges. Now, Manabí is the province leading Ecuador in the exportation of these crops.

The region is also the area where corn is an abundant crop. Small and large farm operations raise corn for seed and livestock feed. The corn is not raised for human consumption. A hominy type corn (*choclo)* is raised mostly in the sierra of Ecuador for human consumption.

In the Manabí province there are two distinct seasons; dry and rainy. The rainy season is typically December until May and the dry season June until November. The informants relate the time of year in relation to dry and rainy season. An example is that children go to school in dry season.

Recent weather anomalies such as *El Nino and La Nina* have wrecked havoc in the lower coast regions of Ecuador. Typically, the rainy season during *El Nino* is torrential rains which cause mudslides and inundations. Many towns have been flooded and extensively damaged. The extreme rains also affect the infrastructure of the province. Many paved roads are damaged by the rains causing potholes and actual washing away of the asphalt. In the more rural areas where the roads are dirt, these roads may become impassable during the rainy season virtually isolating the people in their home villages except for foot travel. The town of Tosaguahas asphalt leading into the town but the actual main road in the town is completely destroyed and is now dirt and potholes.

General informant:

> Our poor town! The streets are awful! In the rainy season full of mud and water and in the dry season the dust is choking! No one cares! The city should repair the streets but they say there is no money.

Key informant:

> The town has really gone bad. The streets are destroyed. The rains ruined the pavement and then with the buses and trucks, the holes just get bigger and bigger. Right now (dry season), the dust is horrible! We live right on the truck route. Not only is it noisy but we cannot open the windows because of the dust. I could dust every one hour and everything would be covered.

When asked about the health effect of the extremes in environmental conditions, the same informants were quick to expand on their thoughts.

General informant:

> We are sick because of the changes in seasons. The children are sick with coughs and the adults are sick with coughs.

Another key informant says:

> When I work during the rainy season, I have to wear (rubber) boots. My feet sweat and become so sore. The fungus *(hongos)* takes over my feet. I put cream on but they do not get better until dry season comes. This is a very uncomfortable situation.

In addition to the weather many informants report how the changes in the agricultural have affected the environment. Previously the farms were small and family owned and operated. The small farmer used natural *(abono)* fertilizer, manure from the animals. No chemicals were used on the farms. With the increased industrialization in the area, the use of pesticides and farm chemicals has greatly increased. The informant's state great concern about contamination of the food supply, water supply, and the air.

General informant:

> Our environment *(medioambiente)* is very contaminated. The chemicals on the fields and trees are affecting all of the land. The farmers use chemicals all of the time. I think they overuse them. They are used on the food for animals and our food too. This is not good. We should not eat all of the chemicals. I am scared of cancer from eating the chemicals.

Another General informant added:

> The farmers are not careful when using the chemicals. They do not read the instructions. We all are at risk. They are even using chemicals in the animals.

Key informant:

> When I grew up on the farm, we used *abono* and nothing else. Now, the soil is very poor due to the over use. Farmers do not rotate the crops to allow the soil to replenish. Of course, the El Nino's do not help. The farmers use whatever they think will help them produce crops. Without crops, there is no money for them.

Key informant:

> The farmers use pesticides on the fields and the fields drain into our rivers. The city draws the water from the river. Already the water purification is poor. So on top of poor purification, we are getting pesticides in the water supply too. I do not know anyone who drinks the city water without boiling it. The pesticides can make you sick if you do not peel your fruits. You get a stomachache and diarrhea, sometimes a headache.

All of the informants talked about the city water system. The researcher's observation at the city municipio (municipal) agency confirmed the statements that the water system in Tosagua is very old. The pipes are broken in many areas of the town. Most of the town has the original metal pipes that have corroded. The researcher

observed in the hotel where she stayed in Tosagua that the water from the tap had a foul odor and when drawn into a glass of water was not clear but had a brown cast. When allowed to sit, the water did clear after about 30 minutes and brown sediment settled at the bottom of the glass. The researcher drank only bottled water and experienced no ill effects.

Another observation was the number of informants who used water receptacles, large water bottles, in their homes. The receptacles varied from a ceramic base that the 10 gallon water bottle sat in to blue plastic drums that were used to hold the cooled boiled water in the kitchen area. Large water tanker trucks were observed in town that filled cisterns. Trucks were noted to deliver bottled water in all bottle sizes from the small 12 ounce bottle to the 10 gallon bottle.

General informant:

> I do not trust our water from the city at all! It has a bad taste, it looks dirty, and it makes you sick if you drink it. I am not sure I trust the bottled water either. Maybe they just pull it right out of the river and put it in bottles after the dirt has settled.

Key informant:

> Water is life. Our life is not good. Water is very time consuming here. The city system is broken. The pipes are broken in many area and the pipes are very old. The oxidation flows through and comes into the house along with whatever dirt it picks up on its journey. There is a filtration plant. When it rains very hard, the plant system backs up.

Key informant:

> To use the water from the city, it must be boiled. We boiled it twice for 14 minutes each time. The clean water is placed in a drum in the kitchen. Some people do not boil the water before using it to cook. Not me! Boil, boil, boil. I want to be safe. We could have a tanker deliver the water but this is not safe either. I am sure it is from the river and then they charge for the dirty water.
>
> The river is not clean either. Animals walk in it and drink from it. People wash their clothes, bath, and use it as a toilet. We know the farmland drains into the river. No one cares for the river.

Key informant:

> Our town is very contaminated. The water, the air, and the city system of roads are poor. All of these things together keep us from being a healthy city. People try to be healthy by boiling the water but what can we do about the air? The big trucks and buses roll through with their exhaust and stir up massive amounts of dust. We breathe all of this in day after day. The air damages our lungs and throats. The water damages our stomachs. The roads just make life hard in general.

Sanitation is a problem in Tosagua. The current system consists of open storm and sanitary sewers between the streets and the sidewalks. Some areas do have a closed sanitary sewer system but regulations regarding tying into this system are not enforced. Therefore, raw sewage is in the open sewer in many parts of the town. The raw sewage is an ever present source of disease and odor. The researcher observed garden hoses running from homes into the sewer with very putrid liquid coming from the hose. The sewer runs into the local river without going through a treatment process. The filtration system is after the water is drawn from the river for the town's water supply.

4.15 The Family *(La Familia)*

The category of family *(la familia)* is presented here. The family is the center of rural Ecuadorian life. While the narratives of family and family life revolved around activities and a nuclear family, most recalled these as happy times and positive relationships. Only one informant reported a nontraditional home life with a father having two families; one family in Tosagua and another in a different village. All informants report living with a mother, father, and siblings. Several informants reported other relatives living in close proximity on the same property, or in the same home. Relatives included grandparents, widowed aunts or uncles, and various blood relatives.

Informants freely invited the researcher to their homes. Upon entering the home, the researcher was consistently offered a seat which appeared to be the choice seat in the home. The researcher was consistently asked if she was getting enough food to eat and how she liked staying at the local hotel. Within minutes of arriving in the home, the researcher was presented with a small plate of crackers or fruit and either a soda or herbal water. This scenario was consistently repeated in all homes.

When observing in the village market, mothers who are selling vegetables are accompanied by small children who play among the stalls and older children who help keep the fruits or vegetables in order and help with sales. After school, there is a large increase in the number of children with mothers in the market area. A small crate may be flipped upside-down for a writing table to work on homework.

Not only in the fruit and vegetable market but in the small street front stores that sell everything from soap to nails and fresh cheese and bread, children are part of the workplace in a family run business. The young children can be seen doing a small task just like Mom or Dad; shelling peas, sweeping the floor, or talking with customers.

General informant:

> I bring my children with me to the store because I can care for them here. At home, they would be by themselves. This is not good. I never know what they will get into or who may come to the door to bother them.

A key informant says:

> When I was a small girl my mother took us to the market with her. I helped with the fruit. I played with my friends and sisters. My brothers helped my dad on the farm raising the fruit we sold. The whole family worked together.

When asked about the children in the market during the day, a key informant clarified:

> Some families do not send their children to school. In the past it was very difficult for a family to send all of their children to school because of the cost of uniforms, books, and school fees. Now, the government has a new

> initiative that there are no tuition fees for public schools. Very low fees for books and uniforms or they may be free if a family qualifies. Now, there is no reason for children to not be in school.

Key informant added:

> Children should not be unsupervised at home. Some parents who do not care for their children have no one watching out for the children while they are out. Sometimes the parents are at work or sometimes the parents may just be drunk. These children run all over and cause trouble. Later, when the children are older, this is a big problem as they start drinking and doing drugs. They never go to school to have a chance to make their life better. This is very sad and troubling to the community.

The informants were asked to describe the roles of the parents in the family. Many of the informants shared memories of happy times in their childhood living in the rural area.

> We grew up in the country. We worked hard and played hard. We did not have much. Our house had no indoor plumbing or electricity. No one did at that time. We all slept in one room. We grew our own food. We went to a government school until 6th grade. We ate together, worked together, and went to church together.

One general informant shared stories of an absent father or a father who also had another family with another woman in another town.

General informant:

> My father was like a part-time father. He stayed at our house for a couple of months and then he may be gone for a couple of months. I did not understand when I was small but as I grew up, I learned that he had another woman and family in another town. I have half brothers and sisters that I have not met. My mother was very sad and ashamed. She tried very hard to keep father happy but was not able to keep him just at our house. We were very poor. Three of us went to school and three of us stayed home. We alternated school years. No one went beyond eight grade because there was no money.

Key informant:

> In previous years, not as much now, men were very machisto. They tried to exert their control over the woman. He would threaten the wife and demean her in front of the children.

Machismo was a term readily defined by the informants as a man exerting his dominion or will over a woman. All reported that this is much less common than in years

prior. All related the difference to increased education of both men and women. The role of the family as a nuclear part of the life in Ecuador is related by all informants.

Key informant:

> The family is the center of family life. Within the family is where you can dream and be safe. Within the family is where you are loved and supported. The family is what makes us human. The family is where you grow as a man and spiritually with God.

Key informant:

> My family is everything to me. Without them I would not exist or survive. We do everything together. We live together, love together, and respect one another. We work during the week and the children go to school. The week is so busy. Once the weekend comes, Saturday we work in the morning and then in the afternoon take care of things around the house: cleaning and laundry. On Sunday, we go to church and then spend the afternoon together either in the house or a small trip to the river for relaxation. More people need to take time off and spend with the family just being.
>
> In the family I have multiple roles as mother, wife, and maid *(hace toda).* My husband and I work together to make a nice life for our family.

When discussing roles of the family with the informants, the responses were uniform in the roles of father, mother, children, and grandparents. Mothers were usually in the home caring for children and the home. Fathers worked outside of the home either on family farms or for someone else on a farm or in a small business such as a carpenter shop. Per all informants fathers handled the household finances and usually the purchasing of food and supplies for the home and family.

General informant:

> My parents were very traditional. Mother stayed in the home and did everything around the house for the whole family *(ama de la casa).* She was the first one up in the morning and the last one to bed at night. She cooked, cleaned, and cared for us kids. Our grandmother lived with us too. Mother cared for her too. She also made my fathers lunch for him to take to the field. Father did not work in the house at all. He did not (perform) care for the children.

Key informant verified the above and added:

> While Dad did not actively care for us or discipline us, he was the head of the house. Dad handled the money. Dad bought what we needed. If we needed hoes, Dad bought them and brought them home. If we needed paper for school, Dad gave us the money to buy the paper.

The roles of the family members have changed in recent years. Four of the 19 female informants reported staying in the home as a housewife (ama de la casa). Fifteen of the informants work outside of the home for small businesses, teaching, or for the city (municipio).

Key informant:

> My husband and I both work. In the morning I get the kids ready for school and get the breakfast. I walk them to school and the maid *(empleada)* stays with the baby. She is in the home when the children get home form school. She helps with laundry, cleaning the house, and meals. My husband buys the food from the market and whatever else we need in the house.

In addition to the care of the home, informants who are parents discussed their roles in the health of children. Parents stated great feelings of responsibility to care for the health and wellness needs of their children. Fathers and mothers reported different roles, but both reported working together to care for the children.

Female general informant:

> Being the mother means that I take care of the children. They depend on me for their well-being. I feed them good food to eat, make sure they are getting their education, and care for them when they are ill.

Male general informant:

> I am not the one who gives the care but I make sure that my wife does her job. I make sure we have food for her to prepare and if the children are sick, I go to the store and buy the medicine. We all go to church together and pray everyday for good health.

> While mothers report caring for the physical needs and fathers the support of providing the mother with the tools to care for the children, both have an active role in the care and upbringing of the children. Both parents report a desire to spend time with the children and see the children develop both physically and spiritually.

General informant:

> Just as I am caring for my children, I am also caring for my mother. She lives on the same property in her own house right now. We make sure she has food and medicine. She comes and goes from our house to her house. She is not alone. This is very important to me.

Key informant:

> Here, we take care of our families; old and young. We do not have places for them to go when they are old. We keep our parents with us. Sometimes we move into their house and they move into a smaller house of the same land. We care for them and help them with chores. They help us too by being home all day to watch the houses and protect from thieves. They help with the children by being here after school. When they are too old to help, we just love them and keep them as happy as possible.

4.16 Nutrition

The category regarding nutrition is presented here. Nutrition encompasses more than food but the meaning of food in relation to culture. Observing in Ecuador, the visual prevalence of obesity is much less than in the United States. No statistics are in the Ecuadorian census data regarding overweight and obesity. What is observed is the lack of fast food marketing and fast food availability in rural Ecuador. Fast food in rural Ecuador is considered what is available from the street vendors and includes: homemade ice cream, sno-cones, white bread, white rice, soda, fruit juice, fried hot dogs, fried potatoes, fried pork, roast corn served with mayonnaise, and fried plantains.

General informant:

The food from the street vendors is awful (nutritionally) but it tastes really good and is cheap. The children almost beg for it.

Key informant:

Our food has changed a lot over the years. When I was growing up, we ate only at home or in the homes of family members. We ate at home before and after school. Now, the children eat one meal at home and then eat at school. If they go to school in the morning, they may take a snack and then eat lunch and dinner at home. The older students eat lunch at home and then go to afternoon school. They may not get out of school until seven in the evening and then have afterschool activities. It may be ten in the evening before they get home. When this happens, they end up eating from the street vendors. Pure sugar and fat!

Key informant:

In the times of my grandparents and great grandparents, they were on the farms. They had cattle and worked on the land. Now, we live in times with better services and different activities for work. Because of this, we now get our food from the market. Someone else grows what we eat.

I am very upset about what our children eat at school. The children do not have time to come home and eat a meal. They do not want to take anything to eat because it is inconvenient. They want to eat on the street because it is easy, tastes good, and saves them time. The school provides no food but they allow the vendors on the school property. It would be nice if the school would promote good eating habits by not allowing all of the fatty foods on the school grounds.

Key informant:

No one teaches our children to eat. If parents do not teach them how to eat at home, no one tells them. The school has no nutrition education. I teach my children to eat fruits every day. I do not buy cola. I know they get it on their own but not at home. It takes time to make good food but we need it to stay healthy now and in the future.

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4.17 Exercise

The category of exercise is presented here. The category describes activity above and beyond activities of daily living. In rural Ecuador the main modes of transportation are walking, bicycles, motorbikes, or public or private vehicles. By far, the majority of people walk everywhere. In observation and experience in Ecuador, walking is at times

very difficult due to the absence of sidewalks or poor road conditions. In the rainy season, the rutted roads are full of water puddles and the mud is thick and very slippery. Not only is falling a risk, but being splashed with muddy water by passing vehicles is a common occurrence. Some roads become impassable due to standing water, deep mud, or landslides. Most of the rural areas do not have heavy equipment available to repair roads or move the landslides. Sometimes days may pass before the roads reopen. Traffic may be re routed but there are no warning barricades or traffic reports. Knowledge of road closures is passed via word of mouth at local gas stations or happening upon them. In the dry season the opposite is true. The muddy roads become dusty. The dust is thick and choking. The dust also hangs in the air long after vehicles have passed by.

The informants see walking as an activity of daily living; a necessity. Only four of the 28 owned vehicles. All reported using the public bus for transport out of Tosagua to the larger cities in the province if needed. Most informants stay in Tosagua and do not leave except for a medical reason or to visit family members who live out of town.

Exercise above and beyond daily activity usually consists of more walking but in a group of two or more. Walking is described as a desirable activity but at times unattainable due to many barriers. In the very early morning at the center of town the town square is very busy with walkers. Men and women of all ages walk around the square multiple laps in groups of usually two to four. The researcher joined in the morning walks on several occasions. Arriving at five AM was about the time the people began to arrive. Most walked 30-45 minutes and then walked home. The square was full of chatting and laughter as people walked. The parks emptied out by seven AM. As people were leaving a local bread vendor arrived on a bicycle with fresh bread rolls.

Many people bought these to take home for the family breakfast. On the square on Saturday and Sunday mornings, a group aerobics session is held in addition to the usual walking.

General informant:

> Exercise is very important part of my life. I work hard to get to the park for the morning walk. I try and be there three mornings a week. Walking helps me control my weight. My husband walks with the men and I walk with the women.

Key informant:

> I know we walk everywhere but walking together at the park is special. Many of my friends walk. We walk for our health but the fellowship and prayer is important to be a whole healthy person.

Informants report barriers to exercise as lack of time, time constraints, lack of childcare and lack of initiative to do so.

4.18 Education

The category of education is presented and describes the education available to the informants of Tosagua. The school systems in Tosagua are private, government, or parochial. The younger children, preschool to sixth grade, go to school from 0800 until 1230 and the older children, seventh grade through high school, go to school from 1300 until 1900. The same school buildings are used for both age groups at the different times. A university has a campus extension in Tosagua. The university classes meet 7 days a week after regular school hours in one of the government school buildings.

In observation, the university classes were filled to over capacity of the classroom seats available. University students were observed to be sitting on the floor taking notes. No computers were in the classroom. The professors lectured and the students took notes.

General informant:

> Education is changing here. My parents were the first in their family to graduate high school. Of course, they were older when they graduated because my grandparents could not afford to send all of the children to school every year.

General informant:

> School is important for change. The government just changed the regulations on schools. Now, there are no school fees at all for the government schools. Each child is given books and uniforms for school. There are no inscription fees. While this may sound good, it is not all good. There are not enough teachers for all of the children, not enough desks, books, or supplies. Now, I am not sure the children are getting the education they need.

Key informant:

> As a teacher, I am thankful I teach in a private school. The class size is smaller and I know that I am going to be paid every month. Because I am in a private school, our students are usually a little better off than the government schools. Parents sacrifice to send their children to private school. In the government school, many of the teachers in the rural areas do not want to be here. They want to go to the bigger cities where they can be paid better and have kids who come from better families. These rural schools are hard. The parents are poor and uneducated. The children come to school dirty, hungry, and unprepared for class.

A member check was done with the above key informant information regarding education and a second key informant:

> Yes, this is all true. Rural schools are very hard. But, the education they receive from school is key to change. Education is how they can make a better life than their parents. The university that holds class here in Tosagua allows people who work the opportunity to advance themselves also.

Key informant:

> Ecuador has so much to offer but we must move forward. The way we were educated is not what the students need today. I do not know anything about computers but I see that the world is using computers for everything. On TV you see children using computers. My grandchildren are in school and there is one computer for the whole school. I have other grandchildren in Guayaquil (Ecuador second largest city) who have computers in each classroom. We need that here!

4.19 Health Education

The category of health education is important to the residents of Tosagua. Health education for the rural Ecuadorian is something that is seen as desirable by all of the informants. All informants report getting their health education from four sources: word of mouth, television, radio programs, or the newspaper. Those who reported a relationship with a physician added that some education was given during office visits.

General informant:

> I am interested in how to take care of myself. I always want to learn more about why people get sick.

General informant:

> No one tells us what to do to take care of ourselves. I have a lot of questions about my health. As I am getting older, I have more concerns. Also for my kids I am concerned.

In the Ecuadorian school system, private or government, there are no health education courses. The schools do not offer any health teaching or health services. The schools have no nurse or healthcare aid in any of the schools.

Key informant:

> There are a couple of programs on the radio regarding health. They are weekly programs. They talk about health issues like healthy eating and exercise. On the TV there is a program about health once a week from Mexico on Univision. These are good because they give advice on illnesses that effect families. They talk a lot about weight and diabetes.

Key informant:

> My doctor here in Tosagua is good about answering questions and telling me about my condition. In the past, when you went to the doctor it was here's your prescription and go home. I did not like that. The doctor treated you like you were not smart enough to understand.

Key informant:

> Parents tell children about health issues. I think they are trying to help or protect their children but this does more harm than good. The things I have heard are incredible, especially about sex. The children are told that babies are born from the mouth. Why would they say this? Ignorance, I guess. These same children then go on and start having sex very early

because they are too young to realize the correlation between sex and childbirth.

4.20 Technology

The category of technology is presented here. The diversity of Ecuador is pronounced in the area of technology. In the major cities, electricity and running water are readily available. Occasionally, there are rolling blackouts of power when the hydroelectric plants are low on water.

The cell phone has really revolutionized communication in Ecuador. In the rural areas, telephone lines are scarce. The lines that are available are very old and unreliable. Cellular telephones have become more common place than the landline. Over the past five years, cellular towers have sprung up all over the country. The price of cellular service is still very prohibitive for most people. A popular method of service are the prepay phone cards.

The internet has been very slow to come to the rural areas due to the poor phone lines. Outside of the major cities it is very difficult to obtain any internet service. The researcher tried to purchase a global plan for wireless internet before leaving the United States and was told over and over by various providers that due to the poor phone lines and no satellite receiving towers in Ecuador that this would be impossible to obtain. Nor did a global cell phone plan exist for Ecuador.

In Tosagua, there are two internet café's. Each has six computers that connect to the internet via dial-up. The service is very slow and costs $1.00 per hour. The café is not busy until right before the high school classes begin and right after high school classes dismiss. Then, the café is bustling with activity and students. The students are observed

using the computer for social networking such as Face Book, Hotmail, and other chat rooms. Also, they use the computers for word processing and printing.

Casual conversation with the students reveals that none of these students have access to the internet, computers, or printing at home or at school. They are self taught computer users. Most report they are excited to go to university where they will have access to the university computer lab and computer classes.

The informants state that none of them have a computer at home. Twenty of the 28 informants have not visited the World Wide Web. Five have never used a computer. All state they have a television, radio, and read a local newspaper regularly. An observation when traveling through rural Ecuador at night is the number of homes with open frame windows without screens and the glow of a single light bulb and the flickering light of a television. Many of these homes have no refrigerators or other appliances but have television.

General informant:

> In my house, it is a very simple house like most here in Tosagua. I have a phone, a television, a radio, stove, and refrigerator. I wash my clothes outside by hand and hang them out to dry. I have a cell phone but only use it when I have extra money for the cards.

General informant:

> Growing up we had nothing. No phone, television, only the radio. I still prefer the radio to anything else. Little by little we added a refrigerator, a gas stove, a television. I still prefer the radio.

Key informant:

> We have the same kind of usual technology as others here in Tosagua but since I teach, I have a computer and printer at home. This makes a big difference for me. I have to keep up with grades. I like to use the computer for assignments too. I can make up assignments and then copy them on the way to the school. Someday, I really want internet at home. Now, just like everyone, I go to the internet café. You know what this is like. Slow and very inconvenient.

Key informant:

> I am 70 years old. I do not know anything about technology except for the TV and radio. I know what computers are but I do not have an idea about how to use one. The younger people like them. I think it would be nice to have access to information but I would not know how.

4.21 Role of nurse

The category regarding the role of the nurse is presented here. In Tosagua over the past seven years, the researcher has not met a nurse. In the two doctor's offices it is staffed with the doctor and a secretary. The doctor takes the vital signs, calls the patients back to the exam room and all care except scheduling appointments and answering the phone. There are no hospitals or clinics in Tosagua. A nurse living here would have to travel out of the town to work in a larger town where there is a hospital.

All but two of the informants report having had some interaction with a nurse. All of these interactions were in an acute care center whether for themselves or for a family member. One informant related the experience as positive.

Key informant:

> I was a patient at the clinic in Calceta. It was a private clinic. The nurses who took care of me were very nice. They were caring and attentive. I have nothing bad to say about that experience. But, when my mother was in the government clinic in Portoviejo, the experience was much different! The nurses were horrible. They were lazy, rough, and uncaring. They worked there to get paid good money not because they cared about people.

Key informant:

> I want to tell you that hospital care is very different here than in the United States or even in Quito. In Ecuador in general when a patient is in the hospital, the family is in the hospital too. The family has responsibilities that vary depending on what kind of hospital.
>
> In the government hospital, the family has a lot of responsibility. First, you have to pay a big fee upfront. This shows the hospital you are going to be able to pay your bill. Even if you have government health insurance, you still have to pay your part. Once the patient is admitted, the family gets a list of medicines and supplies to go out and buy. Someone in the family goes to the pharmacy or a couple of pharmacies until all of the

> supplies are bought and then brings them back to the hospital. The family buys needles, syringes, intravenous fluids, medicine, everything! You give all of this to the nurse. If you are lucky, she will use them on your family member and not sell them or take them herself.
>
> Also, the family has to bring in food for the patient, The doctor tells you what kind of food and you bring it in. If you do not have any family in the town where the hospital is located, you go to a restaurant and buy it. The family must also care for the patient. Walk them to the bathroom, bathe them, just do whatever they need. The nurse's responsibility is to give the medicine and if the patient has an intravenous, to keep it going.
>
> A caring family has at least one person with the patient at all times. You never know when something may be needed. You should have two people.

This scenario was repeated over and over about how to care for someone in the hospital and the family responsibility. No difference was noted about nurses in the government hospital. They were described as rude, rough, uncaring, absent from their duties, and in the job for the money. Nurses were also described as poorly educated and incompetent.

General informant:

> I think the biggest problem with nurses is that they are poorly educated and not competent to care for people. They act rude because they do not know what to do. Sometimes you go out to the nurse's desk and they are reading a book or painting their fingernails. They do not get up to help.

Nurses in the private hospitals and clinics were noted to be a bit better in caring for patients and more caring.

Key informant:

> The nurses who took care of my daughter in the private clinic were very nice. They were attentive, kind, and competent. Just like in the government hospital you need to be there for your family member. You need to bring the food and help with the care but you feel like you can leave for a few minutes and not worry.

Key informant:

> My hope for nurses would be to help us! We need help. Nurses could help take care of us and teach us to care for ourselves.

4.22 Politics

The category presented here is politics. The political history as previously described is very complex. This category focuses on the recent local elections in Tosagua. Recent elections had taken place in Tosagua for mayor. The old mayor was voted out and a new mayor elected. The political parties in Ecuador are numerous and vary province to province.

General informant:

> Yes, we have a new mayor. Finally! She says that she is going to make changes in Tosagua. She has a plan for repairing the streets, getting the municipal workers back to work and helping to bring in a hospital to our town. This was her platform. God willing, she will be able to accomplish all of this.

General informant:

> The new mayor is a welcome change. The old mayor did not even live in our town. He lived in a big house in Portoviejo (about one hour away). How could he know what we deal with day to day?

Key informant:

> The new mayor ran on a platform of change. She has set out very specific goals of what she wants to change. She wants to repair the road, repair our water system, get the municipal workers back to work, build a hospital, and more! People are so funny here. They believe everything the politicians say! I would like to believe but I am skeptical. We have a saying here: *Si dice!* (So he/she says). Everyone talks about the mayor using that phrase and *Ojala, que si.* (God willing, yes it will happen). This is our hope for our mayor and town.

4.23 Hope for the Future

The category presents data to support the hope for the future as expressed by the informants. The informants during the interviews used several phrases as previously described: "God willing" *(Si Dios quiere)* or *(Ojala que si).* Both of these phrases reflect a hope in something beyond your our control. All informants regardless of religion professed faith in a higher spiritual power that has control over life situations.

When describing a difficult situation or something unpleasant the informants would wrap it up by saying something to the effect that if God was willing He could change the situation or expressing a hope that God would in fact change a situation. Hope is used to express a desire not only for a change but to maintain one's health, job, family, and community.

> Key informant:
> We use "God willing" as a phrase all of the time. We say see you tomorrow. But really, only God knows if we will see each other tomorrow. It is His will.

Speaking with informants and saying good bye was another occasion when "God willing" was heard.

> General informant:
>
> God willing you will be able to return to Ecuador and see us again.

Summary

The data was collected in the forms of interviews with 28 informants mostly in their homes, field notes, and observational data. The data was then analyzed to tease out the presented categories. The interviews and their analysis reveal deeper insights into the culture, health beliefs, and care practices of rural mestizo Ecuadorians. These insights will further be teased out in the presentation of patterns and themes.

4.3 Presentation of Patterns

Phase three of data analysis is the discovery of patterns of data inherent in the categories related to the DOI. The interviews were conducted until data saturation of patterned meaning in context. Six patterns of data inherent in the categories emerged from this phase of data analysis and are presented below.

1. A pattern of belief in God and the power of prayer. All informants revealed that they believe in a higher power named God (*Dios*). The informants describe communicating with God in the form of prayer and worship. The informants describe a belief that praying to God has an effect on health. The use of prayer is used by the informants in times of illness and health. Prayer is an act used on a daily basis.

Supporting categories and cultural context: Spirituality, family, meaning of health, meaning of illness, and hope for the future. Comments regarding prayer from the informants included:

> Key informant:
> I thank God daily for my health. My health enables me to work, play, and enjoy my family.

> Key informant:
> I also pray that God will protect and keep us healthy also.
> Once I was sick and could not work. I prayed and prayed that God would make me well. He did but it was a long trial. The church was so valuable to me during this time. My brothers and sisters in Christ surrounded us with love, prayers, food, a little money, and lots of visits. It is good to know that your family is beside you.

> Key informant:
> But, my most important job as a Christian mother is to teach the children about God. We pray together and I teach them about faith. We all go to every church service together. I can lead them to God but they must make their own relationship with Him.

2. A pattern of valuing self-care and preservation practices. The informants discuss ways in which they care for themselves and their families. A desirable healthcare belief is the ability to care for oneself and do what is necessary to be healthy.

Supporting categories and cultural context: Spirituality, meaning of illness, meaning of health, medicinal plants, nutrition, exercise, and health education. As the previous informant quotes support, prayer is used to ask God to protect an individual,

family, or community from illness or disease. The informants report that praying to God is a method used to stay healthy. Other practices of self-care are evidenced by:

Key informant:

> The things I do everyday make me strong. I eat nutritious food, exercise in the park with my friends, and I drink my teas. This is what I have learned through life experiences that keeps me well.

General informant:

> Teas and herbs help keep me healthy. If the curandero recommends something, I do it. He knows what I need to stay healthy.

Key informant:

> It is important for me to take care of myself. I am single and I live with my Aunt. She is busy and I am busy. Drinking teas, eating good food, and if needed some medicine from the boticero.
>
> My mother taught me how to grow vegetables in the garden and herbs. I am doing the same with my daughter. I have a small patch to grow my own. When we were first married my husband went to the market and bought the fruits and vegetables for us. We both learned about good nutrition from our parents.

3. A pattern of external factors negatively effecting health. The informants reveal that their health is affected by external factors of which they have little or no control. These negative factors such as natural forces of seasonal rain and dryness, lack of adequate municipal infrastructure, and pollution are described below.

Supporting categories and cultural context: Common illnesses, environment, family, politics, and health education.

Key informant:

> Our town is very contaminated. The water, the air, and the city system of roads are poor. All of these things together keep us from being a healthy city. People try to be healthy by boiling the water but what can we do about the air? The big trucks and buses roll through with their exhaust and stir up massive amounts of dust. We breathe all of this in day after day. The air damages our lungs and throats. The water damages our stomachs. The roads just make life hard in general.

General informant:

> We can become very sick here. Children are very susceptible to illness of the throat and lungs due to the dust. Lots of children have runny nose and cough year around. Just last winter (rainy season) my son was sick with tonsillitis and had to be on antibiotics.

General informant:

> I do not trust our water from the city at all! It has a bad taste, it looks dirty, and it makes you sick if you drink it. I am not sure I trust the bottled water either. Maybe they just pull it right out of the river and put it in bottles after the dirt has settled.

Key informant:

> Water is life. Our life is not good. Water is very time consuming here. The city system is broken. The pipes are broken in many area and the pipes are very old. The oxidation flows through and comes into the house along with whatever dirt it picks up on its journey. There is a filtration plant. When it rains very hard, the plant system backs up.

Key informant:

> To use the water from the city, it must be boiled. We boiled it twice for 14 minutes each time. The clean water is placed in a drum in the kitchen. Some people do not boil the water before using it to cook. Not me! Boil, boil, boil. I want to be safe. We could have a tanker deliver the water but this is not safe either. I am sure it is from the river and then they charge for the dirty water.
>
> The river is not clean either. Animals walk in it and drink from it. People wash their clothes, bath, and use it as a toilet. We know the farmland drains into the river. No one cares for the river.

Key informant:

> Our town is very contaminated. The water, the air, and the city system of roads are poor. All of these things together keep us from being a healthy city. People try to be healthy by boiling the water but what can we do about the air? The big trucks and buses roll through with their exhaust and stir up massive amounts of dust. We breathe all of this in day after day. The air damages our lungs and throats. The water damages our stomachs. The roads just make life hard in general.

4. A pattern of identified barriers to health care. The inability to access the desired care is unsatisfying to many informants. In some cases the care desired is not offered in

Tos Agua. The informants discuss multiple issues that interfere with their ability to have the type of optimal health they desire. These barriers are discussed below.

Supporting categories and cultural context: Meaning of illness, folk healers, professional healthcare, environment, education, health education, politics, and hope for the future.

Key informant:

> The doctors here help the town but they just are not enough. They help with control of chronic illness but we have to leave for so much. I do like that when I see her; she takes time and explains what is wrong with me. She gives me lab tests to do, I go back with my results and then, she tells me what to do. She gives me a prescription if I need it and tells me what kind of water *(herbal tea)* to take it with. Taking the medication with the right water is important. You want to have the medicine do what it is supposed to do.

In rural Ecuador, the local physicians may have student physician residents working with them in practice. These residents are unaware of the cultural desires of the rural mestizo people such as the desire for the healthcare provider to pray with them. The informants express that not being prayed with is a barrier to the health care practices they desire.

> Key informant:
> Something else I want from my doctor is to be prayed for. I would really appreciate prayer after the visit before I go home. You know God has given us the medicine. I see the doctors as an extension of God.

Other barriers to healthcare have been reported by the informants:

General informant:

> Our medical care in Tosagua is very poor. I mean, I like the doctor I go to but if something serious is wrong with me, I have to go to Chone for care and if it is really serious all the way to Manta.

General informant:

> Not only do we not have a hospital here, we do not even have a healthcare center. We are very lucky to have the doctor, but this is not enough.

Key informant:

> Yes, it is true we do not have a place for emergency care or surgery. In the cities, they have ambulances to carry sick people. Here, if you break your leg or need your appendix out, they put you in a car or the back of the truck and take you to Chone or Manta. This is not good. People are miserable en route. If you have an auto or bus accident, it is the same, back of a truck.

Key informant:

> The doctor here manages my high blood pressure very well. She checks me every 3 months. If I get a cold, she sees me in between. She makes me do a mammogram in Chone every year. This is hard to do because I have to not only pay the doctor visit, but I have to pay transport to Chone and back. Then, the cost of the mammogram. Very expensive.

5. A pattern of hope being essential to well-being and health. Hope is an essential and best described in the Ecuadorian culture as a desire with expectation for something in the future. In relation to health, the desire to have good health as seen as essential to it actually happening.

Supporting categories and cultural context. Meaning of health, meaning of illness, spirituality, family, professional healthcare, politics, role of the nurse, and hope for the future. This pattern is of vital importance to the informants as a source of physical, psychological, and spiritual well-being for the individual and for their family. The support the informants shared within this faith-based community is vital for their wellbeing of body-mind-spirit within the nursing paradigm. The ability to meet together during times of need or during times when the informants could support someone else in need was an act that was desirable. Not only does the faith-based community meet the spiritual needs, but also meets physical needs through the use of health education, healthcare provision, and tangible support of needs such as money, food, or medicine.

Key informant:

> When I meet together with my church family, I feel as though I can go on and live my life because we have hope for a better future. We hope in a life in heaven after death but also we have the hope for the future to be better here on earth.

General informant:

> The hope for our children is that their lives will be healthier than ours.

Key informant:

> God willing, we will soon have a health center here in Tos Agua. And I hope it comes soon to help us all.

General informant:

> Because I am in a church, I feel cared for, I feel that there are others just like me who are trying to raise families and make a better life for ourselves and others, God willing. Many years my family and I did not go to church. We were sad and nothing seemed to work in our life. This has changed and has changed us.

6. A pattern of valuing family caring. The values of family and caring within the DOI were important to the informants. The values described influence health in a positive manner.

Supporting categories and cultural context: Meaning of health, meaning of illness, spirituality, family, education, and hope for the future.

The pattern of valuing traditional human values has a positive effect on health and well-being. The supporting information for this pattern is the informant's statements regarding concern for the children, elderly, and preservation of the family unit in times of social and economic change. The family is the center of rural Ecuadorian life. While the narratives of family and family life revolved around activities and a nuclear family, most recalled these a s happy times and positive relationships. Only one informant reported a nontraditional home life with a father having two families.

General informant:

> I learned a lot about taking care of my children from my mother. She taught us to care for each other and those around us. Our house was very full with an aunt and my grandparents living with us.

Key informant:

> When my family is sick or when I am sick, we take care of each other. The sick person needs special care and food so they can get well. Thin chicken soup is good. Extra teas, too.

The information from this key informant is a summary of the role of the mother in caring for the family both physically and spiritually:

Female key informant:

> I am a good mother. I know that my children are happy and growing strong. I work very hard to make sure they are clean, fed well, go to school, go to church and that my oldest girl is learning to cook and clean also. Someday she will have her own family to care for. She can cook rice, chicken, and make juices, simple things. But, my most important job as a Christian mother is to teach the children about God. We pray together and I teach them about faith. We all go to every church service together. I can lead them to God but they must make their own relationship with Him.

The researcher also experienced the care of family when entering the informant's homes. The researcher was always offered and accepted food and drink. The informants served the food and drink in their best glassware and shared stories of why the pieces were special Most were passed down from mothers or grandmothers.

From the setting, data collection, and the use of Leininger's Four Phases of Data Analysis related to the Domain of Inquiry and research questions, the culmination of the findings are now presented in themes in accordance with the fourth phase of data analysis.

4.4 Presentation of Themes:

The four major themes from the study will be presented below:

Theme One: Spirituality and prayer are necessary for health and well-being.

The patterns that supported this universal theme are a pattern of belief in God and the power of prayer, a pattern of valuing self-care and preservation practices, a pattern of hope being essential to well-being and health, and a pattern of valuing traditional human values.

Key informant:

> For me, my health means everything. It is a gift from God to me. I thank God daily for my health. My health enables me to work, play, and enjoy my family. I also pray that God will protect and keep us healthy also.

Key informant:

> At our church (Protestant) we talk about caring for our bodies and our families as Christ cared for the Church. How can we care for others if we do not care for ourselves? In the church we come together and support one another in prayer. Not only do I pray for my own health but I pray for my brothers and sisters in Christ. I know that in the church, I am safe and I am loved. My children are cared for by the Sunday School teachers also. I do not look at church attendance three times per week as a burden. The church feeds me and my family spiritually.

Theme Two: Living in a community with like-minded people positively affects health and well-being. The patterns that supported this universal theme are a pattern of belief in God and the power of prayer, a pattern of valuing self-care and preservation practices, a pattern of hope being essential to well-being and health, and a pattern of valuing traditional human values.

Key informant:

> The men from our church have started our own walking group. We all meet at the church. We walk and share our lives with one another. We help each other through prayer and advice. It is hard to be a Godly man today. Walking helps me be healthy physically and spiritually.

Key informant:

> Something else I want from my doctor is to be prayed for. I would really appreciate prayer after the visit before I go home. You know God has given us the medicine. I see the doctors as an extension of God.

General informant:

> Because I am in a church, I feel cared for, I feel that there are others just like me who are trying to raise families and make a better life for ourselves and others, God willing. Many years my family and I did not go to church. We were sad and nothing seemed to work in our life. This has changed and has changed us.

Theme Three: Incorporation of traditional medicine with modern medicine is essential to health. The patterns that supported this universal theme a pattern of belief in God and the power of prayer, a pattern of valuing self-care and preservation practices, a pattern of identified barriers to health care, and a pattern of hope being essential to well-being and healthcare needs of the people but the people report missing some crucial elements.

Twenty six of the twenty eight informants reported seeing a medical doctor in the last 5 years. All reported self care practices such as herbal teas, nutrition, exercise, and following health advice received from a doctor, local boticero, trusted friend, or media source. All indicated that healthcare should incorporate both professional and traditional healthcare practices. As a primary measure, some informants discuss use of the curandero because they have a weak “spirit”. A weak spirit means you are susceptible to illness either biological or spiritual. A curandero may be used as a secondary resource for those

affected by an illness, and tertiary as an ongoing source of treatment and prevention.

Others may begin their healthcare search with a medical doctor or the boticero.

Key informant:

I was taken as a child to the curandero for mal de ojo. Her house is just up the road. She has people who come and go all day and into the night. She treats all sorts of illnesses. Some are our illnesses, you know, mal de ojo and susto. Some people go to the curandero because the medical doctor has not helped them. Sometimes the medical doctor sends them because the problem is spiritual and not medical. The treatments vary from egg, herbs, or baths with herbs. The person usually gets better over the next few days and then is back to normal.

If the problem is a demonic problem then the person needs to go to the brujo. The brujo uses witchcraft to help the person. I have never been to the brujo but what I hear is that he uses candles and incantations to saints and devils. This scares me. I would never go.

There are some problems that the curanderos cannot treat but I still go to them to be sure I have my health covered. The medical doctors focus on pills too much.

General informant:

The curandero can be used to treat other sicknesses too. Some people who do not want to take pills can go to the curandero, tell the curandero the diagnosis from the medical doctor and be treated with the egg and herbs.

Key informant:

Depending on what I am sick with I may go to the doctor or the curnadero or both. Mostly what I want is the doctor to tell me what medicine I should take and then also tell me what I can do with herbs to get well and stay well. For many, the days of just one or the other are over. No one wants to give up herbs though.

Theme Four: Environmental context beyond the control of the people greatly affect health and well-being. The patterns that supported this universal theme a pattern of valuing self-care and preservation practices, a pattern of external factors

negatively effecting health, a pattern of identified barriers to health care, and a pattern of hope being essential to well-being and health.

General informant:

> Yes, we have a new mayor. Finally! She says that she is going to make changes in Tosagua. She has a plan for repairing the streets, getting the municipal workers back to work and helping to bring in a hospital to our town. This was her platform. God willing, she will be able to accomplish all of this.

Key informant:

> The new mayor ran on a platform of change. She has set out very specific goals of what she wants to change. She wants to repair the road, repair our water system, get the municipal workers back to work, build a hospital, and more! People are so funny here. They believe everything the politicians say! I would like to believe but I am skeptical. We have a saying here: *Si dice!* (So he/she says). Everyone talks about the mayor using that phrase and *Ojala, que si.* (God willing, yes it will happen). This is our hope for our mayor and town.

Key informant:

> Imagine being sick all of the time! Adults and children are sick year around. The rains bring colds *(gripe)* coughs *(tos)*, tonsillitis *(amigdalitis)*, and skin infections *(hongos)*. The dry season brings allergies *(alergia)* and asthma *(asma).*
>
> The older I get, the worse the weather and rains. The rains cause so much mud that sometimes we cannot get to church because we walk everywhere. The streets are very slippery and full of mud. We stay home because it is uncomfortable to be full of mud. I miss church so much but what can we do. We get out as we can.

4.41 Summary

Twenty-eight informants from Toas Agua, Ecuador were interviewed to uncover informations related to the DOI. The research questions and a semi-structured interview guide were used as guides to uncover data related to healthcare beliefs and practices.

Eighteen categories were extracted from the raw data of interviews, observation, and field notes. These categories were the meaning of health *(la salud)*, meaning of

illness *(la enfermedad),* folk and common illnesses *(enfermedades común y folklóricos),* folkhealers *(curanderos)* medicinal plants *(plantas naturales),* professional healthcare *(cuidado professional,* spirituality *(la espiritualidad),* environment *(el medioambiente),* meaning of family *(la familia),* nutrition *(nutricion),* exercise *(ejercicio),* education *(educación),* health education *(*educa*ción sobre la salud),* role of the nurse *(papel de la enfermera),* politics, and hope for the future *(eperanza por el futuro.*

Phase three of data analysis is the discovery of patterns of data inherent in the categories related to the DOI. The interviews were conducted until data saturation of patterned meaning in context. Six patterns of data inherent in the categories emerged from this phase are a *pattern of belief in God and the power of prayer, valuing self-care and preservation practices, pattern of external factors negatively effecting health, pattern of identified barriers to healthcare, pattern of hope being essential to well-being and health, and pattern of valuing family caring.*

From the patterns four themes have been teased out and will be discussed in the next chapter. The themes are *spirituality and prayer are necessary for health and well-being, living in a community with like-minded people positively affects health and well-being, incorporation of traditional medicine with modern medicine is essential to health, and environmental context beyond the people's control greatly affects health and well-being.*

The following chapter will discuss how the information from these categories, patterns, and themes affects the professional care given to rural mestizo Ecuadorians, the relationship of these findings to the Culture Care Theory, and future implications for education, policy, and practice.

Chapter 5

5.1 Introduction

Transcultural nursing studies allow nurses to discover and compare nursing practices and other interconnected issues such as values, health, politics, and economics across and within cultures (Leininger, 2002; Leininger & Mc Farland, 2006). Because each culture views illness and health differently, this research sought to discover and describe the healthcare beliefs and practices of rural mestizo Ecuadorians and the role of the nurse now and implications for future care. No transcultural nursing studies have been published in the literature related to rural Ecuador. The paucity of literature is evident. The importance of studying Ecuadorian health is not only to discover and describe their beliefs and practices but to assist healthcare providers who are caring for rural mestizo Ecuadorians who have immigrated to other countries. By increasing nursing knowledge regarding rural mestizo Ecuadorians in their own culture, healthcare providers caring for rural mestizo Ecuadorians can apply this knowledge to their own patient interactions.

The domain of inquiry (DOI) for this ethnonursing study was the healthcare beliefs and practices of rural mestizo Ecuadorians and the role of the nurse now and implications for the future. The purpose of this qualitative ethnonursing study was to discover and understand the healthcare beliefs and practices of mestizo Ecuadorians within rural Ecuador and the role of the nurse now and implications for future care. The phenomena of interest were the health beliefs and practices of rural mestizo Ecuadorians in the context of their own culture. Discovering these beliefs and practice will enable nurses and other healthcare workers to provide care that is acceptable, culturally

congruent and promotes health. Nurses caring for Ecuadorians in and outside of Ecuador can utilize the findings of this study as a basis for guiding their nursing care and actions.

Tosagua has been visited by the researcher twice yearly during the seven years the researcher lived in Ecuador. While never living in the village, the researcher visited personally and professionally with a medical mission on numerous occasions. The relationships established during the researcher's visits over 7 years were invaluable in allowing for the informants to speak freely and allowing the researcher to move freely in and out of the village.

The findings in this chapter focus on patterns and themes discovered related to the DOI. Data were analyzed using Leiningers's Four Phases of Ethnonursing Analysis of Qualitative Data (Appendix E). The findings of this study were presented in Chapter Four in accordance with Leininger's Four Phases of Data Analysis. The categories of the meaning of health *(la salud),* meaning of illness *(la enfermedad),* folk and common illnesses *(enfermedades común y folklóricos),* folk healers *(curanderos),* professional healthcare *(cuidado professional),* medicinal plants *(plantas naturales),* spirituality *(la espiritualidad),* environment *(el medioambiente),* meaning of family *(la familia),* nutrition *(nutricion),* exercise *(ejercicio),* education *(educación),* health education *(*educa*ción sobre la salud),* role of the nurse *(papel de la enfermera),* politics, and hope for the future *(eperanza por el futuro).*

The data was carefully examined for patterns and meanings in context to support the DOI. The six patterns discovered were a pattern of belief in God and the power of prayer, a pattern of valuing self-care and preservation practices, a pattern of external factors negatively affecting health, a pattern of identified barriers to health care, a pattern

of hope being essential to well-being and health, and a pattern of valuing traditional human values. In the final phase of data analysis, Phase Four, the researcher had confirmed four major themes from the categories and patterns. The four themes are reflective of the informant's perception of the DOI. The four themes are new knowledge that is needed to guide nursing decisions and actions related to the provision of culturally congruent care.

The four major themes that emerged from this study were (a) spirituality and prayer necessary for health and well-being: (b) living in a community with like-minded people positively affects health and well-being: (c) incorporation of traditional medicine with modern medicine is essential to health: and (d) environmental context beyond the control of the people greatly affect health and well-being.

In the following sections, the four themes will be discussed in relation to the research questions, current literature, and the DOI.

5.2 Theme One

Theme One: Spirituality and prayer necessary for health and well-being.

The belief in God and the power of prayer were supported by all informants. All 28 informants regardless of religious preference reported using prayer on a daily basis. The prayers reported were petitions to God for sustained health and for provision of the needs of the family regarding protection from illness. Prayer is an act that may be individual, within the family, within friendship circles, or corporately with the church. Prayer and its relation to health and well-being as a theme is supported in the literature and supported by the Culture Care Theory (Leininger 2002). Prayer is an integral part of the rural mestizo lifeway and is desirable between healthcare provider and patient.

In observation, the researcher attended several church services and home Bible studies with the informants. Each service begins and ends with prayer. During the home Bible studies the informants share with one another their needs and petitions for prayer. Many times a health concern was among the petitions either for oneself or for a friend or family member. At a particular prayer service in a home, a young man was obviously in the last days of his life. He was dying of AIDS. The pastor and several male leaders from the church came to the home. A time of Bible reading and prayer was held with the man and his family. At the end of the prayer, the pastor anointed the dying man with oil and prayed that God would bring peace in the man's last days. Tears were shed by all present as well as embraces for the man and family members. The pastor emailed the researcher about 2 weeks later with the news that the man died surrounded by his family who sang hymns as he breathed his last.

5.3 Theme Two

Theme Two: Living in a community with like-minded people positively affects health and well-being

The belief in God and power of prayer and hope are essential to well-being and health. Not only is prayer an individual practice but a communal one. Twenty seven of the twenty eight informants met together with others of the same spiritual belief at least once a year and most at least twice weekly for a time of prayer, scripture reading, fellowship, education, and even exercise.

The theme of living in community and the positive affect on health is new knowledge discovered in this study. Previous studies in Ecuador have been conducted in

the field of anthropology and have focused on indigenous tribes. No studies have identified the importance of community on positive health outcomes.

Rural mestizo Ecuadorians live, work, and play together. Common examples are men working together. They can be observed walking to work together, working together, eating lunch together, and then at lunch time playing soccer or volleyball together. They also walk home together at the end of the day. The camaraderie is shared off of the field also. Men within the local church also meet together before work to exercise together at the local park.

According to the informants having family and friends are essential to health and well-being. A neighbor may be relied upon for health advice, herbs from a patio garden, or a care of a small child if the mother needs to run an errand. Family is very important for individuals to receive care when ill. In illness, the sick rely on family to care for them. In wellness, families teach the children to care for each other through self-preservation practices such as nutritious foods, exercise, and togetherness. This finding related to family supports existing studies which make the assertion that the concept of family and care within the family is central to Latino/Hispanic cultures (Schumacher, 2006; Zoucha, 1998).

In Ecuador, families stay together. To live alone is not a common practice. Living at home until one marries is the norm. Single aunts and nieces may live together or other single relatives live in the same home or on the same property with extended family. Being alone is not desirable. This information reiterates the importance of a family member being constantly accompanied by a family member. In Ecuador the family member is needed to help provide care and supplies to the patient due to the hospital

system in addition to being support for the patient. This may translate to care differences encountered outside of Ecuador. In hospitals in the United States, the nurse cares for the patients' physical needs and care supplies are supplied by the hospital. Further research is needed to determine the effect of hospitalization and the role of the family in settings outside of Ecuador and the relationship to caring.

5.4 Theme Three

Theme Three: Incorporation of traditional medicine with modern medicine is essential to health.

The universal pattern of belief in God and the power of prayer are again present in this theme. All informants regardless of faith heritage reported to using prayer to protect and give thanks for health. The informants all professed belief, faith, and hope in a Higher Power that is Omnipresent and Omnipotent to guide and protect their health. In addition to prayer, other acts of faith may be used to petition God's good will such as lighting candles, attending church services, or praying to the saints to intercede on the behalf of the individual or family. These actions also lead to hope. Hope that God will hear the prayers and act benevolently on the informants behalf. The acts also were reported to be actions that an individual can do to prevent illness and cure illness.

Not all of the informants have been to a traditional healer (*curandero)* but know who the curanderos are and where they live. All informants related that certain folk illnesses exist and may only be cured by the curandero. The curandero may be used as a primary, secondary, or tertiary healthcare resource.

Medicinal plants are also a key component to traditional medicine and self-care. The plants are prepared usually by the mother or wife for the entire family. The teas are drunk at meal times or during the day. Many informants use teas rather then colas or fruit juices in effort to obtain a balanced diet. Teas are also important to the informants for their properties to fight infection, treat diseases, and bolster the immune system.

The practice of using medicinal plants is supported in previous literature studying indigenous groups in the eastern jungle of Ecuador (Finerman, 1989; Shoenfeld & Juarbe, 2005). In observation in many areas of Ecuador, the practice of drinking herbal teas is common practice. The researcher was an inpatient in a hospital in Quito after abdominal surgery. The water which was offered on a daily basis was steeped with herbs. The usual herb was oregano which the informants report as excellent for intestinal upset. When plain water was requested, the nurse did not allow the researcher to have plain water as this was seen as unhealthy for a recovering patient.

This finding has significant implications for nursing within Ecuador and where rural mestizo Ecuadorians receive healthcare. A repeated concern with professional healthcare is the desire to incorporate herbal preparations in conjunction with modern medicine.

A potentially harmful self-care practice is the practice of self-medication. Rural mestizo Ecuadorians are accustomed to presenting to the local pharmacy and purchasing whatever medication they chose. No prescription is needed except for narcotics. This has not been addressed in any current literature regarding an Ecuadorian population. The dangers in this self-care practice are numerous and include potential drug-drug or drug-herb interactions, under or over medication, using a medication not indicated for the

presenting symptom, or elimination issues with the liver or kidneys. This practice also affects children who may be given drugs by well-intentioned parents. The same adverse affects as above may occur or worse including disability or death.

As rural mestizo Ecuadorians enter healthcare systems outside of Ecuador, they encounter a much different system. Most countries in North America and Europe do not allow direct to consumer sales of medication deemed to under control of prescribing laws and agencies such as the Drug Enforcement Agency in the United States. Ecuadorians may not understand the regulations of other countries and may be unable to care for themselves in the manner they desire. This situation of not being able to access medication as they have been accustomed, lack of local folk healers outside of Ecuador, and the previously experienced tenuous relationships with professional healthcare may be very unsatisfying to a rural mestizo Ecuadorian.

5.5 Theme Four

Theme Four: External context beyond the control of the people greatly affect health and well-being.

Living in Tosagua is difficult. Everything from obtaining safe drinking water to transportation has its own complications. Access to healthcare is very difficult. Two medical doctors work in the town and are very busy. They provide primary acute care and follow chronic conditions such as diabetes and hypertension. The local physicians are partially meeting the healthcare needs of the town's people. But the informants revealed they would like more services as in the larger towns and a healthcare facility providing urgent and emergency care.

Other factors that negatively effect health and are out of the control of the people include the weather, the environment, the politics, and infrastructure of the town. In rural Ecuador the main modes of transportation are walking, bicycles, motorbikes, or public or private vehicles. By far, the majority of people walk everywhere. In observation and experience in Ecuador, walking is at times very difficult due to the absence of sidewalks or poor road conditions. In the rainy season, the rutted roads are full of water puddles and the mud is thick and very slippery. Not only is falling a risk, but being splashed by passing vehicles is a common occurrence. Some roads become impassable due to standing water, deep mud, or landslides. Open sewers remain in much of the city adding to sanitation problems and potential disease.

Other safety issues that adversely affect health are the lack of seatbelt use and in most cases vehicles do not have seatbelts. Motorcycle riders are rarely seen with helmets. Especially in rural Ecuador a common sight is a small motorcycle with 3 people riding or large open trucks with passengers riding while standing in the back.

The contexts of people's lives are affected by external factors such as weather is out of the control of the informants. After effects of weather such as flooding, mudslides, and impassable roads continue to ruin an already damaged infrastructure of roads and bridges. The water filtration plant was damaged 3 years ago by flooding and has only partially been repaired. Recognizing the external factors as being out of their control, the informants rely on hope. They hope or wait expectantly for a better future. They hope that the government will repair what is broken and restore a safe and sanitary water supply to their homes. The newly elected mayor ran a campaign stating she will improve these issues and the changes will allow the residents to drink water from their own taps

again and that the roads will be repaired. Many of the informants expressed hope in the potential changes in the future.

Similar external factors affect Ecuadorians in other parts of the country. In the mountainous areas which are populated primarily by indigenous people endure similar hardships such as lack of potable water and poorly maintained infrastructure (Puertas & Schlesser, 2001). From the current literature it is not known to what extent external factors affect the context of indigenous groups or if this group expresses hope for potential change.

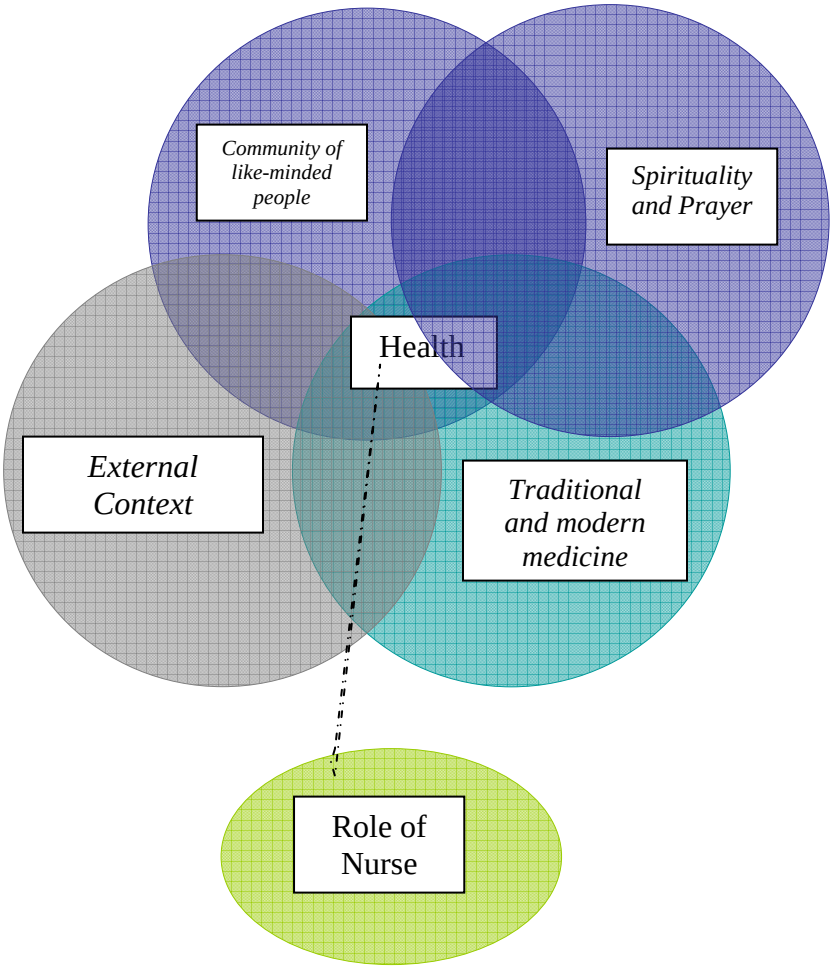
5.6 Summary

Four substantive themes were teased out and named in this study. The themes are complex and inter-related. Spirituality and prayer are necessary to maintain health, healing and well-being. Rural mestizo Ecuadorians living in a community with like-minded people positively affects health and well-being. The incorporation of traditional medicine with modern medicine is essential to health. Many external factors beyond the control of the people greatly affect health and well-being. The intertwining thread between all of the themes is hope. The rural mestizo Ecuadorians are buoyed by hope in something better for the future. Their hope lies in the power of God to change their circumstances and the core value of living in community.

5.7 Themes Pictorially Conceptualized

The author, through extensive immersion into the culture and life-ways of rural mestizo Ecuadorians and data analysis of the data collected for this research study, abstracted the themes to a pictorial model. The pictorial model includes the major themes as related to the domain of inquiry (DOI).

Themes Conceptualized



The themes from this study are pictorially represented above. The diagram represents the four themes identified in this study. The four themes are overlapped and not mutually exclusive. The center of all of the themes is health. Health has been identified as extremely important interwoven theme through all themes. The overlapping themes represent the factors affecting the health of rural mestizo Ecuadorians. Just as health is the center of the pictorial model, all informants were quick to state that health

means everything to them. Health is essential for work and to provide for the family. The four themes influence health and each other. An example of the overlapping nature of the themes are commonly heard in the stories of the informants. A mother related a story of how her daughter during dry season (external context) suffers with asthma (health). She prays (spirituality) and petitions her church (like-minded community) for prayers that her daughter will not have asthma attacks. In addition to regular medical check ups and prescription inhalers, the mother takes her daughter to the curandero for treatment for mal de ojo due to her weak spirit from the asthma (incorporation of western medicine and folk medicine).

The role of the nurse is situated outside of these themes. The role of the nurse within Tosagua is non-existent. Any interactions with nurses have occurred outside of Tosagua in a larger city or in a large medical clinic. The interactions the informants have had with nurses, the researcher excluded, have been overwhelmingly negative. The informants use terms such as rough, uncaring, mean, distant, in it for the money, and incompetent to describe nurses. Therefore, the role of the nurse and the interaction with the four themes is represented with a dashed line representing the tenuous relationship between nurses and rural mestizo Ecuadorians. The role of the nurse requires further study to deepen the understanding regarding the desires of the rural mestizo Ecuadorians regarding nurses, nursing care, and to uncover the motivations of nurses in practice, educational preparation, and professional desires of nurses working in rural Ecuador.

5.8 Discussion of Culturally Congruent Nursing Care

Transcultural nursing studies allow nurses to discover and compare nursing practices and other interconnected issues such as values, health, politics, and economics

across and within cultures (Leininger, 2002; Leininger & McFarland, 2006). Because each culture views illness and health differently, this research seeks to discover and describe the healthcare beliefs and practices of rural mestizo Ecuadorians and the role of the nurse now and implications for future care.

The purpose of this qualitative ethnonursing study was to discover and understand the healthcare beliefs and practices of mestizo Ecuadorians within rural Ecuador and the role of the nurse now and implications for future care. Discovering these beliefs and practice will enable nurses and other healthcare workers to provide care that is acceptable, culturally congruent and promotes health. Nurses caring for Ecuadorians in and outside of Ecuador can utilize the findings of this study as a basis for guiding their nursing care and actions. In concordance with the culture care theory, rural Mestizo Ecuadorians act and make decisions regarding health guided by the following: a) culture care preservation and/or maintenance, (b) culture care accommodation and/or negotiation, and (c) culture care repatterning and/or restructuring (Leininger, 2002; Leininger & McFarland, 2006).

Data from informant interview reveal a large gap in care practices in the home and professional care. The care given in the home, primarily by the mother, is nurturing and caring. The care that rural mestizo Ecuadorians have received in hospitals or from some providers is vastly different. The care provided in the home is the benchmark by which care practices are compared. While rural mestizo Ecuadorians report not expecting care in the hospital to be “just like home”, the expectation is to be cared for in speech and actions. The negative actions by nurses toward patients and families is seen as uncaring and unprofessional. These actions have caused rural mestizo Ecuadorians to distrust

nurses in general and not link caring with nurses. Rural mestizo Ecuadorians recognize that the underpinning of the nursing profession is caring. This assumption is supported in the Culture Care Theory (Leininger, 2002; Leininger & McFarland, 2006) and in previous research studies using the Culture Care Theory (Luna, 1989, Schumacher, 2006, and Zoucha, 1998).

In relation to the DOI, the role of the nurse caring for rural mestizo Ecuadorians is not satisfactory to the patient and the family. Patients and families state the care they receive at the hands of nurses within their own country is not meeting their cultural needs. These unmet needs cause feelings of distrust and resentment during a time of patient need. Even though the nursing experiences related to the researcher were overwhelmingly negative, the informants express hope that this tenuous relationship will change. An important recommendation for future research is the care received by rural mestizo Ecuadorians in the larger cities within Ecuador and in areas where they live outside of Ecuador. These points will be discussed later in the chapter.

A nurse who begins to work with rural mestizo Ecuadorians may encounter a long history of negative nursing experiences and images to overcome. Though no literature exists regarding the nurse patient relationship in Ecuador, the findings of this study can be used as an initial step to reestablishing the caring image of nurses. The image of the ideal nurse was reported by the informants as the nurses from the soap opera's *(telenovela's)*. The nurse ideal nurse is described as kind, caring, and professionally competent.

The data from the informant interview reveals that the development of trust between rural mestizo Ecuadorians and nurses begins with nurses understanding the

importance of the concept of care in the nurse client relationship. Without the expression of care from nurses towards clients, the nurse patient relationship will continue to be unsatisfying to the rural mestizo Ecuadorian.

The following recommendations in Culture Care Preservation and/or Maintenance can be applied by Ecuadorians nurses working within Ecuador and by nurses in other countries working with Ecuadorians.

5.9 Culture Care Preservation and/or Maintenance

Culture care preservation or maintenance refers to the "assistive, supportive, facilitative, or enabling professional actions and decisions that help people of a particular culture to retain and /or maintain meaningful care values and lifeways for their well-being, to recover from illness, or to deal with handicaps or dying" (Leininger & McFarland, 2002, p. 84).

Nurses and other healthcare providers working with rural mestizo Ecuadorians are encouraged to integrate the following practices into their care.

1. *Be open, warm, and welcoming.* Living in Ecuador for many years, the researcher has witnessed that a friendly smile, a firm handshake, and greetings are crucial to forming a trusting relationship with rural mestizo Ecuadorians. Culturally, a time of small talk before proceeding with the medical part of a visit are expected. Generalities such a weather, family, and common interests are appropriate opening topics. Greetings and small talk are appropriate for both genders. Also, small talk shows an interest in the person and not just their illness. The researcher has observed that he closer the friendship, the more intimate the greeting, Good friends and co-workers kiss right cheek to right cheek. In professional settings, a

handshake and friendly smile are acceptable. In settings where small children are present, it is important to refrain from touching the head or staring without talking to or about the child. As a healthcare provider, your status may be perceived as stronger than the child and the fear is that you may put the evil eye (*mal de ojo)* on the child. *Mal de ojo* has been documented in Mexico, Central and South American countries (Leininger & Mc Farland, 2006, Schoenfeld & Juarbe, 2005, and Schumacher, 2006).

2. *Acknowledge spirituality and rituals.* Spirituality is essential to the rural mestizo Ecuadorian personal value and community. According to the theme *spirituality and prayer necessary for health and well-being,* all 28 informants reported using prayer on a daily basis. From the informants interviews, the rural mestizo Ecuadorian desires that the healthcare provider should assess the spiritual desires of the patient, ask what spiritual care has been done, or is desired by the patient or family. An example of a spiritual act is prayer. The informants report prayer is an act that is done individually, within the family, and among friends. A healthcare provider who would ask if the patient or family would like prayer before and/or after the visit will promote trust. Assessment of illness should also encompass a spiritual assessment. Asking if the problem at hand is of a physical or spiritual nature acknowledges the integration of body-mind-spirit and is supported by the Culture Care Theory and in other studies in Latin America (Leininger & Mc Farland, 2006, Schoenfeld & Juarbe, 2005, Schumacher, 2006, and Zoucha, 1998).

3. *Respect cultural beliefs and values.* Understanding another culture begins with a personal culture and values assessment. Each provider should be aware of their own values, beliefs, and biases. An open and accepting presence with rural mestizo Ecuadorians is important to promote trust and open communication. Zoucha (2002) recommends that each provider examine their own values, beliefs, and biases not for comparison of any culture against another but as a way to understand universal lifeways and values such as caring which has been documented to be present in all cultures.
4. *Maintain a caring family presence.* In the rural Ecuador, caring is demonstrated by being present. If a rural mestizo Ecuadorian is in the hospital, it is essential to allow and accommodate a family member staying with the patient. Presence equates with caring as evidenced by the pattern of valuing family caring. Family is central to the rural Ecuadorian way of life. A family may desire varying levels of involvement depending on their own role in the family. The roles of the family members include providing direct physical care, providing support to the patient by maintaining the function of the home, or providing monetary support.
5. *Demonstrate hospitality.* The researcher did not ever enter the home of an informant without being offered some type of food or drink. To demonstrate caring, rural mestizo Ecuadorians offer food or drink in their home to friends and visitors. It can be extrapolated from the data that at an educational gathering it would be culturally pleasing to offer food and drink. Additionally, the healthcare provider could present foods that are nutritionally sound to compliment the expressed desire for the nurse to provide health education.

The implications for nurses outside of Ecuador are of importance also. As rural mestizo Ecuadorian immigrate to other countries they enter into a healthcare system that is very foreign to them. Not only is there the potential for language barriers and ineffective communication but mistrust of the nurses they may encounter. The negative experiences may be perceived as universals within the nursing profession. The negative perceptions may interfere with rural mestizo Ecuadorians accessing needed healthcare.

5.10 Culture Care Accommodation and/or negotiation

Culture care accommodation and/or negotiation refers to those "assistive, supportive, facilitative, or enabling creative professional actions and decisions that help people of a designated culture (or subculture) to adapt to or to negotiate with others for meaningful, beneficial, and congruent health outcomes" (Leininger & McFarland, 2003, p. 84).

In order to accommodate for or negotiate cultural care for the rural mestizo Ecuadorians healthcare providers need to incorporate the following into their care.

1. Accommodate for presence with family members during illness. Being present with family members during illness is a cultural value that expresses caring as evidenced through the pattern of valuing family presence and the theme of living in community with like-minded people. Not only family members but members of the community may want to be present also. Members of a local faith community may be considered by the patient as family members.
2. Accommodate for large volumes of information regarding illness and the symptoms being experienced before beginning to interview the patient

regarding reason for visit. Being patient and listening attentively portrays caring.

3. Collaborate with the local faith based communities to identify areas for needed education and provide venues for health education and teaching. Education should be given by trusted health care providers or community leaders. The education desired is related to health care topics that promote self-care, preservation, and information that is accurate regarding health.
4. Collaborate with the local schools to provide basic age appropriate health education to school age children regarding health care topics that promote self-care, preservation, and information that is accurate regarding health including nutrition, exercise, hygiene, and sexual health education
5. Collaborate with local school officials regarding the type of food being sold by the vendors on and near school grounds. In conjunction to the nutrition education, an effort to promote healthy food choices on and near school property.
6. If the healthcare provider does not speak Spanish, a translator should be used to facilitate understanding during the visit. The non-Spanish speaking provider should be sure to address the patient and not the translator. The healthcare provider and translator need to listen patiently and attentively to demonstrate caring.
7. If the healthcare provider is not Ecuadorian, he should have available a cultural broker who can help the provider understand the interrelatedness

of body-mind-spirit of the rural mestizo Ecuadorians. Included in this interrelatedness includes herbal preparations.

5.11 Culture Care Repatterning and/or Restructuring

Culture care and repatterning and/or restructuring refers to "the assistive, supportive, facilitative, or enabling creative professional actions and decisions that help clients reorder, change, or modify their lifeways for new, different and beneficial health outcomes" (Leininger & McFarland, 2002, p. 84).

The current methods of treating illnesses are inconsistent and vary among the informants. Many informants report care for illness and health promoting behaviors begin in the home. For others care for illness is sought from professional sources. The analysis of the data uncovers that most rural mestizo Ecuadorians utilize a combination of professional and generic (home or folk) care.

A very serious issue was uncovered in this study. The method of self-medication *(automedicarse)* by the rural mestizo Ecuadorians with prescription drugs is common. The prescription drugs are available in the local pharmacies without a prescription from a healthcare professional. Any drug may be purchased except for narcotics without a prescription. Not only are adults self-prescribing but they may purchase and give the drugs to their children. While the informants did not report adverse events from this practice, death or permanent injury is a very real risk.

In response to the data analysis from this study, many of the practices regarding medication need to be repatterned. Without repatterning, the practices may cause harm or even death. In order to accommodate repatterning culture care for the rural mestizo Ecuadorians healthcare providers need to incorporate the following into their care.

1. Initially, the role of the nurse is to begin teaching the dangers of buying medication from the boticero without prescription from the physician. Encourage negotiation between the patient and the boticero for over the counter preparations.
2. Teach dangers of sharing medications between patients especially with children. Many rural mestizo Ecuadorian families share medications due to economic constraints. Education should be provided to stop this practice.
3. The nurse should work collaboratively with a community leader who is trusted by the community members such as a local pastor or priest to assist the nurse in communicating the dangers of using medication without direction from a healthcare provider.
4. The nurse should petition the community activists and policymakers within Ecuador for a change in the regulation of medication sales. A recent change has been made in the regulation of narcotic sales. Narcotics now require a written physician prescription for purchase (Fact-Book Ecuador, 2008).
5. Nurses and healthcare providers should acknowledge the multiplicity of care beliefs and practices. The acknowledgment should include beliefs regarding folk illnesses, folk healers, and professional healthcare. Rural mestizo Ecuadorians are known to incorporate one or all of these practices into their healthcare.

6. Encourage beginning or continuing the practice of boiling water from the tap before consuming or using in cooking. Known infrastructure damage has contaminated the local water supply. Continue to monitor the repair as promised by the local government.
7. Encourage local churches to continue to host medical caravans. The utility of hosting medical caravans is very beneficial to the faith-based community and the community at large by providing free or low cost medical care and medicine.
8. The medical caravan should work closely with the local physicians to ensure follow-up as appropriate for identified illnesses requiring additional testing or progress check.
9. Educate the rural mestizo Ecuadorian people about preventative healthcare practices such as regular healthcare checks appropriate for the gender and age.
10. Continue to lobby the political leadership to follow through in campaign promises of improving the streets, water, and sanitation services within the town.
11. Encourage routine exercise either individually or with others in the community to promote health and well-being.

Nursing Implications

5.13 Implications for Nursing Theory

Use of the Culture Care Diversity and Universality Theory is beneficial to understand "individual cultures, then to group and family, institutional, regional, and community, societal and national, and finally, global human cultures" (Morgan, 2006, p. 416). Research using Leininger's Culture Care Diversity and Universality theory is most appropriately qualitative method to answer the research questions as this produces information about the people from the people being studied. This results in information that is accurate, believable, and true. The theory also predicts three kinds of nursing care, decisions, or actions. The predictions are for theory in culture care preservation or maintenance, culture care accommodation or negotiation, and culture care repatterning or restructuring (Morgan, 2006).

The Leininger's Culture Care Diversity and Universality developed by Leininger is defined as containing the following essential features:

> "A substantive area of study and practice focused on comparative culture care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures. Transcultural nursing's goal is to provide culture-specific and universal nursing care practices for the health and well-being of people or to help them face unfavorable human conditions, illness, or death in culturally meaningful ways (Leininger & McFarland, 2002).

Leininger defines culture as a learned set of beliefs, values, norms, and lifeways of a certain group of people that are passed from generation to generation (Leininger, 2002). Culture can be examined by the actions of people including their words, symbols,

and actions. Cultural diversity and cultural universality are two key Leininger's Culture Care Diversity and Universality Theory concepts related to culture. Diversity refers to the differences between and among cultures and universality refers to the similarities between and among cultures. Understanding diversity and universality are important goals of Leininger's Culture Care Diversity and Universality Theory. To date 150 and more cultures have been studied and recorded using this theory. The health care beliefs and practices of the rural mestizo Ecuadorians and the role of the nurse have been studied extensively in this study. This will be the first study of this cultural group using Leininger's Culture Care Diversity and Universality Theory to be added to the list. The data generated is both subjective and objective in discovery of factors including worldview, technological factors, religious and philosophical factor, kinship and social factors, cultural values, beliefs and life ways, political and legal factors, economic factors, educational factors, generic (folk) care, and nursing care practices that affect care practices (Leininger & McFarland, 2006).

The understanding of the health and well-being of this group is achieved through understanding two types of care used in rural Ecuador, professional and generic. Professional care is the care given by health care providers and generic care the care given by the people, usually family members or known local folk healers. The generic care is often in the form of folk-remedies and treatments that have been passed down from generation to generation. Many professional nurses do not understand or try to understand these practices. This often leaves large gaps between the people and the nurse. These gaps lead to a sense of ambiguity, cultural misunderstandings, resentments, and even litigation.

The four themes in this study are supported by patterns that reflect cultural diversity and cultural universality regarding care. The assumption that the Ecuadorian culture, like every human culture, has generic (lay, folk, or indigenous) care knowledge and practices vary transculturally and individually (Leininger & McFarland, 2006).

The rural mestizo Ecuadorian community cares for one another during times of wellness and illness. Family members are engaged in caring for the health care needs to maintain wellness and promote healing during illness. One of the major ways of showing care is through being present. This is shown by the family and the community, especially within the faith-based communities. Being present may be a visit to an ill family member or friend, staying with the hospitalized patient and providing care or ensuring that proper supplies are available for care of the patient. Presence may also include prayers, candles, favorite foods, scripture reading, or singing.

An understanding of generic care practices and presence is essential knowledge for the nurse and other care providers to promote health and well-being among rural mestizo Ecuadorians. The specific culture care beliefs, meanings, and practices identified in this study contribute to transcultural nursing and provide a foundation for future study.

5.14 Implications for Nursing Education and Practice

The diversification of the United States population and the increasing trends of immigration are issues that support the inclusion of culture care knowledge in nursing and other health education curricula. Implementation of a transcultural component to nursing education is essential to providing culturally acceptable care. Guiding students through identification of their own personal lifeways, values, and norms will be assistive in learning about other cultures they may come in contact with during their nursing

career. Additionally, for nurses within Ecuador, self evaluation and identification of socio-economic and rural culture bias would be appropriate.

The nursing professionals are viewed by the rural mestizo Ecuadorians as in the profession for the money, abrupt, rude, non-caring, physically rough with patients, and incompetent. This study confirmed these findings. Not one informant would encourage a family member or friend to enter the nursing profession. Based on these findings, most informants express that healthcare providers are very rushed and impatient with patients. The results of this study should be shared in Ecuadorian healthcare professional journals to encourage healthcare repatterning among healthcare providers.

Nursing education like most education in Ecuador is rote learning. Autonomy is not a role that is taught. The evidence for this education is there are no advanced nursing roles or advanced nursing practice. Due to no autonomy being taught in nursing education, a potential conflict could arise if the nurse was in a situation needing an autonomous nursing practice.

The researcher was very surprised that even though the informants did not have good perceptions of nurses, the informants had very specific ideas and hopes for care they could receive from nurses. These suggestions from the informants interviews include:

1. A nurse is desired to take an active role in the health education of the Tosagua community. The hope is that a nurse could conduct health education classes, routine check ups and offer assistive health advice.
2. An expectation for nurses is that they are well-educated in their profession and conduct themselves professionally and respectfully with all clients.

3. A rural mestizo Ecuadorian nurse caring for people in her own community is perceived to be desirable because she has emic knowledge about care that is culturally satisfying.

5.15 Implications for Nursing Research and Policy

As a novice researcher, an international study seemed a daunting endeavor. As the researcher completed the Transcultural Nursing courses at Duquesne, previous experiences while living in Ecuador became unclear as to their meaning in context of the Ecuadorian culture. This sense of ambiguity kept returning to the student. With encouragement from a professor, a trip to Ecuador was planned for just observation. From this observation experience research questions emerged and this presented study ensued.

This international study was enhanced and facilitated by the researcher's prior living in Ecuador. The researcher had etic knowledge regarding the culture values described such as language, culturally appropriate greetings, and values such as presence that was previously described. This etic knowledge enhanced the collection of interviews by allowing the informants to speak freely and with only the researcher. Without cultural knowledge and awareness, ambiguity exists between the client and nurse. This ambiguity leads to feelings of guilt, shame, anxiousness, and powerlessness on both sides.

As nurses encounter patients from cultures that differ from their own, being prepared to assess and give care in a culturally acceptable manner is an essential part of the nursing practice whether in the United States, Ecuador, or any other country. An essential reminder here is that cultural differences do occur within the same nationality as was demonstrated in this study. The WHO (2009) released *Global Standards for the*

Initial Education of Professional Nurses and Midwives. Included in these initiatives are standards regarding education for nurses that includes progress toward a level of university education built on evidence based practice and competency. This initiative includes taking into account national or regional factors such as cultural beliefs and norms of the nurses and the populations they serve. Without cultural competence these informants could be subjected to ethnocentric attitudes, inappropriate communication, inaccurate diagnosis, and ineffective interventions (Davidhizer & Geiger, 2004).

The research findings demonstrate that nursing is not a desired profession in rural Ecuador. The university nursing programs are located in the larger cities of Quito, Guayaquil, Ambato, and Cuenca. The location of these schools is problematic for rural Ecuadorians for two reasons. As revealed in the findings, most families would not encourage nursing as a career or profession. Secondly, many times after leaving the rural Ecuador setting for the city, many do not return to rural Ecuador. Universities have brought teacher's education for aspiring teachers to the rural areas for this very reason: to keep potential teachers in areas of highest need. Nursing education brought to the rural setting may gain more value and acceptance if it would implement similar changes. The results of this study will be submitted to Latin American nursing journals in hopes of beginning the process of change and to help improve the care from nurses and the perception of nurses. There is no end to a study such as this. New discoveries lead to new questions and more stories.

Recommendations for future research:

- Discover healthcare beliefs and practices of Ecuadorians living outside of Ecuador.

- Discover motivations and barriers for choosing nursing as a profession in rural Ecuador.
- Investigate the community desires for healthcare in rural Ecuador and what role nursing can play in improving the health of rural mestizo Ecuadorians.
- Investigate care given to rural mestizo Ecuadorians outside of rural Ecuador in the larger Ecuadorian cities.
- Cultural education outcomes studies are needed to understand the differences between nurses with urban and rural backgrounds.
- Nursing research is needed related to the educational backgrounds of nurses in rural hospitals.
- Nursing research is need related to feelings towards rural mestizo Ecuadorians or toward socio economic bias.

5.16 Conclusion

The presented study investigated the healthcare beliefs and practices of rural mestizo Ecuadorians and the role of the nurse within rural Ecuador and the role of the nurse now and implications for future care. The phenomena of interest investigated were the health beliefs and practices of rural mestizo Ecuadorians in the context of their own culture. With this study, as in much of qualitative research, questions were answered but more questions appeared. The results of this study can be used to begin to enable nurses and other healthcare workers to provide care that is acceptable, culturally congruent and promotes health. Nurses caring for Ecuadorians within Ecuador and those nurses outside

of Ecuador caring for Ecuadorians can utilize the findings of this study as a basis for guiding their nursing care and professional nursing actions.

The four major themes that emerged from this study were (a) spirituality and prayer necessary for health and well-being: (b) living in a community with like-minded people positively affects health and well-being: (c) incorporation of traditional medicine with modern medicine is essential to health: and (d) external factors beyond the control of the people greatly affect health and well-being. The data and discussion presented support these themes.

The findings are consistent with the cultural life ways of rural mestizo Ecuadorians. The rural Ecuadorians live in community with one another. To be a part of the community means you have others who support and stand with you through health, illness, and life. The role of the family in illness and health is one of support and presence.

Rural mestizo Ecuadorians, though they live in an area of great need and multiple barriers to healthcare are very interested in their health and desire to be enabled to care for themselves. The nurse has not been a part of the day to day healthcare of the informants. The desire of the informants is for a relationship with the nurses in the in-patient and out-patient setting that promotes presence, self-care, and education. These three elements have been teased out from the informant interviews and observational data.

5.17 Summary

The researcher after living seven years in rural Ecuador realized that the healthcare beliefs and practices of the rural mestizo Ecuadorians were different yet

similar to her own. Noting these differences and from personal experience with healthcare delivery, the researcher conducted a qualitative ethnonursing study in rural Ecuador to discover and uncover what the healthcare beliefs and practice are of the rural mestizo Ecuadorians.

The paucity of the current nursing literature regarding Ecuadorians lead the researcher to understand the need to research and record the findings to add to nursing knowledge of yet another culture studied using Leinginger's Culture Care Theory.

After a mini-study with 11 informants was conducted a full this maxi study was conducted. Data was collected through informant interviews, observation, and field notes. Data saturation was reached after interviewing 28 informants. Of the 28 informants, 10 were deemed key informants for their in-depth knowledge of the DOI and rich description. Eighteen informants were deemed general informants for their verification of information from the key informants.

The informant's ages ranged from 22 - 78 with the majority ranging from 25-50. Five informants report themselves as single, one in a civil union, two divorced, and 20 married. The informant's religions reported were two claiming no religious affiliation, 11 Catholic, and 15 Protestant. All of the informants reported some level of formal education. Two reported education at the primary level, 18 have graduated high school, and 8 have completed education at the university level. The gender characteristics were 19 female and 9 male. Most were employed outside the home. Occupations included farmers, teachers, homemakers, unemployed, retired, domestic help, and medical professionals.

Data were analyzed using Leiningers's Four Phases of Ethnonursing Analysis of Qualitative Data (Appendix E). Analysis of the data allowed the researcher to refine the data to present 18 categories. The categories are the meaning of health *(la salud),* meaning of illness *(la enfermedad),* folk and common illnesses *(enfermedades común y folklóricos),* folkhealers *(curanderos)* medicinal plants *(plantas naturales),* professional healthcare *(cuidado professional,* spirituality *(la espiritualidad),* environment *(el medioambiente),* meaning of family *(la familia),* nutrition *(nutricion),* exercise *(ejercicio),* education *(educación),* health education *(*educa*ción sobre la salud),* role of the nurse *(papel de la enfermera),* politics, and hope for the future *(eperanza por el futuro).*

The data was carefully examined for patterns and meanings in context to support the DOI. The six patterns discovered were *a pattern of belief in God and the power of prayer, a pattern of valuing self-care and preservation practices, a pattern of external factors negatively affecting health, a pattern of identified barriers to health care, a pattern of hope being essential to well-being and health, and a pattern of valuing traditional human values.* In the final phase of data analysis, Phase Four, the researcher had confirmed four major themes from the categories and patterns. The four themes are reflective of the informant's perception of the DOI. The four themes are new knowledge that is needed to guide nursing decisions and actions related to the provision of culturally congruent care.

The four major themes that emerged from this study were (a) spirituality and prayer necessary for health and well-being: (b) living in a community with like-minded people positively affects health and well-being: (c) incorporation of traditional medicine

with modern medicine is essential to health: and (d) external factors beyond the control of the people greatly affect health and well-being.

The findings of this study will add to the body of nursing knowledge regarding the healthcare beliefs and practices of rural mestizo Ecuadorians. The findings will be presented at scholarly presentations and prepared for publication.

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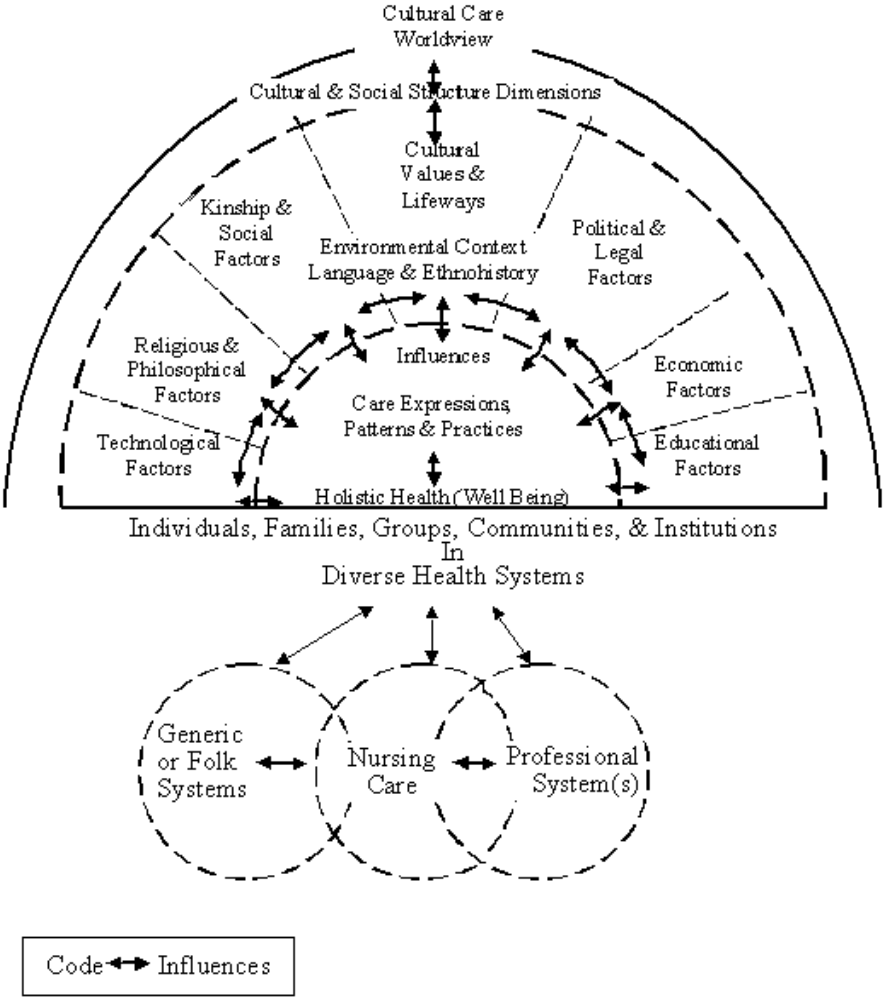
Appendix A

Leininger's Sunrise Enabler Model



Appendix B

SEMI-STRUCTURED INTERVIEW GUIDE FOR DISCOVERING THE HEALTHCARE BELIEFS AND PRACTICES (revised)

I. Introduction

The purpose of interview is to learn from you about you and your family to record what healthcare beliefs and practices are important to you. I would like you to begin by describing yourself, your family and your usual day to day life.

II. Ethnodemographics

Age/Sex	
Birthplace	
Marital Status	
Education	
Occupation	
~~Income~~	
Religion	

1. How many children do you (wife) have living? Deceased? Where do your children live?
2. Describe your current housing. Electricity? Water? Telephone?
3. Who lives with you or on your property?
4. What livestock/animals do you own? Are they kept on the family property? What is their value to you and your family?

III. Kinship and Social Factors

1. Tell me about your family and friends
2. Who is the head of the household?
3. What are the major roles of the husband/wife, elderly, and teenagers in your household?
4. Can you tell me about make/female relationships, marriage and other social unions?
5. To what degree do separation and divorce occur in your village?
6. What is the value of education for children, men, and women in your culture?
7. Have any of your friends or family members immigrated out of Ecuador? What is the social and economic impact on your family and village?
8. How have your family or friends helped you to stay well or become ill?
9. What are your families or your responsibilities to care for you or other family members when you are ill or well?

IV. Cultural Values, Beliefs, Lifeways	VII. Economic Factors
To better understand rural Ecuadorians and your beliefs regarding life and health 1. What specific beliefs, ways of being identify you with being Ecuadorian? 2. What does good health and well-being mean to you? 3. What would you like nurses to know to help you regain or maintain your health? 4. What are some examples of "good caring" based on your care values and beliefs?	"Gana la plata. Guarda la salud." 1. What does this statement mean to you? 2. In what ways do you think money influences your health and access to care or to obtain professional healthcare? 3. Do you find money is needed to keep you and your family well? 4. Who makes the financial decisions regarding health and healthcare ion your family? 5. If you or the main wage earner is ill and cannot work, what happens in your family regarding healthcare and day to day living expenses?
V. Religious/Spiritual/Philosophical Factors	VIII. Political and Legal Factors
In times of trouble or illness, people often pray or use their spiritual or religious beliefs. 1. Can you give me an example of how you have used these beliefs in the past to heal you or face crisis, disabilities, or death? 2. How have your beliefs kept you well or helped in times of illness? 3. To what extent have you used religious healers or healing practices? 4. What religious or spiritual practices do nurses need to incorporate into your care?	1. Politics and political action can influence your health. What are some ways that politics has affected your health? 2. In your community or home what political ~~or legal~~ problems influence your well-being positively or negatively? 3. How do-leaders show care to the community?
VI. Technological Factors	IX. Education
1. In your daily life, what technologies or modern conveniences do you rely on? 2. What modes of communication do you utilize at home or in the village? 3. Do you seek health information via these high tech mediums?	1. What is your highest education level achieved? Have you had non-formal education such as in a trade? 2. In what ways does education influence your well-being? 3. What health education do you think professional nurses should provide? 4. Have you received health education from religious leaders or healers?

X. Language and Communication Factors	XI. Environmental Context
1. What languages do you speak or understand? 2. In what ways would you like people to communicate with you and why? **3.** How would good communication influence your health**?**	1. Are you concerned about your environment and how it relates to health and illness? 2. Are there any relationships between water and food supply and health and illness? 3. Is there anything you would like me to know about your environment and how it relates to your cultures' illnesses or ability to stay healthy?
XII. Professional and Generics (folk or lay) Care Beliefs and Practices	
1. I would like to learn about your home healers or special healers in your community and how they help you. 2. What does health, illness, or wellness mean to you and your family? To your culture? 3. Could you give some examples of healing or caring practices that come from your cultural group? ~~4.~~ What folk or professional practices and food preferences have contributed to your wellness? 5. Have you ever been hospitalized or treated in a clinic? For what reasons? What was your experience? What was the difference in the care given by the doctor and nurse? 6. Have you ever received care from a healer, medicine person, wise woman, or shaman? In what ways do they show care? 7. In what ways is the care shown by these healers different from care shown by nurses or doctors in the hospital or clinic?	8. When a family member is hospitalized what roles do the family and kin ~~wish to~~ play during the course of the treatment or hospitalization? What are your expectations regarding nursing/medical care/treatment? 9. What systems of healing and care do you currently use clinics, folk healing, shaman or all? 10. What is the perception in your culture of using **a curandero/a or** shaman? 11. What factors influence which type of care you or people in your culture choose? 12. Tell me about the traditional health remedies you currently use? For what conditions or illnesses are they used? Who prepares the remedies?-How do you learn about them? 13. What plants are utilized for the prevention of illness and treatment of disease? How are they prepared and used? 14. What are the names of some of the folk-illnesses in your culture? How are they diagnosed and cured? Can they be prevented? 15. Is there anything else you would like me to know regarding care and folk practices?

Appendix C

Verbal Explanation

I would like to introduce myself. My name is Julie Moss. I am a nurse studying in the PhD program at Duquesne University, Pittsburgh, PA. I am interested in studying the healthcare beliefs and practices of rural mestizo Ecuadorians.

The purpose of this research study is to learn about the healthcare beliefs and practices of rural Ecuadorians as well as meanings of care within the Ecuadorian culture. Although you may not directly or personally benefit from this research study, information obtained will be beneficial and helpful in planning and providing health and nursing care for Ecuadorian people.

Should you agree to participate in the study, 1-3 interviews will be asked of you, each lasting about 1-2 hours, at a time and at a time that is convenient for you. All information is confidential and your identity will not be revealed. Your participation is entirely voluntary and you may feel free to withdraw your consent and discontinue your participation in the project at any time should you withdraw from the study, your data will be destroyed and not used.

I would also like to ask for your permission to record the interviews using a tape recorder. This will allow me to review the information you share with me and prevent me from overlooking important information given by you. The recorded data will only be listened to by me. If you do not wish to be recorded, I will not do so.

In the event of any injury resulting from the research, no reimbursement, compensation or free medical care is offered by Duquesne University. In case you have

any questions regarding the research study or your rights as a research participant, I can be reached at the Hotel Tosagua, 09-683-2080.

Explicación Verbal

Me gustaría introducir yo mismo. Me llamo Julie Moss. Soy una enfermera quien estudia enfermería a la Universidad Duquesne en Pittsburgh, PA. Estoy activo en la investigación que concierne los significados de la salud y las practicas del bienestar de las personas mestizos que viven en Ecuador rural.

El propósito del estudio de investigación es de aprender los significados del cuidado, los conocimientos, y las practicas de la salud de la gente mestizo que viven en las partes rurales del Ecuador. Aunque no puede beneficiarle usted mismo, la información que esta obtenido será beneficioso y útil en proveyendo el cuidado de salud y enfermería por la gente ecuatoriana.

Me gustaría invitarle a tomar parte en el estudio de 1-3 entrevistas que dura 1-2 horas en un memento conveniente a usted. Toda la información colectada es privada y confidencial y su identidad no estará revelada. Su participación es totalmente voluntaria y usted esta libre retractar su consentimiento y discontinuar su participación en el proyecto en cualquier momento. Cualquier pregunta estará contestada a mi.

También quisiera pedir permiso a grabar en audio casete las entrevistas. Eso solo me permitara oír otra vez la información me ha dado y confirmar que tengo toda y no se omito nada. Nadie excepto mi va a leer u oír la data colectada por mi.

En el caso que cualquier herida que ocurre a consecuencia de la investigación, nunca reembolso, compensación, o cuidado medico libre ofrecerá por la Universidad Duquesne, Si tiene cualquier pregunta sobre el estudio de investigación o sus derechos cuando esta una participante puede contactarme en el hotel Tos Agua.

Appendix D

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Discovering the Healthcare Beliefs and Practices of Rural Mestizo Ecuadorians

INVESTIGATOR: Julie A. Moss MSN, NP-C, CTN
766 Hendricks Street
Berne, IN 46711
(260) 615-0433

ADVISOR: Rick Zoucha, APRN, BC, DNSc, CTN
Duquesne University School of Nursing
600 Forbes Avenue
521 Fishers Hall
Pittsburgh, PA 15282
412.396.6545

SOURCE OF SUPPORT: None

PURPOSE: You are being asked to participate in a research project that seeks to investigate the healthcare beliefs and practices of rural mestizo Ecuadorians. I will also be investigating the cultural beliefs, practices, professional care and its relationship to health, illness, and well-being within your homes and communities. One to three interviews may be conducted, recorded digitally and transcribed..

These are the only requests that will be made of you.

RISKS AND BENEFITS: There are no risks greater than those encountered in everyday life.

COMPENSATION: You will be compensated $5.00 per interview

CONFIDENTIALITY: Your name will never appear on any survey or research instruments. No identity will be made in the data analysis. All written materials and consent forms will be stored in a locked file in the researcher's home. Your response(s) will only appear in statistical data summaries. All materials will be destroyed at the completion of the research.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Julie A. Moss at 260-615-0433, Dr. Rick Zoucha 412-396-6545 or Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board 412-396-6326.

_____ _____

Participant's Signature Date

_____ _____

Researcher's Signature Date

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENTIMIENTO A TOMAR PARTE EN UN

STUDIO DE INVESTIGACION

TITULO: Discovering the Healthcare Beliefs and Practices of Rural Mestizo Ecuadorians

INVESTIGADORA: Julie A. Moss MSN, NP-C, CTN
766 Hendricks Street
Berne, IN 46711
(260) 615-0433

CONSEJERO: Rick Zoucha, APRN, BC, DNSc, CTN
Duquesne University School of Nursing
600 Forbes Avenue
521 Fishers Hall
Pittsburgh, PA 15282
Teléfono: 412.396.6545

ORIGEN DE APOYO MONETARIO: Nada

PROPOSITO: Quisiera pedir que participa en un estudio de investigar, descubrir, describir, y analizar los significados, creencias, y practicas de la salud de los mestizos Ecuatorianos que viven en lugares rurales. También investiga las creencias culturales, prácticas, y la cuidada profesional y la relación de salud, enfermedad y bienestar. Quisiera saberlos dentro del contexto ambiental de sus hogares y comunidades. Se harán de una a tres entrevistas que dure 45 minutos a 2 horas. Las entrevistas serán grabadas por audio cintas.

RIESGOS Y BENEFICIOS: No hay riesgos conocidos ni beneficios directos por la participación en este estudio.

COMPENSACION: Usted va a recibir $5.00 (USD) por entrevista.

CONFIDENCIALIDAD: Su nombre no parece en ningún instrumento de entrevista o investigación. Opiniones textuales pueden que usar pero sin nombre o cualquier conexión a los participantes. Mantenga identificación en todo momento su confidencialidad. No habrá identificación de los datos de análisis. Todo material escrito y consentimientos serán guardados bajo llave en la casa de la investigadora. Después del estudio toda la información relacionada a este estudio una vez que se haya completada será destruida.

DERECHO A RECOGERSE: No tiene ninguna obligación de tomar parte de este estudio. Está libre de recogerse a cualquier momento. Está libre de negarse a grabación en cinta y todavía tomar parte en el estudio.

SUMARIO DE LOS RESULTADOS: Le daré un sumario de los resultados gratis a su petición.

CONSENTIMIENTO VOLUNTARIO: He leído las declaraciones del abuce y entiendo qué se está solicitando de mí. También entiendo que mi participación es voluntario y que estoy libre de retirar mi consentimiento en cualquier momento por cualquier razón. Con mi firma certifico que estoy dispuesto a participar en este proyecto de investigación.

Entiendo si hay mas preguntas sobre mi participación en este estudio, puedo llama a Julie A. Moss at 260-615-0433, or Rick Zoucha at 412.396.6545, or Dr. Paul Richer, Director del Junto Directiva, y Repaso Institucional de la Universidad Duquesne 412-396-6326 y discutir en confianza cualquier pregunta con ellos.

_____	_____
Firma Participante	Fecha
_____	_____
Firma Investigadora	Fecha

Appendix E

Leininger's Ethnonursing Data Analysis Phases

Fourth Phase

Major Themes, Research Findings, Theoretical Formulations, and Recommendations
This is the highest phase of data analysis, synthesis, and interpretation. It requires synthesis of thinking, configurations, analysis, interpreting findings, and creative formulations from data of the previous phases. The researcher's task is to abstract and present major themes, research findings, recommendations, and theoretical formulations.

Third Phase

Pattern and Contextual Analysis
Data are scrutinized to discover saturated ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are examined to show patterning with respect to meanings in-context and along with further credibility and confirmation of findings.

Second Phase

Identification and Categorization of Descriptors and Components
Data are coded and classified as related to the domain of inquiry and sometimes the questions. Emic and etic descriptors are studied within context for similarities and differences. Recurrent components are studied for their meanings.

First Phase

Collecting, Describing, and Documenting Raw Data (with Field Journal or Computer)
Researcher collects, describes, records, and begins to collect data related to the purposes, domains of inquiry, or questions under study. This phase includes: recording interview data from key and general informants; making observations and having participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the phenomena under study, from an emic focus, but attentive to etic data. Data from the condensed and full field journal is processed directly into the computer, coded by hand.

Source: Leininger, M., & McFarland, M. R. (2002). *Transcultural nursing: Concepts, theories, research, and practice* (3rd ed.). New York: McGraw-Hill

NAME	AGE	SEX	MARITAL STATUS	EDUCATION	RELIGION	OCCUPATION
AJ1	56	F	Single	University	Protestant	Teacher
B1	42	F	Married	Secondary	Protestant	House Wife
A1	58	M	Married	University	Protestant	Veterinarian
C1	35	M	Married	University	Protestant	Public Employee
C2	33	F	Married	University	Catholic	House Wife
E1	78	F	Married	Primary	Protestant	House Wife
H1	30	M	Civil Union	Secondary	Catholic	Public Employee
H2	74	M	Married	Primary	Protestant	Radio Technician
J1	49	F	Married	University	Protestant	Public Employee
J2	22	M	Single	University	Catholic	Public Employee
L1	62	F	Married	University	Protestant	Doctor
M1	41	F	Single	Secondary	Catholic	Tailor
M2	58	F	Married	University	Protestant	Secretary
M3	43	F	Married	University	Catholic	Secretary
N1	62	F	Single	University	Protestant	Teacher
N2	44	M	Married	University	Protestant	Pastor
N3	48	F	Married	University	Catholic	Human Resources
R1	51	F	Married	University	Catholic	Secretary
S1	49	F	Married	Secondary	Catholic	Store Owner
T1	42	F	Divorced	Primary	Catholic	Nanny
V1	40	F	Married	University	Protestant	Teacher
Y1	33	F	Single	Secondary	Catholic	Secretary

COMMON NAME	SPECIES NAME	PROPERTIES	FORM OF USE	INDICATIONS
Una de Gato	*Uncaria tomentosa*	Bark, root, leaves	Tea	Immune Booster
Llanten	*Plantago lanceolata*	Seeds	Paste	Constipation
Guayaba	*Psidium guajava*	Leaves, bark	Tea, oil extract	Anti cancer, diarrhea, inflammation
Arroz	*Oryza (multiple specie)*	Seed	Rice cooking water	Diarrhea and dehydration
Pata de Gallina	*Teliostachya alopecuroidea)*	Leaves	Tea	Ear pain
Cacao		Unprocessed cacao beans	Boiled and ground for oil	Scars
Paico	*Chenopodium ambroidoides*	Leaves	Tea	Worms, parasites, kidney, stomach, hemmoroids
Papaya	*Carica Papaya*	Fruit	Powder	Digestion of protein
Pedorrera/Santa Lucia	Ageratum conizoides	Leaves	Tea	Sudorific
Verbena	*Verbena litoralis*	Herb	Tea	Diabetes
Cedron	*Aloysia triphylla*	Tree	Tea	Nerves
Sabila	*Aloe vera*	Herb	Tea	Inflammation
Altamizo	*Ambrosia arborescens*	Bush	Tea	Myth
Matico	*Aristeguietia glutinosa*	Bush	Tea	Wounds, cancer, ulcers
Ajenjo	*Artemisia absinthium*	Herb	Tea	Cholesterol
Apio	*Apium graveolens*	Herb	Tea, Food	Stomach, menstruation
Zanahoria Blanca	*Arracacia xanthorrhiza*	Herb	Fermented beverage	Laxative
Borraja	*Borago officinalis*	Herb	Tea	Cough, cold, flu
Sauco Negro	*Cestrum peruvianum*	Bush	Tea	Bronchitis, cold, head ache

COMMON NAME	SPECIES NAME	PROPERTIES	FORM OF USE	INDICATIONS
Hierba Luisa	*Cimborpogon citratus*	Herb	Tea	Nerves
Naranja	*Citrus aurantifolia*	Tree	Tea, juice, fruit	Postnatal. Supplement, colds
Culantro	*Coriandrum sativum*	Herb	Tea, paste	Menstruation, pressure
Cipres	*Cupressus macrocarpa*	Tree	Compresses	Postnatal
Nispero	*Eriobotrya japonica*	Tree	Tea	Kidney
Eucalipto Aromatico	*Eucalyptus citriodora*	Tree	Tea	Bronchitis
Eucalipto	*Eucalyptus globulus*	Tree	Vapor from boiling water, paste	Myth, postnatal
Hinojo	*Foenicum vulgare*	Bush	Tea, water for barrida (sweep over skin)	Diabetes, kidney, liver
Guayusa Monte	*Hedyosmum cumbalense*	Tree	Tea, water for barrida (sweep over skin)	Liver, kidney
Guayusa	*Ilex guayusa*	Tree	Tea, water for barrida (sweep over skin)	Against infertility
Escancel	*Iresine celosioides*	Herb	Tea, water for barrida (sweep over skin)	Liver, wounds, kidney
Malve Blanca	*Lavatera arborea*	Tree	Tea, water for barrida (sweep over skin)	Inflammation
Canela	*Licaria*	Tree	Tea, water for barrida (sweep over skin)	Pressure

COMMON NAME	SPECIES NAME	PROPERTIES	FORM OF USE	INDICATIONS
Linaza	*Linum usitatissimum*	Herb	Tea, water for barrida (sweep over skin)	Anti inflammatory
Tronojil	*Melisa officinalis*	Herb	Tea, water for barrida (sweep over skin)	Nerves
Menta	*Mentha x piperita*	Herb	Tea, water for barrida (sweep over skin)	Stomach
Hierba Buena	*Mentha viridis*	Herb	Tea, water for barrida (sweep over skin)	Stomach, anti parasitic
Poleo	*Minthostachys mollis*	Sub shrub	Tea, water for barrida (sweep over skin)	Myth
Albaca Dulce	*Ocimum basilicum*	Herb	Tea, water for barrida (sweep over skin)	Energy
Olivo	*Olea europaea*	Tree	Tea, water for barrida (sweep over skin)	Pressure, postnatal
Mejorana	*Origanum x majoriana*	Herb	Tea, water for barrida (sweep over skin)	Menstruation. energy
Esencia de Rosas	*Pelargonium x hotorum*	Herb	Tea, water for barrida (sweep over skin)	Kidney, nerves, colic
Congona	*Peperomia congona*	Herb	Tea, water for barrida (sweep over skin)	Postnatal, myth, foot perspiration
Perejil	*Petroselinum crispum*	Herb	Tea, water for barrida (sweep over skin)	Heart, Jaundice

COMMON NAME	SPECIES NAME	PROPERTIES	FORM OF USE	INDICATIONS
Hierba Mora	*Solanum nigrescens*	Herb	Tea, water for barrida (sweep over skin)	Stomach, gums
Rosa Muerte	*Tagetes erecta*	Herb	Tea, water for barrida (sweep over skin)	Bath of luck
Diente de Leon	*Taraxacum officinale*	Herb	Tea, water for barrida (sweep over skin)	Liver, kidney
Valeriana Chilpaltal	*Valeriana protenta*	Sub shrub	Tea, water for barrida (sweep over skin)	Nerves
Valeriana Castilla	*Valeriana*	Herb	Tea, water for barrida (sweep over skin)	Nerves
Valeriana	*Valeriana*	Herb	Tea, water for barrida (sweep over skin)	Nerves
Pelo de Choclo	*Zea mays*	Herb	Tea, water for barrida (sweep over skin)	Liver, kidney