

Knowledge and health care trajectories in damaged population in Mexico': an interdisciplinary approach

Saberes y trayectorias de atención a la salud de poblaciones vulneradas en México: un abordaje interdisciplinario

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Resumen

El objetivo de este artículo es evidenciar la potencialidad que tiene el abordaje interdisciplinario en la comprensión integral del proceso salud/enfermedad/atención de poblaciones vulneradas de tres comunidades, una rural ubicada en el Estado de Oaxaca (Charco Redondo) y dos en la Ciudad de México (Xochimilco y Magdalena Contreras). La experiencia y los *saberes* (representaciones y prácticas sociales) se recuperan desde la perspectiva de sus habitantes, siguiendo la estrategia basada en aproximaciones multi método. Con base en referentes teóricos y metodológicos compartidos, se revisó el material empírico producido en tres investigaciones previas. El abordaje interdisciplinario se orientó hacia la reinterpretación histórica, antropológica y psicosocial de los *saberes* y de las trayectorias de búsqueda de atención de la población, para lograr una comprensión más amplia e integradora del proceso salud/enfermedad que contribuya a la elaboración de políticas públicas orientadas a mejorar las condiciones de salud de poblaciones vulneradas. Al final del trabajo se plantean algunas reflexiones sobre los alcances, limitaciones y los retos para impulsar la investigación interdisciplinaria.

Palabras clave: Interdisciplina; Representaciones sociales; Saberes; Vulnerabilidad social; Proceso de salud/enfermedad; Trayectorias de atención en salud.

Abstract

The aim of this paper is to demonstrate the potentiality of an inter-disciplinary approach in the comprehensive understanding of the health-illness-attention process in Mexican damaged populations, one of them in a rural community in Oaxaca (Charco Redondo) and two communities in Mexico City (Xochimilco and Magdalena Contreras). The experience and *knowledge* (representations and social practices) are obtained from the perspective of the inhabitants, using a multi-method strategy. Shared theoretical and methodological references are used to review the empirical material acquired in three previous research studies. The inter-disciplinary approach focused on the historical, anthropological and psychosocial reinterpretation of *knowledge* and the population's trajectory in their search for attention, in order to achieve a broader, more integral understanding of the health-illness process that contributes to the design of policies meant to improve the health conditions of damaged populations. The article ends with some reflections on the scope, constraints and challenges of promoting inter-disciplinary research.

Keywords: Inter-Discipline; Social Representations; Knowledge; Social Vulnerability; Health-Disease Process; and Attention Trajectories.

Introduction

In recent years, the issue of interdisciplinarity has gained an increasingly importance, from the complexity of the problems that humanity presents and that, as González-Casanova says (2004), force to “seek new meanings to the set” since the specialization of disciplines has led to a partial and fragmented vision of the knowledge. In the social sciences this interest is manifested, especially in the field of health research, for example Choi and Pak made a review of the international literature around the concepts of multidisciplinary, interdisciplinary and trans-disciplinary in the period of 1982 to 2007; their findings are written in three interrelated items. In the first, they give practical definitions and scope of the interdisciplinary (Choi and Pak, 2006). In the second, the main difficulties for interdisciplinary work (Choi and Pak, 2007) and in the third, the possibility of carrying out the collaboration between different disciplines (Choi and Pak, 2008). Lolas (2004) mentions that in the multidisciplinary, each researcher retains his professional identity and specialized lexicon. In the interdisciplinarity there is a sense of integration and creation of bridges between disciplines, while in the trans-discipline, disciplinary identity is left, you share a task, there are common interests and work context. But for the complexity that the interdisciplinary work represents, --the hall to the trans-disciplinary-- it is common to publish papers in which each author approaches a specific issue without establishing a dialogue or a theoretical or methodological reflection in relation with the object of study, something very similar to the sum of the parts. In this regard, González-Casanova says that the interdisciplinary dialogue suppose: “... the articulation of texts and social and cultural contexts, and from authors-readers for the construction of mediations between realities and utopias” (González-Casanova, 2004, p. 84). Aboelela et al. (2007) based on an extensive review of the literature, they define the interdisciplinary in terms of:

.... a conceptual model that links or integrates theoretical frameworks derived from these disciplines, uses study designs and methodologies that are not limited to a single field and require the use of pers-

pectives and abilities from the disciplines involved through multiple stages of research (Aboelela et al., 2007, p. 341).

This proposal is a first approach to the possible dialogue between social anthropology, social psychology and the history of the mentalities; we have called this process *trialogue* which differs from the sense proposed by González-Casanova (2004), in terms of a interdisciplinary construction of the studied object. Our interest was to obtain from the analysis of empirical data from an interpretive exercise based on the exchange of experiences and knowledge around the health-disease care in three different locations in which we made some previous research (Mora-Ríos 2008; Espinosa and Ysunza, 2010-2012; Salas, 2011).

Theoretical references

We begin with this *trialogue* identifying the theoretical references and epistemological assumptions from which the investigation proposals were built. From this review appeared two conceptual axes: The social representations and the notion of *knowledge* in the process of health/disease/care, dynamic and relational process that allows the understanding of how every social subject lives and explains the disease, suffering and damage to health, according to the context of the universe of beliefs, values and behaviors from the sociocultural environment and living conditions in the social group to which he belongs (Kleinman and Benson, 2004; Menéndez, 1994).

For interdisciplinary collective interpretation of the process, it was necessary to approach through the Theory of Social Representations proposed by Moscovici (1961) as an heuristic theoretical reference to get deep inside the knowledge of the social reality of the population, to facilitate the theoretical proximity between social anthropology, social psychology and history of mentalities. The use of this concept from an interdisciplinary concept is a kind of concept-framework (Ibáñez, 2001) that enriches and enhances the theoretical and methodological status of many social disciplines, although this multiplicity can be a weakness/limitation while it is perceived only as a social construction, by its

symbolic nature or for the methodological difficulties to operate its categories.

In our case, the shared theoretical referent was the processual approach proposed by Jodelet (1986) and Banchs (2000), favoring the interpretative disciplinary dialogue because “the study of the processes and the products through which individuals and groups construct and interpret their world and their lives, allows the integration of the social and cultural dimensions with the history, as oriented diachronic evolution” (Jodelet, 2000, p. 10). The triologue was enriched by the contributions of Blaxter and Paterson (1982), Boltanski (1971) and Blair (1993).

As authors of this paper, our interest was to establish a respectful and equitable dialogue between scientific knowledge, humanistic, technological and socio-cultural to the construction of the knowledge (Choi and Pak, 2007), which favored the interdisciplinary approach, as an antithesis of the fragmentation that leads to the divorce between the disciplines and to the separation of academic *knowledge* and the subordinates. We used the notion of *knowing* as a methodological abstraction, because the *knowing* is represented and is implemented by individuals and particular social groups and it is systemically shared as a whole society (Menéndez and Di Pardo, 1996). And we also used the notion of *knowing* while it refers to the knowledge --Opposed to ignorance-- on a specific problem (Menéndez, 2005). Therefore we consider that to achieve the interdisciplinary *praxis*, the dialog between the scientific knowledge and the common sense knowledge is necessary because only from the intercommunication and the mutual enrichment between the social actors, it is possible to build conceptual and methodological bridges to approach into the comprehension of the reality as a totality to achieve a more inclusive knowledge and holistic process of health/disease process/attention.

Social suffering and self-care were two shared notions. The first one because a disease is “an unfortunate event, a misfortune that threatens or modifies” the individual life and affects the collective balance whose mystery “does not get clear with the medical diagnosis” (Banchs, 2007, p. 234). The self-care to health according to the terms proposed by Menendez refers to the constant and intermittent activity that

the subjects and social groups performed independently and has “as decisive secondary reference the other forms of attention” (Menéndez, 2005, p. 54); also includes no professional and is developed in homes and families.

In the Latin American Conference for measuring welfare and promotion of the progress in the societies that took place in Mexico City in 2011², it is said that Latin America remains as one of the most unequal regions in the world, in terms of the population’s income and access to education and health services, it is estimated that social security coverage corresponds to only 37% of the population. Specifically in the case of Mexico, a country characterized by obvious inequalities originated avoidable iniquity that reaches the social injustice and violates most of the Mexican population. The three locations, in which we realized studies, have similar socio-economic conditions (Table 1).

The access to quality health services is limited by the systematic state renunciation to its responsibility to attend the health of the population; although there are important social programs to combat poverty like *Oportunidades* and the *Gratuidad*, their principles of spending, leave out social sectors that are not considered potential beneficiaries (Adelantado and Scherer, 2008). The popular insurance established between 2000-2006 and active to the present, with the objective to ensure universal access to health services, still presents limitations because in the practice it does not cover the entire population without social security.

The rural population with limited access to these services is higher in relation to urban, for example. In Charco Redondo (Costa Chica in Oaxaca) more than 97.6 % of the population did not have this service in 2005 and in 2010 48.72% (CONEVAL, 2012). In the cities there are also areas with similar conditions. In the Federal District, the population without insurance is in the southeast demarcations (Milpa Alta, Xochimilco, Iztapalapa y Tláhuac), and the Southwest (Cuajimalpa, Álvaro Obregón, Magdalena Contreras y Tlalpan (Gomes-da-Conceição, 2002). In 2008 the population without insurance

in Xochimilco reached the 50.1% and in Magdalena Contreras 45.3% (SSA-GDF, 2009).

We consider the *social vulnerability* as a result of the accumulation of inequalities to the subjects and populations, to which they cannot fully guarantee their rights, and according to the constitutional right to health, presents a bigger possibility of having a damage, derived from social and cultural causes as well as personal and individual characteristics. Understood in this way, vulnerability appears as possibility and potentiality. Because of that we prefer to use the concept “damaged populations” because not only did they have the potential inequality but the systematic violation of their fundamental rights, which reinforces the position of subordination of the populations studied, that limits the possible impact on the proposals in the macro social and macro politic decisions that they involve.

With these shared notions, the objective of this work was to build -from the specificity of our disciplines - an interdisciplinary *dialogue* that reinterpret the empirical data with an integrative look, in order to contribute to the public policy development oriented to better conditions of health in damaged populations.

The paths of the *dialogue*

The investigations were raised from three social disciplines: the History of the Mentalities, Social Psychology and Social Anthropology. The three of them suggested the dissatisfaction with the active health care model that limited the care necessities of the damaged population and placed them as passive and as beneficiaries from the health services; besides a critical posture regarding the vertical character of the health system that does not make any consideration of the opinion from all the social actors to establish the public politics of the sector.

Each researcher selected the empirical data that they considered relevant to realize a collective interpretation, shared it with the team and later were processed along with the analysis of the narratives of the informants. In the table 1 there

² (INEGI, FCCT, OCDE et al., 2011) Conferencia Latinoamericana para la Medición del Bienestar y la Promoción de la Salud. Del progreso de las sociedades, 11-13 de mayo 2011, Ciudad de México.

Table 1 - Features of the studied communities

| Investigations | General objective | Study Subjects | Selection techniques | Analysis strategy |
|---|--|---|--|--|
| <p>1. The research was done between 2008 and 2009 in Charco Redondo, municipality of Villa de Tututepec, Costa Chica, Oaxaca with an Afro-Mexican population dedicated to agriculture (lemons, corn, bananas). It has cattle; some women raise pigs and poultry. Men work as masons and in other activities. The houses have electricity, there is a health clinic building where doctors from the Oportunidades Program visit monthly to assist residents; they go to the particular doctor and to the regional Hospital (Espinoza and Ysunza, 2010)</p> | <p>To build a socio-cultural epidemiological profile from their experiences in health-disease-care.</p> | <p>Users of traditional medicine, healers, doctors, ethno- botanical and key informants (local and municipal authorities)</p> | <p>In-depth interviews Life history Structured questionnaire Document review</p> | <p>Discourse analysis by subject and theme</p> |
| <p>2. The research was conducted between 2008 and 2009 in Xochimilco, southeast of Mexico City, where inhabitants (originated and domiciled) settle in marginal and semi-rural areas. They do not have all urban services; urbanization is recent and chaotic. 50% of the population have social insurance, the rest only have services from the city's Ministry of Health. The families go to these services and to the inexpensive private doctors. The mothers interviewed work in the home and outside the home. The fathers, in all surveyed households, work in different paid but unstable activities. The territories they inhabit are highly marginalized. (Salas, 2011)</p> | <p>Describe and analyze the social relations and representations between the domestic groups and health staff about the alimentation of babies younger than 6 months under the subordination of the first as part of the self-care system.</p> | <p>Ego babies Domestic group/familiar Nurses, doctors, social workers Workers and authorities</p> | <p>Observation In-depth interviews Document review</p> | <p>Development of child feeding paths. Ethnography of consultations and household practices. Thematic analysis of the narratives and textual</p> |
| <p>3. The research was conducted between 2000 and 2003 in a highly marginalized community in the Magdalena Contreras delegation, south of Mexico City. Located in an irregular settlement without public services (water, sewage, etc.). The population is heterogeneous by the place of origin. It is a passage town; some families are waiting to migrate to the United States. Only 15% of the population had social security systems. Since 1994 the community has had a health center. Its operation is irregular (Mora-Rios, 2008)</p> | <p>Research about the conditions and emotional distress, individual and social resources to deal with the stress.</p> | <p>Adult population and health personnel in the community and key informants</p> | <p>Multimethod approach: Document review In-depth interviews Group interviews Participant observation. Semi-structured questionnaire</p> | <p>Textual analysis, thematic and content</p> |

are presented the general characteristics of each project. In the three investigations it was required of the participants to make, authorize and record the interviews and socialize the collected information, it was explained to them the reason of the interviews, the confidentiality of the data and fake names were used in the publications. The three investigations were approved by the committees of Ethics / Bioethics from the affiliation of the authors institutions.

During 24 months the dialogue process unfolded through regular face to face sessions where the authors of this work participated. In many of them, there was an exchange of bibliographical resources and these encounters were even registered in audio. There was also constant communication through email and by phone.

Women in the health-disease-care process

It should be clarified that although the shared initial interest was to recover experience of different social variables in the process of health/disease/care, in this first exercise we reinterpret interdisciplinary discourses only for the women, because we had the empirical information that showed its role in the process. Now we describe the main findings, which are enriched with the stories of the participants from the three referred investigations.

Being sick, being healthy

Women in the three localities defined and explained the disease from the physical or biological dimension as a limiting state because with it, the energy is lost and also the force to work and face its conditions of economical precariousness.

They considered that being sick not only meant losing energy or strength, but losing the liberty not being able to do daily activities and accordingly, not to fulfill socially assigned functions. They did not limit to explain the symptoms of the illness but they covered the psychosocial dimension and they let us see that underlies the discomfort created by their poverty. In contrast the notion of being healthy was associated with joy and family harmony; two states that allow coexistence within the family nucleus and interaction with the collectivity.

In the interpretative exercise we discovered the association of being sick without eating. Some women considered that eating well means health, so from their vision, whoever is in charge of the family, should put attention in the changes that the members of the domestic group presents at the time of eating and look for discomforts in order to chose the path of attention to follow.

The poverty, greatest emotional ailments

In the speech of women, poverty is shown as the main distress and they explained why they could not solve their health problems because their illness could get worst. Manuela explained that she felt worried about the bad conditions she was living in: “Worried, yes, what makes me more worried, I mean the health of my little girls, because for example, everything is humid all the floor are like soil”. From the perception and social representation of the health-disease for this woman and for others that live in poverty, has a hereditary nature. Adriana said:

This thing of the childhood that you say, well, me in my parent's home, they were really poor, I did not have economical resources. We had lots of needs, work, yes! and that is all, and we grew up and grew up. Then we get married and we fall in the same situation with our husband, we are from poor families and our husband are as well, we work with our children. Then come our sons, and we suffer to help our kids. It goes, it goes, but as the time goes, at the beginning we suffer because of the economical situation, but then we work, and when you stop to think, we are making it, we are making it [...]

Also, the informant claimed to the inherited poverty the reason that her lungs ache, because to face the adversities she had to prepare and sell “tamales”: “[...] I get sick a lot, I have lungs ache caused by the effort of making the “tamales”, you have to use a lot of force to move the mass, so the “tamal” is well done”

In the case of Angela, habitant of the urban area of Contreras, says that she emigrated to this place to overcome the poverty, but she found herself creating a new suffering that is bigger when someone of her family gets sick, because she settled on a high risk zone of floods, and the overflow of the river. In the rainy season she lost all her possessions and her

house was full of mud. About this, she said “ [...] it is suffering getting wet, that is a suffering for me, that is [...] Well, we suffer a lot! We lived there where the Virgin of Guadalupe is, here where the rock is, on top of this hill”

Social suffering

Being sick does not only generate physical suffering, but also social suffering because the person stops being useful to his family that counted with his will, abandons its social assigned function and stays defenseless, the opposite of being healthy. About this suffering, Eusebia, explained that she had a sharp pain on her knees; this worried her because if she went to collect lemon, her condition could get worst, but if she stopped working, she was not going to receive her only income about that she said: “ That it is a bad disease the one I have, and that I do not gain enough money to get better”. Cutting and recollecting lemons represents for this woman the main source of income, which is enough to cover the basic needs of her family, besides transport expenses. At the end, she used traditional medicine hoping that it was an effective remedy, or at least decreased her physical suffering.

Strategies to face adversity

A disease is one of the main ways in which collective and individual suffering is socially expressed. For damaged social groups, this situation makes them use different survival strategies including migration, and child work in order to face adversity. In the three locations, women counted with the traditional figure of man as the family economic provider, although, in some of them, they were really the main breadwinner, however, his participation was not recognized not even valued because the activities they realized to increase or complement the family income, were considered by them as an extension of their daily activities at home, among them, catalog sales was one of the most common, making tamales or other food, or as domestic workers, sometimes performing activities hidden from their partners. Also, others were part of public space like community work, and occupied jobs that were by tradition jobs for men, like construction in case of urban communities and agriculture or fishing in rural zones, and in some cases local government positions, but

the authority patterns still continued, reinforcing the subordination relationship in front of males.

By the way, what happens when the man, as the main sustenance of the family, gets sick or dies? For some women this jeopardizes the household. The reflection of remedies, a rural community informant shows the social implications that it has with the condition of her partner, changing the assigned role of each member of the family. She and her kids had to be inserted into the local-regional productive system as a day laborer and them as farm laborers to face adversity:

[...] I am also going, more now! That he is sick (referring to her husband). I go on the day, with my children, my three kids, sometimes I make ten boxes, nine, eight, seven, and so on, until my body resist [...] Sometimes when we do good, we make ten, and when there is little we make eight, seven, in this way there could be money. And I tell you, we have to keep going, and go to work.

For the capitalist agricultural production system, the work of women, boys and girls is valuable in two senses: a) for the survival of the household where the labor force is made and b) To the reproduction of the capital that gives this union to a marginal economy to the economical development, as workforce and reproduction of this force. By their precarious economic conditions without the economic incorporation of the child labor force, the family incomes would be reduced in half. On the other hand she said that she agreed with her husband that, while he got better, he would take care of the food preparation and housework.

Some women showed an ambivalent posture against the adversity, in one side the resignation, assuring that “ this is what I had to live”, on the other hand, the hope of a better future and the end of the circle of poverty through the migration of their sons and daughters, that in the rural area is almost at the age of 16 or when they finish middle school. This is why, Alejandra emphasized: “[...] the youth, is the one that want to change their life, they do not want to live the life that the grownups live, because they want to live their life better, give their children a better life [...]”. In contrast, for the women of the urban area of Contreras the migration had another meaning.

Some of them were from Central America; and even when there was a cultural diversity, all them faced the modification or loss of their social networks, and prevailed the feeling of homesickness because of the shared family activities in their community or country of origin. In the middle of this, they lived a process of construction of identity and belonging. The women of Charco and Contreras agreed that the main causes of migration were: 1) lack of land to live or produce; 2) insufficient income; 3) bad crops; 4) aspiration to better conditions of life for them and their children; 5) partial or permanent loss of land caused by natural disasters (hurricanes or droughts) and 6) the wars, displacement or community conflicts.

Self-caring

The self-care is the first true level of health care in the three localities studied (Menéndez, 1992) and the women have it, with a fundamentally preventive character. Gender identities were defined from the sexual division of labor that locates them in the private scope, dedicated exclusively to the breeding and care of children for which they have been prepared since they were little. Socially, their function is to learn to diagnose and identify the signs and symptoms of the disease to determine the severity or lightness of it, and from that, decide the health care path, with them being the first healers. The interviewed women said that the social and cultural relations with other members of the family and the community are fundamental to feedback on their knowledge, including the mass media and the medical system. The reasons that guided the choice of routes were: 1) they use self caring because they do not have other possibilities but to be poor, 2) because the diseases can only be attended by traditional medicines 3) the conditions can be treated by both medicines (traditional and academic) and 4) It depends on the quality of the link with local health staff, whether it is traditional, private, or institutional. The use of the traditional services of health or “particular” medicine, or from the health public services integrate the itinerary that follow in an indistinct or combined way.

Knowledge and care pluralism

The road in search of health is complex, not only for women from the studied localizations, but from all the societies and social groups. Our interdisciplinary exercise allowed us to confirm that the initial diagnosis is made by the mother or other women from the family. The diagnosis techniques are used and the treatments are collected, interpreted and given a meaning from different knowledge, especially from traditional knowledge and from some knowledge of biomedicine that they acquired from oral tradition, mass media and medical consultations.

The history of Andrea living in the community of Xochimilco, used auto medication (part of the care) and a mixture of knowledge. She says that when her baby got sick, she used a remedy and she included a pharmaceutical chemical: “[...] well, he was bad from his stomach for one night, we gave him Tempra. Two drops of water. Who recommended it to two? Well, we knew”. Eugenia recognized that she learned through the television how to cure the hangover. Also, in the description of the trajectories, we observed that the diagnosis adjustment or treatment, and the decision taken adapts to the presented health problem, if there is no recovery they go to the closest health center, to the traditional healer according to the suffered disease, or private medicine, or all at the same time. Frequently, at the end of this path there are the regional public hospitals.

Inattention to health

Through this interdisciplinary exercise we identify the evident dissatisfaction with the health care system, that gives few attention to the populations with low income, leaving them as passive beneficiaries of the health services and without a critic posture respect to the vertical nature of the system, that omitted the views of the social actors in the design of public politics in health.

In general and from its lived experience on health issues, the access to the public services, whenever they are available, is limited and are deficient services of low quality. They emphasized the *lack of medicines*, as one of the main problems they have when they go to the Health Centers or the Public Hospitals. The lack of these goods did not allow them to face an emergency, from a stomach or head ache

as it happens with the poisoning of the sting of a scorpion, very frequently in the coast region where it is the main cause of death of children under 5 years old. It is important to mention that Hospitals, Centers and Health houses were perceived as provider places for health care resources, for example: Andrea preferred to go to close pharmacies because: “[...] in case they recommend me some medicine and if they have it there, they give it to me for free. It is like the communitarian center. And there is everything, there is Dermatology, there is Odontology, there is weight control, and diabetes control”. Also, in the coast they were considered a place where they control of who goes so they can continue as givers of the *Programs of poverty combat*, among them *Oportunidades*.

Another element that from the vision of the users shows careless to the health was the *lack of personal health*, including doctors. Their critic was focused on the irregular function of the public health services, because of that, they established the necessity of improving the attention. The women interviewed recognized that their community (Xochimilco) had some institutions of health care, but they considered that they did not have the sufficient doctors nor hours of attention, as Catalina exposed: “There are few clinics, but not all of the doctors go [...] or they go all the time”.

They also criticized the dehumanization of the medical attention and that it is translated in the lack of quality in the doctor-patient relation. From her perception. Catalina added:

[...] apart that the people that attend are despots, the nurses are from the same background. It is really rare that you find a doctor that is a good person and that really loves his profession, loves the humans, because a lot of them are really bad people. They look at you and it seems they are experimenting with animals and it is not until you are dying that they put attention to you, if not, there is no attention [...]

The asymmetric relationship between patient-physician and other health professionals also involves scolding, as another element of inattention to health perceived by women. This act proves the conflict between patients-physician that comes from the cultural shock between these two social actors.

For Remedios (Charco Redondo) receiving a good threat and not receiving scolding from her position of no alternative in the health system, was a matter of luck, of divine grace and for her obedience to the authorities and the professionals of health: “thank God, I saw a good doctor, good! And I saw, I thought they were going be next to the door and will scold me (...) I give thanks to God that I was attended.

Discussion

The objective of this article was to analyze the potentiality that the interdisciplinary approach has in the integral comprehension of the process health/disease/care of women of three damaged populations in México, because we consider that one of the challenges in the field of health investigation is to encourage the interdisciplinary dialogue. In Mexico there are valuable theoretical contributions about the subject, but the concrete experiences of investigation are rarely common. In this sense, this work is a first effort to analyze jointly the findings of three studies in which topics addressed, as well as approaches and similar methodological strategies.

As authors of research in the mentioned areas we agree with the approach of Minayo (2008) that refers to the complexity of the health field, the exchange and combination of various knowledge in their approach, like:

.... different looks to explain and understand it: historical and contextual aspects, structural and relational dimensions, regularities, singularities and, usually, subjects' interventions and their interpretations in the production of reality. In these circumstances, we need to produce statistics and qualitative information of different types that a single method cannot approach (p.6)

Qualitative research strategies, mainly the participatory methods are used, showed that the interviewed women had a big need to talk about their experience and externalize what they have felt and lived, the interview also represented certain kind of intervention and when it promotes reflection on these issues, it allowed the interviewed to give a new meaning to their everyday experiences. This attitude, paraphrasing Martínez-Hernández (2010) was part of a dialogic process involving the interviewees

and interviewers in a relational way that allowed them to give sense to their experiences.

This exercise allowed not only to identify the methodological coincidences in our investigations, but also to confirm the explained in other studies of social representations in the process of health/disease/care. Boltanski (1971) he exposed that the difference between the most favored social classes, the popular ones focus their attention in the corporal symptoms related to physical strength or ability, a search to “make your body work for a long time and to its maximum capacity” (Castro, 2000, p. 52). Indeed, two women interviewed in the rural community of Charco Redondo, without little sons or daughters they reported the loss of strength or energy as a sign of being sick and stated that while they had strength they will continue working and holding their discomfort as far as they could; they were only concerned in the case of having sons or daughters depending on them.

From the vision of some women, poverty had the character of heritability, as Blaxter and Patterson (1982) noted in their study. For the people living in rural areas, for the younger people, the migration represented an alternative to break the cycle of poverty, but for those who had lived the experience of migration, meant being reunited with it, their main concern was the disease of a family member. The childhood, just like Toumaala (2005) showed in her work, was the start point of the stories to share their experiences and explain the basic needs not overcome, why and how they lost their health.

In a gramscian way we affirm that in the entire medical model, the relations of hegemony/subordination prevail. In the biomedical model the patient in his position, adopts an attitude of obedience not to be scolded, but others also the posture of revelry and criticism. The critique of the health public service and the relationship doctor-patient was focused in: 1) the dehumanization of the medical work 2) the lack of warmth in the doctor-patient relationship; 3) lack of interest for what the patient or mother lives; 4) lack of medicines and health professionals and 5) the scolding. In this last action they emphasized for Boltanski's (1971) evidence of the conflict between patient-physician that comes from the cultural gap between these two social actors, the undeniable fact

that the patients disease does not match with the notion of disease that the doctor has, furthermore, the health centers were considered as providers of resources, rather than healthcare.

In the three studies it was confirmed one more time that the care route starts in the house where women frequently go to the “people in their immediate social space, and continue with the type of healer considered more appropriate, and whose consultation depends on the economical and cultural resources of the group and the infrastructure of the existing services” (Menéndez, 2005, p. 58), so that there isn't a unique attention path. The interviews allowed to see the medicalization in the care practices resulting from the “synthesis processes of juxtaposition or exclusion of practices and representations from different knowledge” (Menéndez, 1994, p. 75).

Comments

This experience allowed to identify the aspects that favored and limited interdisciplinary dialogue and largely coincided with those reported by Choi and Pak (2007). The more important aspects that favored this collaboration in a methodological level were: the vision shared focus by the authors in relation with other study topics; share a flexible theoretical framework toward the theory of the social representation; the dissatisfaction with one disciplinary vision ; the interest to rebuild the knowledge, overcoming the local context and the use of different methodological strategies. In an organizational level, influenced the physical proximity, available time, proper spaces to work together, the institutional support to impulse the collaborative work, proper working places, the institutional increase the collaborative work in red, fulfill as long as possible with the assigned commitments at meetings, also to establish an agreement to respect the disciplines and collective work.

Initially, we had difficulty to integrate or articulate the more relevant themes in each investigation and limit the information in relation with the empirical findings that were relevant for the development of this manuscript. On the other hand, there were difficulties to conclude the agreed working sessions, that we solved, through electronic communication

and audio recording of those sessions. Finally, the most important and worrying aspect, were the disagreements that put in risk the collaborative work. According to Choi and Pak (2007), this work may be hampered by the lack of tolerance, rigidity, lack of openness of the members and power issues.

From our experience, the disagreement, friction, the dissensions were overcome being flexible, without generating obstacles impossible to overcome, possibly by the proximity of our disciplines, all linked to the field of humanities. But this raises new challenges, for example, how to integrate to this interdisciplinary exercise to other investigators of different disciplines that sheared the same interest for the process health / disease / care (Choi and Pak, 2008); also, how to maintain the communication and dialogue from a particular concrete study object to prevent this learning to be diluted.

From what is written here, one of the most valuable learning in this experience was the generated information in the investigation at a communitarian level that was enriched with the criticized and shared view among the different disciplines (social anthropology, history of mentalities and social psychology), which offered the possibility to reinterpret the data several times without exhausting the analysis and even when the investigations were realized in different periods and sceneries, we find ourselves with its validity that comes from the historicity of knowledge. In this exercise we share the similar experiences from the social actors and meanings to their diseases and trajectories of care search.

When we presented the challenges to promote interdisciplinary research in health, it is not possible to make reference to the traditional ways of power to the academic groups and health institutions (Choi and Pak, 2007). In this level we observed a discrepancy among discourses and practices, since on one hand, the importance of collaborative work is established through the formation of groups and inter-institutional networks, and on the other hand, in practice it is observed an overvaluation of the individual work above the collective, for example at the moment of privilege the first author of an article or the corresponding author responsible for research. What happens in the interdisciplinary works that each author is responsible for his re-

search as was our case? With base on which criteria it is established who is the first author or the leader in the publication? No doubt this is a challenge for publications that incorporate an interdisciplinary approach.

As far as possible, we tried to use democratic and equity criteria, and stay out of corporate practices re-functionalized on the field of investigation that privilege one discipline over another or identify as leader who has the greatest institutional hierarchy. The main challenge of an interdisciplinary exercise is the resignification of the collective work based on the reciprocity between the demand and evaluation, between rhetoric and practice, in this way, the order of authorship was agreed, and even when it is not desirable, we use a traditional practice that consists in the degree of participation, but only in the last writing and editing. Finally, we recognize that while this exercise was enlightening to know the scope of collective work, it will always be better to formulate an interdisciplinary object of study, as proposed by González-Casanova (2004), because the exercise we used to explain the empirical data *a posteriori*, reduced the level of depth in the analysis.

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