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Ways of seeing and doing: health, disease and care in marketers' family units

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Abstract *The concepts of health, disease, care and care practices in family units of marketers in Feira de Santana (BA), Brazil, are the object of the study, which aimed to understand the relationships between the concepts of health, disease, care and ways of seeing their care practices. An exploratory research through qualitative approach was conducted with 16 marketers through a semi-structured interview. The corpus was submitted to thematic content analysis. The concepts about health, disease and care are linked to the explanatory models of health-disease process emanating from the professional sector of care and to the socially constructed of action rationales and are coordinated with the ways of daily acting to provide care. The family stands out in the care of its members through solidarity, leveraging resources in order to overcome health problems. Among the therapeutic options, the marketers use the informal sector, especially home care provided by their support network. The family is a network of social support that assumes a moral and solidary duty in the provision of health care to its members without relinquishing the healthcare networks.*

Key words *Health-disease process, Family, Care, Social support*

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Introduction

The critical issues of research on family and care aim to establish the adopted family concept, to define the perspectives through which the relationship between family and care are being addressed, and to have a theoretical reference that can guide the empirical material's analysis process. Thus, in this research, whose objects are the concepts of health, disease, care, and care practices in family units of marketers in Feira de Santana (BA), the family is understood as a complex institution, a social body and a socializing agency ensuring social reproduction. Other concepts around the family indicate that it transcends blood ties, and its members are united by affection, identification or needs[1,2].

The family unit is the first reference of an individual's health care system, mainly due to the care inherent to family life. It is a social body whose members have shared experiences of sickness and culture and live the health-disease process in a similar way[1].

Family care, the primary core of care, encompasses health, well-being and happiness. In general terms, in the illness of any of its members, it rearranges the ways of living and caring, because the process of illness reaches the whole family unit[3], requiring the satisfaction of new care needs[4,5].

The family builds a particular world of meanings, knowledge and practices in line with its sociocultural environment and daily experiences within and outside the family. Moreover, this context includes the realm of health and the search for care systems[5,6]. The concepts about health, disease and care are related to the characteristics of the sociocultural context and the subjective experience of each subject[7].

These concepts are historical and social constructions linked to the historical, social, economic and political moment experienced by a certain generation in a territory. As a result, popular theories are elaborated[8] and develop from the material conditions of existence and daily experiences[4]. These theories reorganize and shape themselves around scientific knowledge, while taking into account the influence and relevance of a common knowledge learned and passed from generation to generation to family members, observing a family hierarchy.

Recognizing the health-disease process, as well as care practices as spaces of interaction between social subjects in their life context, the concepts of health, disease and care range from the most biologicist to the most holistic[7].

Care is part of the health-disease process[9], consisting of symbols and meanings that permeate family relationships, and allow its members to organize, understand, interpret, relearn and face barriers to overcome health problems.

In this study, care is assumed as a phenomenon in the existential sphere, as that which is part of being, endowed with rationality, cognition, sensitivity and feelings; care confers humanity. It is relational or co-existential, since it occurs vis-à-vis the other, and also contextual, insofar as, for its practice, it is necessary to consider the circumstances in which it occurs, assuming variations, intensities and differences in its ways of providing care[10].

These forms of care, also called caregiving or care practices, are ways of doing of population groups referenced in their life contexts, seeking to identify practices related to their health and disease experiences. That said, care practices may be linked to ways of acting in which individuals and their families seek alternatives based on their rationale of action, and not only those linked to norms and rules underlying a given culture[11].

Therefore, care practices are present in the family units of the most diverse social groups, classes, and ethnicities. Each social and family group will address health needs by developing means or practices that consist of care strategies and tactics, according to their culture, values, beliefs, education, access to formal and informal health services networks, and socio-familial support networks[11-13].

The research problem was structured based on the following guiding questions: What are the concepts of health, disease, care, and care practices of marketers' families working at the Feira de Santana Supply Center (CAF) in Bahia? How do family health-disease-care concepts interrelate in coping with the health-disease process? Based on these questions, this work aimed to understand the interrelationships between health, disease, care, and how workers in the in Feira de Santana CAF see care practices in their family units.

We highlight the relevance of considering marketers as social actors of the research because they are a group of informal workers about which there are few studies focusing on their ways of seeing and doing concerning health, disease and care in their family units; as a network of mutual support that mobilizes efforts and reorganizes itself before health needs[12].

Farmers also have peculiarities concerning the environment and working conditions, exposure to risk factors, and protection, which put

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them in a situation of vulnerability concerning disease and care required to meet their health needs[14].

Working on the family-centered health-disease process is still a challenge since this unit has singularities. Therefore, understanding the meanings assigned to care and ways of providing care in the family's daily living is a complex and challenging social dynamic[5].

Methods

This is an exploratory research with a qualitative approach. The empirical field was the Feira de Santana Supply Center (CAF), in Bahia (Bahia), Brazil, which gathers retailers and wholesalers of foodstuffs and handicraft products. Sixteen participants from both genders who worked at the CAF with family members were selected, and the initial inclusion criterion was to have been working for at least six months, and to accept to participate in the study after initial contact and explanation of the study proposal, with the clarification of the possible risks and benefits of the investigative process. Confidentiality and anonymity were preserved through the adoption of pseudonyms. Marketers who worked alone or those with employees with whom they had no family ties were excluded from the study.

Data were collected and information produced through a semi-structured interview, so that the marketers could discuss the proposed theme, defining the terms of their answers without previously fixed conditions[15].

The progressive listening of social actors took place until the concepts, explanations and meanings attributed by them to health, disease and care were regular, which was a criterion of saturation, which was understood as when it was "possible to identify symbolic patterns, practices, classificatory systems, categories of reality analysis and worldviews of the universe in question, and recurrences [...]"[16]. This study observed the ethical precepts of human research and was based on respect for the autonomy of social actors, treating them with dignity, maintaining a posture of respect vis-à-vis their ways of thinking about health-disease and providing care. The Human Research Ethics Committee of the State University of Feira de Santana (CEP/UEFS) approved the research, observing Resolution Nº 466/12 of the National Health Council.

We used thematic-related content analysis. From this choice, initial readings were carried out, which allowed us to arrive at a first impression of the corpus, followed by the definition of registration units, context units and empirical categories. Then, we proceeded with the analysis, or material exploitation, which consisted in successive readings of the corpus, in order to carry out its codification, through theme clustering into units that would allow the description of the relevant characteristics of the content. Finally, the results were addressed, in which an understanding of the underlying content was sought by inference and interpretation.

The data analysis and interpretation process enabled the elaboration of the empirical categories: Concepts of health, disease, care, and ways of seeing care practices; Family leadership in care practices; Performance of social and professional support networks in the health-disease-care process.

Results

Sixteen marketers, eleven women and five men, who were working at the CAF with family members participated in the study. They originated from Feira de Santana (BA) and other cities in the metropolitan region, and from the states of Pernambuco and Minas Gerais. Women were aged 20-68 years, and men 36-66 years. The marketers self-declared as white, brown and black.

Most were married, six of the respondents were single, and the number of people residing in the same household was between two and six. The monthly income ranged from one half to eight minimum wages; schooling ranged from five to 17 years of study, from incomplete primary education to incomplete higher education; however, the years of study included drop-outs and repetition years. Concerning religion, they self-declared Catholics and evangelicals.

The marketer's activity is the only occupation. The working day lasts 10-13 hours on average. The time of operation as marketer ranged from one to twenty-three years. In the tent, stand or warehouse, which are the working environments in the CAF, the number of family members working in the area ranged from two to five. The bond between the relatives is father-mother-child, who underpin the family core, and uncles, nephews and cousins, who make up the extended family. The duties performed are seller, store clerk and cashier.

The following category describes how concepts about health and disease relate to the con-

cepts of care or even ways of practicing care in the family context.

Concepts of health, disease, care, and ways of seeing care practices

The health-disease-care process concepts are related to the care practices when the way of understanding the world and its social dynamics legitimize actions, attitudes, interpersonal relationships, orientations and advice. In this relationship, health is attributed to an idea linked to the use of hygienic practices, above all, those required for food cleaning, which is taken as care action. *Health is everything, it is hygiene, washing hands, when going to the bathroom, washing your hands, washing your hands before you pick up food* [...] (Maria). Maria ratifies the reductionist health-disease concepts, by emphasis on biologicism, adopting hygienic practices as health and disease avoidance measure.

Disease is perceived in analogy to the functioning of a machine; it is noted that something is not within the "normal" and, thus, marketers associate disease with some biological body disorder; it is when signs and symptoms manifest themselves in the body and the marketers express them when referring to malaise or pain. *Illness is when you do not feel well, the body is fading, without strength, without courage, feeling pain.* (Lia). Thus, feeling good for the marketer is not made of the various realms of well-being (physical, social, mental), it boils down to the proper functioning of the organs and not feeling pain.

The health concepts are social constructions and can be resignified by subjectivities. They carry influences of experiences and assume a value relative to living life, and living it in the best possible way. There seems to be an understanding that to make life pleasant, one must be healthy. *Health is life because without it, you don't have a life. Health is what makes you alive, right?* (Jacó). For marketers, life depends on the state of health.

The health concept, in this vision, expands and makes sense when feeling alive, in the capacity to work and enjoy life. *Health is to live well, is to be willing to work, to be without disease, without stress, to do physical exercise, to walk, right?* [...]. (Raquel). There is a concept of health that encompasses health promotion practices. According to Naomi: *the disease stops everything in life, being sick is horrible* [...] *sometimes you stop working, stop studying because of the disease* [...]. Also, we can perceive social aspects of the concept of health-disease through the influence of capitalist society, in which the idea of being sick is associated with the inability to generate work.

Some concepts of caring somehow approximate the concepts of health reported by the marketers. Therefore, a biological realm of the idea of caring is present (visits, periodic tests, health understood as the absence of disease), and, nevertheless, other concepts take on broader realms of disease prevention. *Care, as the name is already saying, is to take care of the body, right? Caring for food, eating correctly, going to the doctor at least once a year.* (Matheus).

Care can be taken by carrying out preventive practices: taking care of food, paying a visit to the doctor periodically; or healing practices such as buying the prescribed medication. In fulfilling these needs, one takes care of the family to preserve life and provide essential subsistence resources.

It is argued that despite the indistinction regarding concepts of care and health, often present in the perception of the marketers, a more comprehensive notion of care is found. While unlike health, it can do without the relationship with the process of illness, by imbricating inborn aspects to the human being. In this line, caring assumes an affective dimension, with aspects related to happiness, and social dimension, related to the needs of the family as a social body.

The ontological realm of caring – in its true meaning – is revived by Jacó and Naomi, insofar as they understand caring as concern, zeal, attention, as a process inherent to the human essence. According to Jacó, care *refers to you caring, loving, because who loves cares, isn't that so? The concept is love; you love, you care.* Naomi, in turn, said: [...] *It depends on each one. We have to take care of ourselves first, to value ourselves; take care of myself and then take care of the other.* The statements refer to the human meaning of caring, an altruistic meaning, inherent to the human being because it is understood that care is intrinsic when considered a subjective competence.

Based on these reflections, the following category addresses the importance attributed by marketers to family care in care practices, a process in which the family provides care and promotes health.

Family leading role in care practices

The family can be understood as a leading unit of human development, standing out in care practices. Thus, solidarity in the family unit is reaffirmed to strengthen the forces aiming at

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overcoming health problems. *Our family is very united. When necessary, everyone is willing to provide care, accompany to the doctor, stay at the hospital, give support and comfort as well.* (Marta). We notice that, for Marta, all the relatives can participate in the practice of care. She says any family member, when triggered, will be willing to join other family members and enhance care. An idea is in the air where everyone can and should take care, either as an "obligation", a family duty, or as a responsibility towards the other, readily assumed, without impositions.

The woman-caregiver figure stood out in the statements, signaling that even the woman of modern society, when assuming other social roles, internalized the role of caregiver, monopolizing knowledge and care practices. As a result, the still sexist society naturalizes and submits women to a domestic scenario, something that occurs mainly in the popular classes. [...] *I believe the mother always takes greater care, unlike the father* [...] *when it comes to illness, I think it's even more important.* (Judith). She is responsible for "greater care", surrounded by attention, diligence, and love, and it seems, thus, natural that it is up to her to take care of the practical aspects in a situation of illness, such as taking to the doctor, for example.

The family is valued as an area of security, care and transmission of values, and, in certain aspects, it approaches the concept of contemporary family that exercises its citizenship through responsibility with the health-disease process, in its political connotation. Thus, the health services are charged by the subjects as bodies that ensure the right to health. *We have the Community Health Worker. If it is something we cannot go to, it is up to the Health Worker's obligation to go.* (Maria).

Maria emphasizes the role of the Community Health Worker (ACS) as a mediator in the relationships between families and the primary healthcare facility to meet health needs. These, in turn, presuppose the sharing of rights and duties between users and health services.

The family becomes a primordial resource for the health-disease-care process, reiterating its supportive role, which provides objective and subjective resources for the reestablishment of health. *The family has to be in the first place* [...] *to be united, to be together. As it is said, union is strength.* [...]. *Marriage is fundamental, this love, family care helps a lot, especially in extreme cases; family support, care helps people to reestablish themselves, to recover, family help, all this counts a lot.* (Jacó). It is observed that the way of thinking the family as a source of strength and union articulates with the thought that there are ideal ways of acting: in caring, in love and affection that are provided as care practices and as strength restorer of diseases, even considering the individuality of each member, their personality and their attitudes.

However, the feeling of family union brings living experiences; it is necessary to reflect how the family relationships, previously conflicting and distant, will be established. Is the phenomenon of illness capable of mitigating or eliminating such characteristics of family relationships for the sake of healing? Jacó believes the family must provide support and care until the restoration of "health conditions". However, when dealing with chronic illness, for example, such a practice can result in the rupture of the daily routine of family members who exercise care, or in abandoning caregiving.

In short, the family is one of the components of the social support network in the health-disease process and works together with other (formal and informal) institutions that complement health networks in the professional context. This thematic approach is outlined in the following category.

Performance of social and professional support networks in the health-disease-care process

The concepts of health, disease and care interfere in the way of acting and moving across the health services underpinning the care systems. Thus, one cannot speak of the health-disease-care process without relating it to the concrete experience of having transited through the network of health services, whether public or private. *We usually go to the health post in the neighborhood, right? If we cannot solve things there, we must seek another resource in the private service.* (Acsa).

Social actors seek assistance to their health-disease process through the health services provided by formal and informal care systems. These services refer to the professional doing or approaching this through the empiricism of non-specialists, who through popular wisdom, support health needs through advice on the use of home remedies. *Care is provided by the people who are prepared for it, that is, doctors, nurses, professional care and also personal care, right? A visitation from relatives, friends, all this helps* [...] *seek, if it is the case, it may be herbs, adding herbs helps* [...]. (Jacó).

The formal system of care constituted by the healthcare network does not exclude the search for the informal or popular system represented by the family's social network: mother, father, siblings, relatives, friends, neighbors and institutions such as school and church. The resources of the popular system, for the actors, are restricted to the use of herbs (teas), possibly because it is a family-rooted knowledge, passing from generation to generation, by the experience of use, surrounded by ideas that the consumption will not do any harm, or by the most affordable price and availability, as some types of medicinal herbs are grown or sold by the marketers themselves.

The social support network provides social protection and is primarily stems from the family, extending to informal institutions, such as philanthropy, churches, social institutions and schools that assume this role. They are based on cooperative and solidary relationships, which favor a sense of closeness and security. [...] *sometimes you do not have transportation to take to the doctor, neighbors help in any way they can* [...]. *Neighbors are the first family that we have* [...]. (Judite). According to Hosanna*: At church, each one plays his part, one prays, another helps* [...], *then we help them help, they collect here to help other people* [...]. Marta says*: School also helps to educate the children, doing these campaigns, gymkhana that collects objects to donate, stuff like that.*

Neighbors provide social support as they are close to families and can help with financial aid, or obtain transportation to take the sick person to health service, among other aid. They are also considered members of the family, as reported by Judite. Thus, a web of relationships is established and protects the subjects in diverse situations, mainly against illness.

The church is a space of social support and provides spiritual and emotional support, which promotes health and care, through words of comfort, hope, strength and determination to move forward in the pursuit of health, or even of its prevention and promotion. Although they are more restricted, schools are seen as health promoters, providing guidance on health measures, developing the socialization of children, conveying the idea of solidarity.

Given the diversity of interpersonal relationships and the socio-political-economic context, networks that involve social actors seek to meet many shortages or needs, among them, those of health.

Discussion

The health-disease-care process has a marked relevance and influence in the daily life of a family since it involves different aspects of life in society. It is argued that no organization has the power to impose human behavior; they can guide and perhaps influence decisions and establish limits[17]. However, the views of social actors on this process reveal the power of a given social organization, in this case, the family unit – in converging predictable reactions.

The family usually thinks in tune and acts similarly. Thus, the idea advocated is that, even with different reactions to pain and the process of becoming ill, subjects have, to some extent, predictable reactions, since they belong to a group; and its members share the social meanings attributed to this process. Therefore, it can be inferred that family life, sharing values, beliefs and behaviors reflects in the identification of "being family", and this ultimately converges shared feelings and attitudes in the illness process[18].

The concepts of health, disease and care are articulated, and their conditioning by an unfavorable social and economic context can lead to one-off, reductionist care practices. For example, when the concept of health is restricted to hygienic practices, it is thought that they may only have the purpose of warding off diseases caused by pathological microorganisms.

Social actors seem to regard health and disease as interdependent categories. Thus, the disease, as opposed to what has been said about health, may mean not adopting hygienic practices, a notion that is also related to hygienism, consisting of hygiene practices that are personal, structural, such as cleaning and aeration of environments and basic sanitation measures[19-21].

Conceptual reductionism about the health-disease-care process can support care practices geared only to rehabilitation and prevention of illness, because if the disease is established, the actors will live with daily routine rupture, probable changes in income, increased involvement of family members and, sometimes, the support network management; however, it is not appropriate to generalize such concepts, since, for some marketers, health expands and assumes a social perspective[22]. This feature is manifested by the exploration of aspects that pre-empt own concepts of a given group, influenced by socioeconomic characteristics, epidemiological profile and by the work environment, resulting in social vulnerability.

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From an expanded view of health and care, it can be seen that the unfavorable socioeconomic conditions of the marketers do not prevent them from seeing the health-disease-care process critically, understanding the existence of risk factors in their work environment, which deviate them from the quality of life and healthy life habits; therefore, perceiving health through subjective aspects, of well-being, feeling good, having quality of life. Health assumes the idea of value, of the preciousness of living, "health is life". Thus, health is understood not only as a duty of the State, because individuals enjoy their autonomy, assuming the responsibility vis-à-vis their health and that of their relatives.

The concepts of health-disease-care and the practices of care adopted are related to the cultural constructions, beliefs and values that underpin or enable the family to improve and maintain life, since culture is a web of meanings that exerts powerful influence on behavior and practices[22,23], despite the prescriptive nature that seems to emanate from the biomedical discourse on health-disease and self-care ways.

However, this prescriptive nature does not invalidate preventive-oriented actions, in which health practices are expanded through a vision of disease prevention, measures that meet the needs of basic subsistence and those related to well-being (emotional support, genuine caregiving), characterized as care practices (less biological and broader).

Care practices are inherent to the health-disease process, perhaps because of this, authors such as Rosa et al.[25] use the nomenclature *health-disease-care process*, which was adopted in this study. The statements of social actors reveal that they understand care as a strategy to overcome and avoid disease, as a requirement for health, a situation in which the synonymy between concepts, or better said, ways of seeing care and health with one's practices is noted – ways of doing care and health. A conceptual indistinction between concepts of health and care is also noted. However, one also perceives that care involves and contains, compared with a mathematical diagram, health and disease, since it is performed to avoid disease and to approach health.

The concepts about the health-disease-care process are tools, that is, they train from the theoretical-reflective plane, of ideas, advice and beliefs, to the ways of doing within this process; these are practices that allow the family unit options for health care, planning care actions, sharing and suggesting prevention strategies and overcoming the resulting problems, as well as, the knowledge and realization of the care options provided by healthcare sectors: professional, informal or popular.

It is emphasized that the way of seeing, understanding the world, family dynamics and advice by family, friends and neighbors are a power of persuasion of ideas, ways of seeing and doing that govern family relationships and guide pre-diagnoses, health measures and search for health services[25,26]. In a situation of illness or the demand for prevention practices, these teachings support decision-making, interaction and attitudes within the health-disease-care process.

Therefore, the internalization of habits and ideas shared and accepted in the family unit can influence the decisions and attitudes of care, the search for health services, and even the emotional strengthening that the situations of illness and prevention of future events require. The health-disease-care process is subsidized by semiotics (symbols and re-significations), which helps in tracking and overcoming this process, through the reorganization of family dynamics, concepts and practices, to meet the demands of care, and to cope with the hindrances of overcoming health problems.

This shared empiricism is supported by the experience of situations lived by family members, even if each re-signifies his/her own experience and has his/her concepts[27]. New individual concepts can be understood as variants of social norms long supported by the family unit. On the other hand, adopting new concepts, based on scientific knowledge, for example, which enjoys broad access to contemporary generations, will establish intergenerational conflicts[28].

According to the reports, faced with an illness situation and the demands of care that emerge, at first glance, limits to the roles of family caregivers are inexistent or not observed. Notwithstanding, the alleged readiness of the solidarity network that is the family, and of the assistance to the health needs of the health-disease-care process, the female figure still holds a prominent place in a socially naturalized role, since women are seen (and assume) as more fit and available for care.

The family is a fundamental tool in caregiving, along with health services, as it has the capacity to be disseminating care and information, and influencing its members to seek health services, as well as helping to understand and prevent diseases within the family, because it has a keen eye as a producer of health and care. It seeks to overcome health problems and articulates with

the various healthcare institutions. Thus, besides preventing, it promotes health and facilitates the conditions that promote well-being and quality of life[29].

It reaffirms itself as a social and basic structure for the psychosocial development of its members; moreover, it operates as a social support – perhaps the most representative – and of health network; it is a system that mobilizes efforts when one of its members requires care, catering for it, helping them financially, giving them good advice and supporting them mutually in illness situations, with the other institutions.

The social actors, based on their lay concepts coupled with the learned scientific knowledge of social institutions, use strategies and tactics and seem to elaborate an explanatory model to clarify the state of health[19] and care actions. Marketers use the informal sector, notably in the home care provided by the family and its support network. In the formal sector, services of the Unified Health System (SUS) appear as the primary care network, emphasizing that the search for care in private services occurs mainly due to obstacles in access – high demand to the detriment of few professionals, delay in care, shortage of diagnostic resources, or even lack of urbanity in care – in public services.

Final considerations

Concepts of health, disease, care, and health-care practices help the family to provide care. The family is responsible for transmitting values, habits, information, and guidelines that will influence their members around the healthcare network, and the provision of care related to the promotion or rehabilitation of health. The families allow the subjects to re-signify the explanatory models established on the health-disease-care process and thus make therapeutic choices to attend to their health needs and also reflect critically to readjust their health-care concepts and practices, that is, their ways of seeing and doing.

It was observed that health and care concepts are not always well defined and differentiated by the marketers. Similarly, this indistinction extends to the synonymy between health practices and care. However, ideas are advocated that purport that the concepts and practices of care, the first in the field of cultural reflection and perception, and the second, of care attitudes, are different levels – care practices, which become more comprehensive, assuming multiple realms, among them an affective realm of emotional support to the members.

Reductionist health and disease concepts seem predominant. They base health practices aimed only at rehabilitation and prevention of illness, because if the disease is established, the actors must coexist with a daily living rupture, probable changes in income, greater involvement of family members, and sometimes, the agency of the support network, however, does not abstain from the broader and more promotional realm of disease and health problems prevention attitudes.

The strong idealization of the family as a solidary and altruistic network of social support, always ready to attend or follow-up on the demands of the health-disease-care process, can lead to conflicts due to task accumulation, absence from work, emotional distress, among others, resulting from the new health needs in a member's illness process.

We note ways of seeing and doing that approach biologicist concepts, well as other that evoke other expanded concepts of health, disease and care. The latter seem to stem from po-

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litical-social and scientific empowerment that fosters expanded concepts and actions, allowing social actors to lead the health-disease-care process, in a relationship of sharing rights and duties between health services and their social support network.

Collaborations

MNG Saturnino worked on the concept and delineation of the research, on data analysis and interpretation, on the drafting of the paper and the approval of the version to be published. TP Santos and PRLF Vale worked on the writing of the paper and the approval of the version to be published.

MGG Aguiar worked on the concept and delineation of the research, on the critical review of the paper and the approval of the version to be published.

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