

Therapeutic itinerary of patients with obesity treated in high-complexity services of a university hospital

Itinerário terapêutico de pacientes com obesidade atendidos em serviço de alta complexidade de um hospital universitário

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ABSTRACT This paper reports a qualitative research that aimed to analyze the Therapeutic Itinerary (TI) of 21 patients enrolled in a High Complexity Assistance Service for Individuals with Obesity provided by the University Hospital of the West of Paraná. In-depth interview was (State) applied as a means of data collection and, for data organization and analysis, it was adopted Kleinman's (1978) referential, which advocates the interference of subsystems family, popular and professional in the TI path of those that seek to solve their health problems. In family subsystem, the support of family and friends in the search for obesity clinical treatment was observed. Few patients adhered to alternative treatments, characteristic of the popular subsystem itself. Intervention and orientation of health professionals, inherent of the professional subsystem, proved to be crucial in the search for obesity specialized treatment. The TI study of the research subjects revealed that the family and professional core influence is stronger than the popular one. Kleinman's referential is limited as for the TI analysis of obese individuals, because it does not comprise important elements towards the obesity problem approach.

KEYWORDS Sociocultural environment. Health care. Bariatric surgery.

RESUMO Este artigo relata pesquisa de natureza qualitativa que objetivou analisar o Itinerário Terapêutico (IT) de 21 pacientes cadastrados no Serviço de Assistência de Alta Complexidade ao Indivíduo com Obesidade do Hospital Universitário do Oeste do Paraná. Utilizou-se a entrevista em profundidade para a obtenção dos dados e, para sua organização e análise, adotou-se o referencial de Kleinman (1978), que defende a interferência dos subsistemas familiar, popular e profissional no IT percorrido pelas pessoas na busca de solução para problemas de saúde. No subsistema familiar, observou-se apoio da família e amigos na procura por tratamento clínico para a obesidade. Poucos pacientes aderiram a tratamentos alternativos, próprio do subsistema popular. A intervenção e orientação de profissionais da saúde, característica do subsistema profissional, mostrou-se decisiva na procura por tratamento especializado para a obesidade. O estudo do IT dos sujeitos da pesquisa revelou maior influência do núcleo familiar e profissional do que propriamente do núcleo popular. O referencial de Kleinman apresentou limites para a análise do IT de indivíduos obesos, não incluindo elementos importantes na abordagem do problema da obesidade.

PALAVRAS-CHAVE Ambiente sociocultural. Atenção à saúde. Cirurgia bariátrica.

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Introduction

The paths walked by individuals seeking therapeutic care do not coincide, necessarily, with the flows predetermined by modern medicine or health services. The choices made represent subjective, individual and collective constructions about the process of illness and forms of treatment, conceived under the influence of socio-cultural contexts, personal experiences and health services provision (ALVES; SOUZA, 1999). These choices, in turn, define actions that, successively, will constitute a certain path. The socio-anthropological literature uses the Therapeutic Itinerary (TI) to define this pathway (CABRAL ET AL., 2011). Identifying the trajectory traced by patients helps to interpret the processes by which people, whether individually or collectively, elect and adhere to a specific form of treatment. This issue is based on the evidence that people are faced with different ways of solving their health problems (ALVES; SOUZA, 1999).

According to Silva Júnior, Gonçalves and Demétrio (2013, P. 2, FREE TRANSLATION),

health is a dynamic social process related to other social processes, in which each individual constructs and understands his health and his illness through the sociocultural representation in consonance with the reality in which he lives

Thus, it is essential to consider the sociocultural environment in which each person is inserted, his/her experience with the disease, the concept of health, illness and culture that each individual forms for himself/herself to better understand their demands and needs. The concepts and problems of individuals, in turn, will influence the decision about the choice of the intervention alternative that best meets their needs. In this sense, Silva Júnior, Gonçalves and Demétrio (2013, P. 2, FREE TRANSLATION) state that:

[...] the choice of treatment for his/her illness will be based on the comprehension and understanding that each person will have of his/her psycho-social state next to the different socio-cultural representations in health-illness-care constructed in tangency to the universe that is inserted, which will carry out therapeutic pathways and processes in order to better respond to their distress.

Kleinman (1978) proposed a theoretical model that contributes to the comprehension of the process of the choices of people to maintain or solve health-disease problems. This author argues that most health systems and care are made up of three social subsystems where the disease is experienced: the professional, the popular and the family. The professional subsystem is comprised of scientific knowledge, medical and non-medical health professionals as well as traditional Chinese medicine, for example. The popular subsystem consists of people officially not recognized by modern medicine for health care, such as healers, witch-doctors, among others. And the family subsystem comprises non-specialized knowledge based on the experience, livingness and observation of a group formed by family, friends, neighbors, among others.

Obesity, given the complexity involved in its etiology, considering its social determinants and the need to also understand it as a social problem, makes it important to know the therapeutic path of obese people who seek different treatment alternatives for their health condition.

Therefore, the study of TI in obese patients can be used to help the health teams that accompany this population to understand the socio-cultural context in which these individuals are inserted, as well as contribute to the decision-making regarding the approaches adopted in different care lines.

This study aimed to analyze the TI of patients enrolled in the High Complexity

Assistance Service for Individuals with Obesity (SAACIO) of the University Hospital of Western Paraná (HUOP), aiming to contribute to the work of health teams and public managers in the expansion of the approaches adopted in the care of obese patients.

Material and methods

It is a research of a qualitative nature, that was oriented in the theoretical model of Kleiman (1978) for the collection and treatment of the data. Data collection was carried out through a semi-structured interview, with 21 patients (28.0%) of the 75 subscribers at SAACIO, that, in addition to individual care, holds monthly meetings with patient groups by a multi-professional team. The interviews were conducted between February and May 2016, in a reserved place, in the out-buildings of the HUOP, on days of meetings of the three working groups. The patients come from 21 municipalities in the western macro-region of the state of Paraná.

The inclusion criteria were: be in clinical treatment of obesity or in the preparatory phase for the accomplishment of bariatric surgery; of both sexes; be at least 18 years old; agree to participate in the research by signing the Free and Informed Consent Form; be from different municipalities; and belong to different SAACIO groups. For municipalities with more than one patient in the service, the choice was for convenience, i.e., being present on the day of group meetings and having time to participate in the interview before or after the meetings. The project followed the norms established in Resolution n° 466/12 of the National Health Council and was approved by the Research Ethics Committee, opinion n° 1.180.202.

The systematization, analysis and interpretation of data were based on the theoretical framework built arising from the critical literature of human sciences and collective

health; in legal frameworks that guide the construction of the Network of Attention to People with Chronic Diseases; and in the care subsystems proposed by Kleinman (1978). The empirical data originated eight thematic cores, seven of which were associated with Kleinman subsystems. The Family subsystem generated nuclei (i) self-perception about obesity, (ii) the daily life of an obese, and (iii) the obese in modern western society. The Popular subsystem generated (iv) the search for alternative treatments. And the Professional subsystem, generated (v) the professional subsystem in the construction of TI of people with obesity, (vi) the surgical treatment because of the TI of people with obesity, (vii) the TI is constructed: which could have been different. The thematic core (viii) the mercantilist approach to obesity does not belong to any of the subsystems.

Results and discussion

The results are presented in nine topics, the first one of characterization of the research subjects and the others compose the eight thematic nuclei indicated in the methodology.

Characterization of research subjects

Of the 21 interviewees, 71.43% are female; 66.66% are between 30 and 49 years old; 52.38% are married; the average number of children is 2.57, ranging from one to six, and only one interviewees answered not having children; 80.95% live with their children; 66.66% live with husband or wife; and 33.34% of those interviewed have completed high school or higher.

Regarding the socioeconomic profile, 19.05% have a statutory employment relationship and the same percentage works under the Consolidation of Labor Laws (CLT) regime. The option 'others',

covering the household, beneficiary of the Bolsa Família, pension for the death of the husband and illness aid, totaled 38.1%; 28.57% of interviewees stated that they worked 40 hours a week; 61.90% answered receiving between one and three minimum salaries; and the average number of dependents per family income was 3.42 people, ranging from two to seven people. The form of displacement up to the HUOP used by 19.05% is the car itself; 76.19% use the transportation provided by the city hall of the county of origin for displacement in the days of group meetings.

Self-perception about obesity

At different times in life obesity can be a problem, but for some throughout life.

In fact, I have been obese since I was a child, I've never been thin, ever since I was a little child, since I was little I see that, I've always been obese, I've never been, so, thin, I've never been skinny, always obese. (E09).

Indicators on the human right to adequate food show the advances of Brazil in overcoming low child weight, although they warn of the high percentage of overweight and obese children and adolescents. Only 1.9% of children under five years old were underweight in 2006, while 7.3% of children in this age group were overweight. In 2009, 33.5% of children aged five to nine years were overweight; in adolescence, this percentage was 20.5%. Nutritional status in the first years of life has an impact on adult life. In 2012, 50% of the adult population was overweight, of which 17.2% were obese (BRASIL, 2015D).

Gestation seems to be a time of weight gain that is difficult for many women to solve.

I have always had a problem with overweight, but when, in 1995, I had my daughter, I could not get back to normal weight, which was always 55

kg. And, since then, I have been increasing, dieting, taking medicine and getting fatter. (E01).

Wow! It's been a long time, 25 years ago, since when I got pregnant, I got pregnant at age 14, I had my son at the age of 15, and in pregnancy I gained 38 kg. Since then, I have never returned to 60 kg. (E18).

National Demographic and Health Survey of 1996 revealed an increase in the prevalence of obesity among women after the first pregnancy, from 1.7% to 9.3%. The maintenance of the weight acquired during pregnancy in the postpartum period seems to be a decisive factor in overweight in women (LACERDA; LEAL, 2004). A qualitative study that investigated the perception and experiences related to obesity among women attending the public health network showed that pregnancy and childbirth are important events in the onset of obesity (PINTO; BOSI, 2010).

The everyday life of an obese

Obesity makes it difficult to perform activities of daily living, with consequences in different dimensions of personal, affective and work life, in addition to associated comorbidities.

You want to do something... even your own hygiene you cannot do it right, even to wash your feet, cut your nails, you cannot. [...] High blood pressure, diabetes... [...] Walking is also complicated because you feel very short of breath, very tired. (E04).

My legs hurt a lot, my legs swell too much; pain in the joints, pain in the spine, because I work as caregiver. I feel a lot of difficult. (E15).

Research carried out with obese women in order to evaluate the impact of obesity on functional capacity revealed a commitment of the population studied in daily tasks that included movements of the abdominal

region, such as wearing clothes and tying shoes (60%); bending down to pick up objects from the floor (53.3%); performing household tasks, such as broom and squeegee use for hygiene of the physical environment (50.0%); laying down and getting out of bed (40%); as well as personal hygiene, such as bathing and wiping down (30.0%). The research also revealed that female individuals with obesity had reduced physical fitness when compared to individuals with adequate weight and even overweight, favoring the emergence of cardiovascular diseases (ORSI ET AL., 2008).

Obesity can also be an obstacle to work, personal development and participation in social life.

I was always an active person, I really liked what I did, and I love to this day! If I could go back to work, I wanted to work so that I would not depend on anyone because I was capable and, suddenly, I lost my ability [...] Fat bothers me, it disturbs me... (E11).

What has bothered me most in the old days was trying to work; you look for work and the person looks and sees that you are fat and does not give you work because of it. And then it was a time when I was very sad. (E18).

Study about the influence of the Body Mass Index (BMI) on the salary and the work possibility revealed, in obese men, an association of 2.2 percentage points positive, and among women, 4.3 percentage points negative for the same situation. This difference between men and women in the labor market can be explained as reflecting the greater prejudice against female obese individuals (TEIXEIRA; DIAZ, 2011).

The obese in the modern western society

Sociocultural values have defined different patterns of beauty throughout history.

Modern western society, stimulated by individualistic values, by the fashion advertising market and by the media, has taken on the ectomorphic biotype, i.e. thin, tall and white, as a pattern of beauty, excluding the different and generating prejudice and suffering. Of the 21 interviewees in the present study, thirteen (61.9%) reported suffering due to prejudice, causing low self-esteem and social isolation.

I don't leave the house, I just leave to go to work, I go by car, I'm terrified that someone can see me on the street, because I find myself the height of exaggeration of the size that I am; I have no social life at all. I just leave the house to work, embark in the garage and disembark at the school door, embark back and disembark in the garage; that's all I do on the street. (E01).

The others look... I feel like the others look at me differently. The skinny will eat in the restaurant and can repeat as many times as he wants. The fat man got up, look at the size of that one there. [...]. I really came because I want to feel good, to feel beautiful; I don't think I'm beautiful, I don't feel, do you understand? My self-esteem is down there, I have no self-esteem. Honestly, I said... I even thought about not living anymore. (E02).

Female people with obesity are more prone to insulation, often looking in the realm of illusion pleasures they do not experience in real life. Self-image is

inferiority, dissatisfaction, low self-esteem, inhibition, anxiety, anguish, aggression, sadness, depression, disorders and distortions regarding the recognition of body, anatomical, body size and shape. (SILVA; LANGE, 2010, P. 51, FREE TRANSLATION).

More than possible health problems, dissatisfaction with the body and psychological suffering are a fundamental reason for the search for treatment of obesity. "Dissatisfaction [...] with the body resides in

the perception and desire to obtain another size and body shape that is in accordance with sociocultural norms, which impose the stereotype of thinness as a positive attribute”, especially among female subjects, which present physical demands of social and psychological importance (SILVA; LANGE, 2010, P. 51, FREE TRANSLATION).

Unlike other types of prejudices, what happens in relation to obesity is poorly publicized and discussed by society.

[...] today they talk a lot about black racism, gay, lesbian; you see it a lot on television, but you never see obesity on television, no one is commenting on it, but the most humiliated class you have is the obese [...] today I can sit here in the chair quietly. But when I was very obese, I got at a restaurant to sit, the waiter already brought two chairs. [...] obese suffers a lot with this; some say that obesity is laziness, others say that it is that, but it is something that makes you suffer too much, the obese suffers too much, every hour you are suffering. If you're going to eat in one place, 'look at the fat man who eats everything'. That's how it works. (E13).

Obese individuals are often blamed for their excess weight, in addition to obesity be characterized negatively. One commonly highlighted characteristic is that overweight individuals suffer, as well as physically, psychologically (KUBOTA, 2014).

Prejudice over obese people has been denounced by social scientists for decades. Prejudiced attitudes towards obesity seem to be at the stage where racism was 50 years ago, when it was open, expressive, and widely diffused (CRANDALL, 1994).

I think prejudice should be different, it should be very different, because this prejudice thing hurts a lot. Because I'm obese, I already have very low self-esteem, when I suffer a prejudice, it's even worse. (E09).

Initiatives such as Bill nº 1.130/2015 of

the Legislative Assembly of Rio de Janeiro, which inhibits any type of discrimination against morbid obese people (RIO DE JANEIRO, 2015), are important but not sufficient to solve the problem of modern society, which establishes universal normative standards, disregards sociocultural aspects and excludes the different.

The search for alternative treatments: the popular subsystem

In Kleinman's view (1978), the popular subsystem consists of therapists not recognized by scientific medicine, such as healers, witch-doctors, herbal manipulators, special exercises, witchcraft, and healing ceremonies of a mystical or religious character (ALVES; SOUZA, 1999; SILVA JÚNIOR; GONÇALVES; DEMÉTRIO, 2013). In the case of obesity, such practices seem to have little adherence. In this research, only four (19.04%) interviewees reported having used alternative treatments, interrupted by the low efficacy presented.

Homeopathy, I did and did not work. (E19).

The teas' thing, I tried to do. The Pastoral of Health, it's those herbs [...] I did a little. Then, I am quickly discouraged, I begin to decline, I begin to forget. This is how it happens. Yeah, I did not really continue. (E20).

Even in the case of integrative practices, recognized by the Ministry of Health, contributions are still few in the Brazilian public health (BRASIL, 2015B). The Laboratory for Management of Obesity Innovation in Health Care Networks of the Unified Health System (SUS) revealed some experiences in integrative and complementary practices in the treatment of obesity. One of the experiences that deserved mention was that of the group Gatto in the city of Salvador (BA), which emphasized the complexity of human beings and their living conditions, as well as the magnitude of affection and love

as generators of health and healing, seeking to communicate with different therapeutic forms (BRASIL, 2014A).

The relationship between mystical, religious and health practices is part of the brazilian popular culture. However, in the case of obesity, it was not an option for any of the interviewees.

No, not that. I did not look for any of this. (E03).

No, because most of the time I do not even believe in this thought business; in this business, I do not believe. (E17).

Rituals and sympathies, whether in urban or rural environments, are part of the brazilian culture. In addition to praying, the healers manipulate plants, recommend teas and baths, perform therapeutic massages, alleviating, thus, physical illnesses and spiritual ills (MACIEL; GUARIM NETO, 2006).

The professional subsystem in the TI construction of obese people

Scientific knowledge and medical and non-medical health professionals recognized not only by western science and scientific societies but also by traditional Chinese medicine, compose the professional subsystem (ALVES; SOUZA, 1999).

This subsystem, in addition to revealing the role of professionals in the search for treatment for obesity, helps to understand the IT of the users from the access and flow of care in the health services to the specialized services.

The obese individual who opts for the surgical treatment of obesity through the SUS, according to the Decree nº 425 of March 19, 2013 (BRASIL, 2013B), should be inserted in the organization of the care line for overweight and obese people of the Network of Attention to People with Chronic Diseases. This Network should have as a priority line of care the organization of prevention and

treatment of overweight and obesity, being redefined the guidelines for that purpose. As part of the network, Primary Care (PC) plays a relevant role in the prevention and care of chronic diseases, including obesity. Health care, through family health teams, for individuals who are overweight and obese should follow criteria determined by the BMI classification (BRASIL, 2014B).

Individuals with BMI > 40 kg/m² or more complex cases should be referred to the Specialized Care services, be it ambulatory or hospital. In order to ensure the provision of specialized care, the municipal or regional health network must have the PC as the responsible for organizing the care network. Once individuals are referred to specialized obesity care, it is critical that family health teams maintain the bond with the patient and the staff of the specialized service, performing, thus, their role as care coordinator in the Network of Health Care (RAS) (BRASIL, 2014B).

The lines of care should be agreed between the various heads of the attention points of the RAS, determining reference and counter-reference flows to support the overweight and obese user in SUS. These guidelines determine not only the organization of services and interventions that must be instituted at the primary, secondary and tertiary level of care but also in support systems (BRASIL, 2014C).

Although, under the legal scope, the brazilian health system must be structured to serve all equally in the national territory, what is still observed is, yet, a diversity of procedures and the absence of a standard of care for obese people. In this research, the intervention of a health professional, whether in PC or secondary, was important in the decision of the interviewees to seek a specialized service for the treatment of obesity, in general, aiming at surgical treatment.

[...] then the pharmacist told me: don't you want to get in the queue? Is easy! I can manage it for

you. I said: well, if you can... She did it very fast. (E03).

The general practitioner from the health center referred me to the endocrine [...] She said: go there because there is the specialty that will check if you need surgery [...] in my thinking she said: surgery is needed. That's why I came here. (E11).

But there was also the recognition of SAACIO as a specialized service for the treatment of obesity, not necessarily the surgical one.

I was hospitalized at the HUOP for the cholecystectomy surgery, the doctor said: we have no conditions to operate, it is very dangerous! It's going to have an obesity group, do you want to join it? We cancel the surgery, you do the follow-up, and then we do the surgery. And I joined the group. (E12).

...I went to see the health unit and even asked the doctor why I was gaining weight. She said she was going to take me to follow up somewhere else. (E07).

The personal initiative was also welcomed by the health professional, as reported (E02), who asked a doctor of the Basic Health Unit (BHU) of her city to refer her for bariatric surgery, and he did.

The interviewees revealed that BHU is an important way of accessing the specialized service for the treatment of obesity, although it is not the only one. Although access to the service is fast in some situations, the wait is generally quite large and follows distinct flows.

The doctor advised me: I will give you a form to follow-up... I brought you to the Tenth Regional [...] they called after a long time, two years, so that I could attend the first lecture, and that was all... in 2013 I made the first consultation with

doctor [so-and-so], and I started to follow up here. (E07).

The endocrine of the Intermunicipal Health Consortium said: 'Go there, because you have the specialty to see if you need surgery'. The endocrinologist led me here. Straight to the hospital without going anywhere else. (E11).

While the others were in the queue for a long time, I got it the same week. She referred me in a week and in the other one I was already here. (E03).

It was possible to identify patients referred through the BHU (PC) to the Intermunicipal Health Consortium (secondary care), which, in turn, referred to SAACIO (tertiary care) through the 10th Regional of Health. It was identified, also, referrals of the secondary care to SAACIO without regulation of the 10th Regional of Health. Another identified path was patients who were not necessarily referred to secondary care, and who, through referral from the PC, sought the 10th Regional of Health, which, in turn, forwarded them to SAACIO. Furthermore, patients referred to HUOP for elective surgeries and who, due to significant excess weight, had the contra-indicated surgical procedure and were referred to SAACIO by the team of surgeons.

The establishment of care flows and processes for people with obesity has been subject to regulation by the Ministry of Health, such as Ordinance n° 424/2013 (BRASIL, 2013A), which defined the guidelines for the organization of prevention and treatment of overweight and obesity as the priority care line of the Network of Attention to People with Chronic Diseases. Reference is also made to Ordinance n° 425/2013, which established the technical regulation, norms and criteria for the Service of Assistance of High Complexity to Individuals with Obesity (BRASIL, 2013B).

However, the absence of the

implementation of the care line for the individual with obesity, provided for in Ordinance nº 424, hinders the work of the PC team and the access of the user to specialized services.

Yeah, I think that there was lack of information. There at the health post, they have no information to give us, that we have to look for it [...] I was waiting to be called, I waited, then I decided to go to the Regional Tenth alone to look for it by myself. Then they were informed that I was interested, lost, I did not know where else to go. (E20).

The belief in surgical treatment as the most effective and definitive mean to solve the problem of obesity is part of the common sense of obese people and many health professionals. Modifying this thinking is not an easy task, it requires an interdisciplinary approach, multiprofessional teamwork and innovative alternatives of the health services, aiming at the awareness of the users that it is a chronic health problem that requires adherence and accompaniment throughout the life.

I wish the process was faster until the surgery, but as a doctor [so-and-so] says: there is a whole preparation before it, that the objective of the team is not to do the surgery, it's to lose weight and, preferably, if it happens without surgery. (E01).

The female public, often, opts for the surgical treatment of obesity as a response to the failure of previous treatments, especially of diets for weight reduction (NASCIMENTO; BEZERRA; ANGELIN, 2013). However, due to the chronic nature of obesity and its tendency to recidivism after weight loss, the subject should be followed up for a long period with health professionals. In other words, long-term success is a consequence of constant monitoring of the adequacy of physical activity and food consumption,

requiring self-monitoring, as well as family and social support (ABESO, 2009).

Surgical treatment as outcome of IT of patients with obesity

The option for surgical treatment as an outcome of TI is the result of a series of interferences of the Family, Popular and Professional subsystems, and the support of family and friends is the most important attribute in the opinion of the interviewees, although the decision is always personal.

Who influenced me the most was a friend, because she was the one who told me. Because, in the beginning, my family was afraid, was afraid of me going into this surgery. In fact, they are a little scared yet. But when I entered the service to make my consultations, I also brought them to accompany. So, they're more reassured. (E15).

The choice, sometimes, is against the flow.

No one advised me to anything. My family doesn't want me to do. [...] my daughter also says: mother, be ashamed of yourself and go on a diet. [...] nobody wants me to go into surgery, but I want to. (E01).

The professional nucleus, represented here by the health service in question, has revealed to be an important support in reducing suffering and coping with obesity.

But what weighed was finding the team I found here; not only the doctor, the nurse, the psychologist, it's more, it's friends, more friends than professionals, excellent professionals, that make us feel good. (E11).

The surgical treatment of obesity does not mean its cure, but a moment in the process of coping with the problem that requires important changes in eating and living habits. The follow-up with a multidisciplinary

team is important and should be long-term (BRATS, 2008). The SAACIO has as main objective the promotion of health and clinical care, and bariatric surgery is only one of the alternatives in the treatment of obesity (HUOP, 2014).

A good method of prevention and treatment of obesity is to work on nutritional education carried out in health services, programs, and in any possible space of intervention. It is fundamental that it be idealized from its planning and execution to the evaluation of its effectiveness; in addition, it should not be applied punctually, but continuously (LOCARNO; NAVARRO, 2011).

The itinerary is built: what could be different

Reflecting on the choices that make up the TI of the interviewees can be a motivation for changes in the subject himself/herself, in other people with the same problem and in the approaches practiced by the health services. It's highlighted that personal choices are made from objective conditions, i.e., family context, sociocultural and service provision, and subjective, such as emotional, affective, self-perception.

Maybe, I could have gotten more involved, I mean, in relation to me. There are days when you are well, you get up, you want to do everything. The next day, you already wake up sadder, more discouraged. (E18).

The importance of precocious health care for the prevention of grievances is also perceived by the interviewees. *"In fact, me, if I had been careful before, I would not be like that"* (E21). *"I could have done it, tried to walk more; I was very sedentary"* (E20). The lack of access to information on health care is a determining factor in self-care and prevention of health problems. *"I think that having this information I'm having now, I should have had before"* (E02). The encounter

inherent in the work process between the health professional and the patient in order to stimulate self-care creates a permanent bond between them (FEUERWERKER, 2014). The reception by the health professional, the professional-patient bond and the co-responsibility provide health care in order to obtain health and cure (BRASIL, 2014A).

PC, as the operator of the attention networks, must guarantee access to the different levels of the system, being responsible for the integral care of the users. In the TI studied, there is certain precariousness in this accountability and even in the functioning of the Network of Attention to People with Chronic Diseases.

We seek support, because alone we get nowhere, here I've found, we've found a lot of support that we didn't have in our municipality, that we don't have, that is lacking. (E11).

Ordinance n° 424 guides the organization of the prevention and treatment of overweight and obesity as the priority care line of the Network of Attention to People with Chronic Diseases, which aims to make available

actions and health services in an integrated and harmonious way in the different points of attention, strengthening and qualifying care through the integrality and longitudinality of care, overcoming the hegemonic and fragmented logic in programs. (BRASIL, 2014A, P. 43-44, FREE TRANSLATION).

PC should not only focus on Food and Nutrition Surveillance, but also promote health through stimulating healthy eating, physical activities, among others. It is also important that the clinical follow-up be carried out by an interdisciplinary team, with determination of individualized goals for each patient (JAIME ET AL., 2011), reinforcing the need for health promotion actions for the prevention of obesity.

The mercantilist approach to obesity

The logic of profit making is inherent in the capitalist mode of production that, to expand, commodifies all dimensions of life, transforming social problems into lucrative business opportunities, such as numerous health problems, including obesity.

Fast and miraculous alternatives, such as the trendy diets for solving obesity, as prompted by the 'diet industry', were mentioned by some respondents. It is important to emphasize that this option of treatment does not fit into the health care subsystems proposed by Kleinman (1978), being induced by the communication, economics and marketing sciences of the food and drug industries.

[...] at that time, we did not have access to the nutritionist, so we used to do those crazy diets. I did a lot of diet; I slept without eating, because it is said that you lose weight, but it did not work for me. I made the soup, the moon diet, a lot of things I cannot even remember anymore. Tea, a lot of tea types I drank. At the moment, I think it made a little effect; suddenly, it stopped. I've always tried not to get to the point where I am. (E19).

Look, everything they said it's good to lose weight, I'm doing, I'm taking it, and nothing works. With the lemon diet, you went until nine, and came back from nine to one. [...] Diet of the soup... eating only egg... (E03).

With the increasing prevalence of obesity, the diets industry has become extremely profitable, with promises of fast resolution for excess body weight (PORTAL BRASIL, 2015). There is a large sector of the economy aimed at a population that wants to lose weight. In the USA, the diet industry spins about USD 58 billion per year, while the government of the USA spends about USD 68 million in health. In Brazil, there is no data on how much this market moves.

However, bookstores in Brazil expose on their shelves countless books that promise miracles, such as the blood type diet and the moon diet (CARMELLO, 2016). However, once the interruption of these diets occurs, it is common for the individual to return to body weight gain (PORTAL BRASIL, 2015).

Advertisements related to quality of life and its association with diet and body weight are not neutral. The induction to the consumption of new treatments proposed by the medical, pharmaceutical and food and nutrition industries seeks its legitimation in scientific findings, constituting a consumer traps (OLIVEIRA-COSTA ET AL., 2016).

Taking advantage of the new fast-food niche market in order to seek the aesthetic standard imposed by society, the food supplement industry has expanded since it is considered by many people as a safe and inexpensive alternative when compared to bariatric surgery, for example. However, these products do not represent an effective solution in the weight loss process, and there are contradictions in the scientific literature regarding the efficiency of their thermogenic effects (COSTA ET AL., 2012).

Final considerations

The TI study of the users of the SAACIO revealed greater influence of the family and professional nucleus than the popular nucleus itself in the treatment of obesity. And, more than self-perception of obesity, the consequences in personal and work life, combined with associated comorbidities, prejudice and low self-esteem proved to be decisive for the search for specialized treatment for obesity.

Prejudice in relation to obesity causes psychological suffering, social isolation and harms working life, especially of women, revealing to be also a gender problem. Gestation is highlighted as an important moment of weight gain for women.

Regarding the Kleinman framework, although important for studies on TI, it has been limited in the TI approach of obese individuals, especially regarding the mercantilist view of obesity, since responding to certain socially constructed needs favors undisclosed economic interests.

The empirical data revealed the absence of a multiprofessional approach and the fragile performance of PC in the accountability and care of obese users. In this sense, the care line for the individual with obesity can be an important strategy to be implemented. It is suggested, finally, greater articulation of SAACIO with the first level of attention, especially in the permanent education of the teams and in support of health promotion and early obesity prevention.

Collaborators

All authors participated in the conception, analysis and interpretation of the data and the writing, review and final approval of the article, being responsible for all its aspects, including the guarantee of its accuracy and integrity.

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