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ORIGINAL ARTICLE

Actions to encourage self-care: the role of Primary Health Care professionals

Ações de estímulo ao autocuidado: atuação dos profissionais da Atenção Primária à Saúde

Acciones para fomentar el autocuidado: el papel de los profesionales de Atención Primaria

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Abstract

Objective: To find out about the strategies for encouraging self-care adopted in primary health care, from the perspective of users with type 2 diabetes mellitus. **Method:** A qualitative study, using the Chronic Conditions Care Model as a conceptual basis, with people diagnosed with diabetes, through semi-structured interviews and submitted to Bardin analysis. **Results:** 15 people diagnosed with diabetes took part in the study, four of whom were at low risk and 11 at moderate risk. One of the most frequently mentioned strategies was the follow-up group for people with hypertension and/or diabetes, called the HiperDia Group. **Discussion:** The results showed that the strategies used by the teams to encourage self-care were based on the biomedical model, centered on the doctor, being individualistic and curative in generalized practices. **Final considerations:** The strategies adopted permeate traditionalist assistance, according to the hegemonic model of care, and no effective strategies based on the Chronic Conditions Care Model were adopted.

Descriptors: Self-.care; Diabetes Mellitus; Primary Health Care.

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Resumo

Objetivo: Conhecer as estratégias de estímulo ao autocuidado adotadas na atenção primária a saúde, na perspectiva de usuários com diabetes mellitus tipo 2. **Método**: Estudo qualitativo, utilizando como base conceitual o Modelo de Atenção às Condições Crônicas, com pessoas diagnosticas com diabetes tipo 2, por meio de entrevistas semiestruturadas e submetidas a análise de Bardin. **Resultados**: Participaram do estudo 15 pessoas diagnosticadas com diabetes, sendo quatro de baixo risco e 11 de risco moderado. Uma das estratégias mais referidas foi o grupo de acompanhamento de pessoas com hipertensão arterial e/ou diabetes, nomeado Grupo HiperDia. **Discussão:** Os resultados evidenciaram que as estratégias de estímulo ao autocuidado utilizadas pelas equipes eram embasadas no modelo biomédico, centrado na figura médica, sendo individualista e curativistas em práticas generalizadas. **Considerações finais**: As estratégias adotadas permeiam uma assistência tradicionalista, conforme modelo hegemônico de cuidado, não sendo observadas adoção de estratégias efetivas fundamentadas no Modelo de Atenção às Condições Crônicas**.**

Descritores: Autocuidado; Diabetes Mellitus; Atenção Primária à Saúde.

Resumen

Objetivo: Conocer las estrategias de fomento del autocuidado adoptadas en la atención primaria de salud, desde la perspectiva de los usuarios con diabetes mellitus tipo 2. **Método:** Estudio cualitativo, utilizando el Chronic Conditions Care Model como base conceptual, con personas diagnosticadas de diabetes, mediante entrevistas semiestructuradas y analizadas por Bardin. **Resultados:** Participaron en el estudio 15 personas diagnosticadas de diabetes, de las cuales 4 eran de bajo riesgo y 11 de riesgo moderado. Una de las estrategias más mencionadas fue el grupo de seguimiento de personas con hipertensión y/o diabetes, denominado Grupo HiperDia. **Discusión:** Los resultados mostraron que las estrategias utilizadas por los equipos para incentivar el autocuidado se basan en el modelo biomédico, centrado en el médico, siendo individualistas y curativas en las prácticas generalizadas. **Consideraciones finales:** Las estrategias adoptadas permean el cuidado tradicionalista, en consonancia con el modelo hegemónico de atención, y no se adoptaron estrategias efectivas basadas en el MACC.

Descriptores: Autocuidado, Diabetes Mellitus; Atención Primaria de Salud.

INTRODUCTION

Chronic conditions have a significant impact on the population morbidity and mortality profile and on the costs incurred by the Brazilian Unified Health System (SUS). In 2018, hypertension (HTN), diabetes mellitus (DM), and obesity accounted for R$3.45 billion in hospitalizations, outpatient procedures, and medications paid for by the SUS, with DM alone accounting for 30% of that.[1]

Regarding type 2 diabetes mellitus (DM2), a multifactorial condition that is often asymptomatic and characterized by hyperglycemia resulting from insulin resistance[2], permanent behavioral changes in the user are necessary, which can be addressed through self-care strategies, especially during nursing consultations.[3]

In this sense, self-care is defined as the ability to promote health, maintain well-

being, and manage acute and chronic health conditions through self-control and self-confidence.[4] To overcome the dominance of the traditional and fragmented health model, the Chronic Conditions Care Model (CCCM) must be incorporated into primary, secondary, and tertiary health services, thus strengthening health practices through the articulation of intersectoral actions.[5]

Literature points to the benefits of interventions based on the MACC (Management of Care for Individuals with Diabetes), improving the user's knowledge about their health-disease process and encouraging the selection of self-care practices for their health condition.[6,7,8] Similarly, monitoring individuals with type 2 diabetes through scheduled appointments, according to individual risk, allows the nurse to follow them systematically[9] and increases the chance of user retention and return to the service.[10]

From this perspective, although MACC shows promise in managing chronic conditions, the application of its principles sometimes does not yet correspond to the reality perceived by users of health care services.

Given the above, this study is justified by the need to understand the strategies for promoting self-care adopted in Primary Health Care (PHC), from the perspective of users with type 2 diabetes mellitus (DM2), since this knowledge makes it possible to identify gaps in the care provided to these individuals and, consequently, to support planning actions and the use of necessary technologies and tools, in order to guarantee quality and shared responsibility for care.

Thus, the aim is to answer the following research question: what is the perception of people with type 2 diabetes mellitus (DM2) regarding the strategies for promoting self-care offered by primary health care professionals? Moreover, to answer this question, the objective is to understand the strategies for promoting self-care adopted in primary health care, from the perspective of users with DM2.

METHOD

This descriptive exploratory study with a qualitative approach, linked to the matrix project "Self-care supported in the management of diabetes mellitus in Primary Care: intervention and evaluation," used the Model of Care for Chronic Conditions (MACC) as its conceptual basis. The study followed the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The study participants were individuals with type 2 diabetes mellitus (DM2) registered at a Family Health Unit

(USF) located in a health district of a Brazilian capital city, which had three teams. The study population was selected by convenience and consisted of 295 people with DM2. Initially, a list of these individuals registered at the USF was requested. Subsequently, an active search was initiated through home visits accompanied by the respective Community Health Agent, in order to invite them to participate in the research. After acceptance, data collection was scheduled at the individual's home or at the USF, according to their preference.

The inclusion criteria adopted were a diagnosis of type 2 diabetes mellitus (DM2), and participants were users stratified as low risk (Person with prediabetes: impaired fasting glucose and impaired glucose tolerance or moderate risk (Adequate metabolic and blood pressure control, with no hospitalizations for acute or chronic complications in the last 12 months, excluding type 2 diabetes patients classified as high risk.

The interviews continued until the study objective was achieved and the information began to repeat itself.[11] Data collection took place from October to December 2021, through individual, semi-structured, audio-recorded interviews conducted at a single time by the principal investigator, who had no relationship with the study participants. The interviews were guided by the following question: "Talk about the guidance you receive or have received to manage your own diabetes mellitus." Additionally, questions were used to characterize the participants and to provide support, in order to assist in achieving the study objective, with an emphasis on material resources and strategies for approaching users with type 2 diabetes in the care provided by primary health care professionals, as well as promoting continuity of care within the healthcare network.

The interviews lasted an average of approximately 20 minutes and, after being transcribed in full, were subjected to content analysis, a thematic method proposed by Bardin. The analysis encompassed the stages of pre-analysis, in which a floating and individual reading of the interviews was carried out; exploration of the material, with a meticulous and exhaustive reading of the content, followed by the coding of the messages.[12]

The study was approved by the Research Ethics Committee with Human Beings of the Federal University of Mato Grosso do Sul (CEP/UFMS), opinion no. 4,321,389, in compliance with Resolution No. 466/2012 of the National Health Council, which regulates research with human beings in the country. To ensure

anonymity, the interviewees' accounts were assigned a code using the letter E for "Interviewee," followed by two Arabic numerals, respectively, indicating the order of participation in the research and the interviewee's age.

RESULTS

The study included 15 people with type 2 diabetes mellitus (DM2), four of whom were at low risk and 11 at moderate risk. Nine of the participants were women, aged between 46 and 94 years; furthermore, 10 participants self-identified as mixed-race, two as Black, two as White, and one as Indigenous; the majority (13) had incomplete primary education, and the others had completed primary education, incomplete secondary education, and completed higher education. Regarding marital status, seven were married, four were single, three were widowed, and one was in a stable union; 12 participants were retired, with an average per capita income of R$ 1,524.63. As for the time since diagnosis of DM2, there was a variation between 2 and 34 years, with an average of 18.4 years.

Strategies to encourage self-care in Primary Health Care

This category presents the strategies for promoting self-care used by the teams working in the Primary Care unit, such as DM2 follow-up groups, care approaches/guidance, teaching resources provided in consultations, and the follow-up/monitoring of user care for this disease, named the HiperDia Group, which had as one of its advantages the possibility of measuring blood pressure and capillary blood glucose for diabetes monitoring.

What I and most of these elderly people need is to go back to how it was before, when we had weekly meetings for diabetics to measure blood pressure and do tests (E1, 71 years old).

It's important because it lets us know how we're doing, because if you don't do capillary blood glucose testing, you have to do a blood test to find out if everything is okay or not, and that takes a long time (E12, 67 years old).

However, they report not receiving guidance on managing type 2 diabetes during these meetings.

He does not receive any guidance, he just has his blood sugar and blood pressure measured, and that is it, he goes home (E5, 75 years old).

I rarely go to meetings like that to receive guidance. In consultations, when I go, he [the doctor] explains to me how to take the medicine and that is it (E7, 75 years old).

Participants also mentioned that some guidance on managing type 2 diabetes is provided during consultations, primarily by doctors, regarding diet, exercise, medication, and foot care.

The doctor asked how he could help, and I told him my story. He examined everything carefully, told me to walk because it is good, to take my medication correctly, and to check the soles of my feet for any injuries (E1, 71 years old).

Guidance on what we need, what we have to control, what we cannot eat that's bad for us, what we have to avoid because otherwise, from one moment to the next, we'll get sick (E2, 94 years old).

In addition to the medical consultations, they reported on the actions performed by the nurse during their care.

The nurse asked me many questions about my health, and examined me, put devices on my back and heart; she did a good job examining me. (E2, 94 years old)

Just for prescription refills, I take the paper and hand it to the nurses, they take it, write the prescription, and send it to me (E3, 66 years old).

When I explained my situation, the nurse said, "Let's run some tests"; I got the results and scheduled an appointment to show her, and when she looked at them, she immediately referred me to the general practitioner, who prescribed the medication (E9, 48 years old).

Although information about type 2 diabetes is transferred, some specific user-related details are not considered in the individual care planning process.

All he talks about is "doing physical activity, walking, going to the gym," he says he opened an outdoor gym, but we do not have any professionals, and I'm afraid because if something goes wrong, then I prefer not to go (E12, 67 years old).

...because this is my routine, I work 24 hours a day, I try to do something from the guidelines, something to change, but it's difficult (E9, 48 years old)

I think we should talk more because we do not understand, explain things better. There were things there that I did not even know how to answer because I didn't study, I don't know. (E1, 71 years old)

Regarding educational resources, users reported receiving information about type 2 diabetes care during their appointments.

I have been sent lots of pamphlets about diabetes, things like that, hypertension, about food, cutting out salt, cutting out certain things (E3, 66 years old).

Once they gave us a little book about diabetes, it said to be careful with your feet, any wound, because it's very dangerous; my sister-in-law's mother just had to cut off a little toe, she's diabetic. (E5, 75 years old).

Furthermore, those who did not have access to material resources during the sessions highlighted their importance for learning.

It would help a lot, a video perhaps, a booklet with guidelines, something that I could access daily. (E11, 46 years old).

I think it's good for us to know, even at home my wife reads everything, if I arrive with this paper she'll immediately grab it and read it all, so we can stay informed (E10, 62 years old).

Conversely, in some cases they pointed out that although there are teaching resources/guidelines to encourage self-care with type 2 diabetes, they sometimes forgo their use because they believe they possess sufficient knowledge due to the length of time they have lived with the disease.

But I already do my own thing, I guide myself, I know what I can't eat, I know what I can't do, I don't do it, I don't eat certain things (E14, 80 years old).

We have all the materials, we have all the resources, we just don't look for them; I myself have them, I work in a hospital, I always see someone with diabetes problems, even though I don't pay much attention to it. (E9, 48 years old).

DISCUSSION

In this context, participants cited the support group for people with hypertension and diabetes mellitus, known as the

HiperDia Group, as one of the strategies to encourage self-care. A study conducted between 1998 and 2018 showed positive effects on reducing the number of hospitalizations due to stroke and acute myocardial infarction.[13]

However, evaluating only blood pressure and glucose parameters, coupled with the indiscriminate renewal of prescriptions, prevents the professional from supporting the user in adjusting their lifestyle through individual and systematized care planning.[14] Therefore, the health team fails to provide opportunities for HiperDia group meetings to encourage monitoring of the chronic condition, in addition to fostering user distrust in the interventions carried out in Primary Care Units for the management of their care.

Furthermore, participants pointed out that guidelines for diabetes care are limited in these settings, which exacerbates the development of chronic and acute complications of these diseases, even though the obstacle often lies in the increased demand from people in these groups, hindering health education.[3]

To that end, a study conducted in Bahia with residents and professionals from the family health team pointed to the conversation circle as a feasible intervention strategy related to health education within the HiperDia program. This is because it promotes dialogue between group participants and health professionals based on themes related to the user's illness process, allowing for an understanding of health determinants that affect their care.[15]

Furthermore, interaction among group members allows for the sharing of experiences and constitutes an important support network for behavioral change.[16]

Although many are aware of the importance of improving communication in the work process[17], the lack of professional qualification and the absence of self-reflection regarding attitudes towards the user end up compromising the quality of service[18]; therefore, the updating of teams regarding participatory communication strategies must be constantly carried out.

Although guidance on behavioral changes for health care is important, a lack of systematization is observed. This aspect was also observed in an international study that pointed to the fragmentation of medical care and its focus on the individual's pathology as a factor interfering with therapeutic adherence in elderly individuals with hypertension and type 2 diabetes.[19]

Studies show that nursing consultations based on supported self-care, with the development of dynamic care plans and agreed-upon goals, contribute to

effective health management by empowering the user over the health-disease process and their ability to select healthier behaviors.[13,3,9]

Although the importance of the nurse's role in monitoring individuals with chronic health conditions is proven, given the educational interventions they develop with the community, the low consolidation of this professional in conducting nursing consultations in Primary Care is still observed. It is therefore necessary for nurses to empower themselves in their responsibilities and organize their work process for the effective care and monitoring of individuals with type 2 diabetes.[20]

In addition to the support provided by healthcare teams, family members and/or friends sometimes represent the main pillar of the user's self-care, given the bond and involvement in daily behavioral practices. Therefore, including them in consultations encourages their participation in the self-care activities of the person with DM and allows for the daily validation of the strategies agreed upon between the professional and the user during the consultation.[16]

Another aspect highlighted was the interference of work routines in adherence to self-care. The changes in daily life caused by the diagnosis of the disease are sometimes challenging and involve feelings such as fear and worry.[16] The individual's long working hours, for example, were identified in a national study conducted with people with type 2 diabetes as a barrier to physical activity. However, the same study emphasized the importance of knowing these barriers, combined with the involvement of the user's support network, in order to assist in decision-making for behavioral change.[20]

In turn, income was also identified as a factor that interferes with self-care practices; for example, the low income of elderly people received through retirement ends up influencing their choices regarding daily habits.[19]

In addition to the care guidelines provided by healthcare teams, research participants perceive that attention to individuals with diabetes mellitus (DM) is greater when there is clinical severity. This association is inferred from the curative practices that still permeate Family Health teams, overshadowing health promotion and prevention activities at the primary care level. The importance of multidisciplinary teams in monitoring people with diabetes, especially those with limitations that prevent them from going to the health unit, is highlighted.[10]

Furthermore, aligned with risk stratification, home visits are an essential

strategy in monitoring individuals with chronic conditions, thus facilitating their flow through the healthcare network.[3] Therefore, knowledge and operationalization of the equipment available in primary health care for organizing care for individuals with chronic conditions according to their risk contribute to the quality of care.

The difficulty users have in understanding the need for continuous follow-up/monitoring of their health condition was also evident in the results. Therefore, valuing primary health care and its capacity to resolve the demands brought about by chronic health conditions also requires the training of professionals and the improvement of their work processes.[11]

One limitation of the study is that, since it was conducted in only one health district, it is not possible to generalize the results to the reality of health services in the region. Similarly, conducting the research solely based on the perceptions of users with type 2 diabetes limits the understanding of the strategies offered, as it does not include professionals. Furthermore, the study did not include field notes and feedback for participants, as per COREQ guidelines.

CONCLUSION

The potential of these results is related to the knowledge produced regarding the approaches used by the team to change the behavior of the person living with a chronic health condition, the inclusion of the users' particularities in the management of the disease, and the failures in the follow-up/monitoring of care.

It is worth highlighting that risk stratification is one of the main tools of the MACC (Management, Care, and Attention) system, enabling the organization of care frequency according to individual characteristics, thus facilitating the work process of primary care professionals. In contrast to the conceptual basis of the MACC, a scenario of prolonged anachronism can be envisioned.

Therefore, current strategies to encourage self-care require professional qualification and training in the area of care for people with chronic conditions, in order to align practices with new modes of health production. Similarly, improving the community's knowledge about its health-disease process and encouraging autonomy in selecting new behaviors implies greater adherence to self-care activities and retention in the continuity of care by Primary Care services.

Therefore, it is expected that the identified gaps will contribute to the planning of more effective interventions to

be implemented with users with type 2 diabetes, according to the tools provided by MACC, in addition to providing input for local managers to consider the current work process of Primary Care Units in serving people with chronic health conditions.

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