



UNDERSTANDING OF DIABETES MELLITUS SELF-CARE BY PATIENTS ASSISTED IN PRIMARY HEALTH CARE

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ABSTRACT

Objective: to understand the perception of patients with diabetes *mellitus* assisted by Primary Health Care about the need for self-care. **Method:** a descriptive study with a qualitative approach, conducted with 12 users with diabetes who participated in the HIPERDIA program and two family members through telephone interviews between November and December 2021. The speeches were transcribed and analyzed lexicographically with support of the software *Interface de R Pour les Analyses Multidimensionnelles de Textes et Questionnaires*. **Results:** the speeches of the interviewees originated three partitions of analysis: Self-care of the patient with diabetes *mellitus*, which refers to the management of self-care and measures of control of DM; Aspects necessary to the patient with diabetes *mellitus*, which reflects on the self-care actions required in patients and health units, and Patient care with diabetes *mellitus* in Primary Health Care, which brings discussions about self-management, care and assistance. **Final thoughts:** users in study recognize self-care actions related to their disease. However, they present difficulties in adhering to the recommendations to promote self-care.

Keywords: Diabetes mellitus. Self-care. Primary health care.

INTRODUCTION

Diabetes *mellitus* (DM) is one of the most challenging chronic diseases for health. Global estimates indicate that about 463 million young people, adults and the elderly currently live with diabetes, and point out that this number is evolving, with the projection of 700 million people affected by 2045⁽¹⁾.

The Brazilian Diabetes Society (BDS) in 2017 estimated that 12.5 million people were affected by DM in the country. In the same year, the Northeast Region showed a mortality rate of 41.7% among adults aged 50 to 59 years old⁽²⁾.

In this sense, the search for global and national strategies is disseminated for the care inherent to

people living with DM, including: monitoring of capillary blood glucose, care for the feet, treatment with oral medicines and, in the cases prescribed, the administration of insulin, in addition to the adoption of healthy habits, such as: proper diet and regular physical exercise, which serve both to prevent and to control those who already have the disease^(2,3).

Chronic DM can trigger serious short- and long-term complications. Thus, changes in conduct related to lifestyle and therapeutic adherence are essential practices to avoid complications, which become irreversible, and whose aggravation directs the individual to situations of disability⁽³⁾.

That said, the care and monitoring of patients with DM for health promotion in Brazil are

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performed mainly by Primary Health Care (PHC), which is configured as the gateway to the health service⁽⁴⁾.

Among the actions for the protection of the patient with DM, pharmacological and non-pharmacological measures stand out, as well as educational interventions, which aim to provide autonomy and self-care of people in chronic conditions and, consequently, greater functional capacity and disease control⁽⁴⁾. Self-care is conceptualized as activities that individuals develop and perform for the maintenance of life, well-being and health⁽⁵⁾.

Current studies indicate that more than 75% of patients with DM have insufficient knowledge regarding the disease and the line of treatment. In addition, errors were also observed in the use of educational technologies for this target audience, which negatively influence self-care practices⁽⁶⁾.

To promote self-care, it is necessary to provide qualified health care and family support, factors that can contribute to the motivation of patients and thus provide a better quality of life for them^(4,5,7).

Moreover, a transforming profile is essential, due to the complexity of the disease. Therefore, the individual's performance in the expert patient modality has been shown to be a possibility of relevant action in many countries, considering that this type of patient has an active function in their health-disease process, when involved in their care and still assisting in the care of the other^(7,8).

The expert patient has an investigative trait and, in addition, seeks experiences, often online, with people who have the same chronic state, which strengthens the patient in self-management of their condition, which refers to the acquisition of skills and behavioral changes, as well as to greater control of the disease^(8,9).

In addition, the practice of self-care is directly associated with the prevention of complications. Thus, it is essential to understand the perception of self-management of patients with DM, since knowing the real perspectives and needs of this population can help in understanding and developing strategies that more effectively promote their self-care, in addition to optimizing the quality and safety of PHC services and reducing public spending. Furthermore, the existing gap in the scientific production on the practice of self-care in diabetic patients is also noticeable.

Therefore, the following guiding question

arises: How does the patient with DM assisted by PHC understand their self-care? The objective is to understand the perception of patients with DM assisted by PHC about the need for self-care.

METHOD

This is a descriptive study with a qualitative approach, which consists of describing/reporting the behavior of a certain element, in addition to allowing the classification and interpretation of the findings, which gives the researcher the maximization of knowledge on the subject examined. Moreover, the study had its methodological design guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) - Portuguese version⁽¹⁰⁾.

The research was conducted online (due to the covid-19 pandemic) and counted on the participation of users of Family Health Units (FHU) and/or their families. These units are part of the primary health care network of the Western Sanitary District of a capital of the Brazilian Northeast, and were chosen because they have the largest number of nurses with training offered by the Federal University of Rio Grande do Norte (UFRN) in partnership with the Catholic University of Múrcia (UCAM), in Spain, something relevant on the subject of the expert patient, since they have pioneering projects associated with the self-care actions of patients from primary care.

The interviews were conducted by two scientific initiation students under the supervision of the doctor responsible for the research, who is part of the investigative committee on the profile of the Brazilian expert patient, in partnership with the Spanish university. The nursing graduate students were students from last semester and received previous training to conduct the interviews, and already developed previous activities in the research group related to the themes covered, as well as participation in scientific events promoted by UFRN and/or UCAM for invited nurses.

Moreover, both students had had previous contact with some of the users and/or family members of the health units included in this research, because they had participated in practical classes in the services during the graduation, highlighting the penultimate semester

of the course, which is responsible for theoretical and practical skills in Primary Health Care (PHC).

The convenience sampling method was used, so that all subjects who agreed to participate in the study and met the following inclusion criteria were included: diabetic patients who participate in HIPERDIA (program for the registration and monitoring of people with hypertension and/or DM assisted by the outpatient network of the Unified Health System) and their families. Exclusion criteria were individuals under 18 years of age.

Participants were invited to join the study sample through telephone contact, provided by managers and nurses of the Western Sanitary District (WSD), who were previously informed about the main project, partnership of UFRN and UCAM, and the importance of conducting research for patients and family members from health units.

Once in possession of the contacts of potential participants, the nursing students were guided by the main researcher to make an initial contact, in order to clarify, clearly and objectively, the relevance of the study, how their participation would take place and how relevant it was. Although patients are the target population of the investigation, some could have limitations, both physical and cognitive. Thus, self-care expands to the families of these subjects. Thus, 12 users and 2 family members comprised the sample of this study, since only two patients were dependent for the effectiveness of self-management of care.

Data collection was carried out between November and December 2021, by phone calls and/or by the multiplatform application of instant messaging and voice calls WhatsApp, with a sociodemographic questionnaire made available by a link from Google Forms for completion, which also included the informed consent form (ICF) and the permission to record the interview.

The data were collected from the questions: What activities do you perform in the health unit? What activities do you do to maintain or improve your or your family's health? What activities should you do but not do? Explain why you don't? Where could the health unit help improve your health? What activities do nurses do for your health? And which ones you can do but still don't?

Those who accepted to participate in the

survey but did not respond through the electronic form within the stipulated period and/or chose to answer the questions by audio messages were instructed by the students to record and, subsequently, send the responses individually and according to the order previously exposed, so that there was no escape from the theme and/or the absence of any replica. The average time of all questions was 20 minutes. There was no repetition of the interviews for any reason, as well as the use of data saturation.

The speeches obtained from the participants were transcribed in the software Microsoft Word 2010 and, later, along with those arranged in Google Forms, were analyzed with the support of the software *Interface de R Pour les Analyses Multidimensionnelles de Textes et Questionnaires* (IRAMUTEQ). To this end, the Descending Hierarchical Classification (DHC) was used, which aims to organize and categorize the text fragments, in addition to the analysis of similarity, in order to allow the identification of the most frequent words and connectivity between them⁽¹¹⁾.

To preserve the anonymity of the participants and the confidentiality of personal information, an encoding was performed using the letters "U", of users, and "F", of family members to identify them, followed by Arabic numbering according to the order of the speeches.

The research was approved by the Research Ethics Committee (CEP) CAAE: 46980721.9.0000.5537 in order to ensure the ethical precepts determined by Resolution n. 466/2012 of the National Health Council.

RESULTS

The final sample consisted of 12 users and 2 family members, totaling 14 participants from six FHU. Eleven were women (78.5%), the predominant age group was between 51 and 60 years, with a mean age of 55.5 years, and the prevalence regarding the time of participation in HIPERDIA was zero to five years, with an average time of 2.5 years.

The analysis performed from the processing of the responses of the participants in the IRAMUTEQ software had a retention of 130 text segments and a use of 76.92% of the textual corpus. With this, three partitions and five classes emerged through the DHC, as shown in Chart 1.

Chart 1. Partitions and classes generated from the Descending Hierarchical Classification of the self-care perspectives of patients with diabetes mellitus assisted by Primary Health Care, Brazil, 2022

Partitions	Classes	Lexicographic analysis		
		Words	%	χ^2 p value
Self-care of patients with DM	Class I - Self-care actions developed by patients with DM (26%)	Glycaemia	100.0	<0.0001
		To eat	100.0	0.0007
		To check	100.0	0.00057
		To take care	66.6	0.00354
Aspects necessary for the patient with DM	Class II - Activities that should be performed by patients with DM (17%)	To practice	100.0	0.0001
		To find	80.0	<0.0001
		Must	71.4	<0.0001
		To walk	66.6	<0.0001
	Class III - Actions that should be performed at the health unit for patients with DM (24%)	Execution	100.0	0.00175
		To improve	87.5	<0.0001
		To help	75.0	0.01478
		Follow-up	66.6	0.0116
Care for patients with DM in PHC	Class IV - Perceptions about care in PHC (20%)	To speak	100.0	<0.0001
		To look	83.3	<0.0001
		To schedule	66.6	0.04019
		Appointment	45.0	0.0177
	Class V - Factors that hinder the care for patients with DM (13%)	Test	71.4	<0.0001
		To begin	66.6	<0.0001
		To assist	60.0	0.00134
		To delay	50.0	0.00544

Source: created by the authors (2022)

From the first partition, entitled "Self-care of patients with DM", the class I derived, Self-care actions developed by patients with DM. It describes activities to control glycemic levels and prevent complications, such as walking, healthy eating, insulin storage and application and foot care, as described in the following:

I walk [...] I'm stopping eating some things, because my blood sugar was always high [...] I receive insulin, there are syringes and pens. I'm careful to put it in the fridge, in polystyrene. I apply it, I apply it on the arm, on the stomach, on the thigh, I take turns because sometimes I get sore. I take care of my feet too, I use foot moisturizer. (U03)

What I do is taking my medicines, do my tests, have a diet that doesn't affect the disease. I check my sugar blood three times a day. [...] My family is diabetic, that's what I'm so careful, I don't use any shoes, I don't walk barefoot, I know every care, I try to take care of myself. (U12)

[...] She takes her medicines and insulin twice a day, I store it in as adequate box, inside the fridge, on the lower shelf. My father and I are responsible for administrating the insulin because her eyesight is too

bad due to the disease, we change the sites for administration, to alternate, which is important. We're also careful with her feet, we pass ointment, gels, sometimes her legs get swollen, so we massage them, but her feet have no lesion. Her diet is great too, we avoid fatty food. (F01)

The second partition, "Aspects necessary for the patient with DM" is composed of classes II and III, related to the practices that need to be developed, according to the participants, both by the patient and the health team.

Class II, called Activities that should be performed by patients with DM, unveils the knowledge of the participants about actions that assist in the treatment of the person with DM, which are guided by health professionals but are not always executed, as described in the subsequent segments:

For diabetic people, health professionals indicate walking. I think I should do it, but I don't. If it's another activity, like doing laundry, cleaning the house, things like these, you're already exercising, doing the housework. (U09)

I should be more careful with my feet, avoid walking barefoot and treat the fissures. Another issue is the insulin, I must be careful with the doses, not to overdose, because, since my eyesight is already affected by the disease, it's complicated for me, and the issue of administering on different sites everyday. (U11)

I currently don't exercise, only physiotherapy. [...] Taking the medicines too, doing the tests, and having a better diet. (U12)

Class III, entitled "Actions that should be carried out in the health unit for patients with DM", exposes considerations for the improvement of care aimed at patients with DM in PHC, such as the execution of collective actions, continuous follow-ups and greater attention to that population, as set out below:

Regarding the health unit I attend, they should pay more attention to diabetic people, sometimes I get dizzy, sometimes when I arrive at the health unit I'm the last patient, even though I know that I'm a priority [...] I also think there should be an incentive for a group walk, I believe that would help a lot. (U04)

Sometimes there are some meetings, but I'm not sure if there are any lectures with diabetic people. I think it's very important to have these actions, because, for example, I know the risks that diabetes brings, blindness and everything else, but other people don't have knowledge about the subject, and if I didn't have it, I would also be there. The follow-up really needs improvement. (U12)

Having more home visits, because my mother hardly ever goes to the health unit because of her condition, this would improve the follow-up a lot, because not everyone can go straight to the health unit, if they offered some simple activities for the elderly, which is the most affected public, to understand what this disease is and that the only way out for a better life is to do the treatment properly. (F01)

Regarding the third partition, "Care for patients with DM in PHC", from which classes IV and V derive, this is about the perceptions of the participants about the care provided in Primary Care (PC) as well as the obstacles in providing quality care to patients with DM.

Class IV, called "Perceptions about the care of patients with DM in PHC", points out situations experienced by patients with DM in moments of individual consultations and embracement in PHC, concerning the relationship between health

professionals and users as shown in the following statements:

[...] I don't like the service. I go because I have to go to see how the diabetes is and be medicated, receive these medicines. The doctor doesn't assist people properly, he doesn't even look at the person's face, he just looks at the keyboard, if we don't speak, he doesn't speak, he doesn't examine you. (U09)

I'm not complaining about everyone, because it's not fair, but from the moment you enter the health unit, the people who work there seem to have no empathy for you, sometimes they don't even say hello, they just want to know if you're there to make an appointment or exam, they don't even ask how I'm feeling, if I've already taken insulin, if I've eaten that day, why I might feel sick, as has happened other times, there is no guidance for diabetes, only in consultations with the doctor and sometimes with the nurse, sometimes only, because most of the time it's just to prescribe the drugs and see the results of my exams. (U10)

My nurse guides me, she does that test on the feet to examine the sensitivity, she gives me the exams, she gives me a lot of advice, because, over time, it can cause harm me seriously and, in the future, I may lose a member, she guides me a lot. (U11)

In class V, "Factors that hinder the care of patients with DM in PHC", there are aspects that impair the continuity of care to the patient. Shortcomings in the services, such as delays in scheduling tests, consultations and referrals, as well as weaknesses in the dispensing of medicines and the lack of some inputs, as presented in the sentences, are highlighted:

You go to the doctor at noon for the appointment to be in the afternoon, and you often go without lunch. The doctor starts working 3, 4 p.m., it's very complicated because I do the housework, and another issue is the dressing room, I need a bandage because a wound opened on my foot, [...] so, at the health unit, it's hard for me to do it, or because there is no one to do it when I go and mainly because there is a lack of materials to do it and I can't keep buying. (U02)

[...] We have to make an appointment every Friday or the end of the month [...] The doctor writes the prescription, you go to the pharmacy and there is no one there because the person who works at the pharmacy has already left. Sometimes it doesn't have the medicine. It's horrible. (U09)

It would be very good if the form for the specialist came out faster, because I asked for a referral, a

couple of months ago or more and they still haven't scheduled this referral to the endocrinologist [...] I'm very sad because these units don't have adequate follow-up and the person may even be feeling sick and be harmed, because the consultation takes a long time and scheduling the consultation and exam is very difficult, so many cases become urgent, that's why the capacity in the ECU. (U12)

Through the similarity analysis presented in Figure 1, one can observe the centralization of the term **health unit** as a primary care environment for the patient with DM, which must **perform activities** aimed at treating the chronic condition in

order to **improve the health** of these people.

Moreover, the verb **to be** stands out, which reveals the condition of patients with DM, as well as the actions that are or should be performed by them in the treatment and control of the disease according to their experiences. Therefore, the similarity analysis showed that the participants of this research center their care in the health environment and neglect their ability to promote self-care independently and dissociated from **health units**.

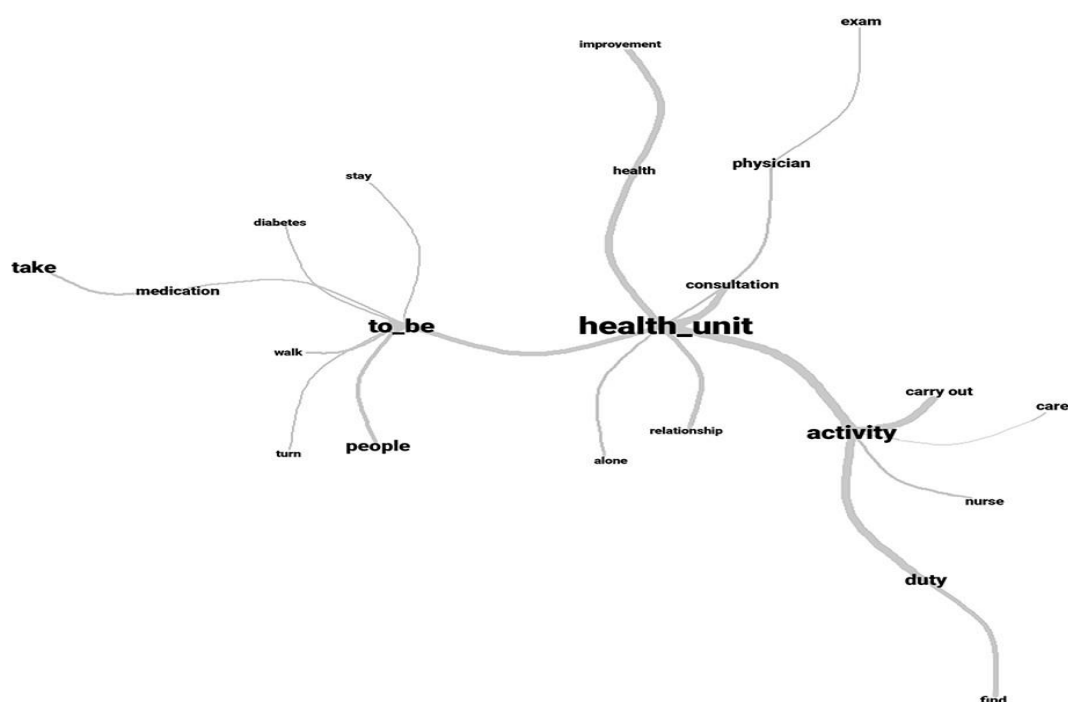


Figure 1. Similarity analysis of the self-care perspectives of patients with Diabetes Mellitus assisted by Primary Health Care, Brazil, 2022.

Source: created by the authors (2022).

DISCUSSION

The speeches showed the understanding of the study participants about the importance of carrying out self-care actions, as well as the concern with the worsening of the disease. The study participants point out the recognition of practices for the prevention of complications arising from DM and the obstacles for their execution.

In this sense, DM, when configured as a chronic disease, requires the commitment and participation of patients continuously in their treatment, so that they act as co-responsible for

their care⁽¹²⁾.

Among these actions, physical activity stands out, also highlighted in the literature⁽¹³⁾, which has repercussions on the sedentary character of this population. This datum is consistent with a research⁽¹⁴⁾ that points to a high percentage of sedentary people with DM (88%), considered an aggravating factor in the treatment and control of the disease. This corroborates a randomized clinical trial⁽¹⁵⁾, which showed greater benefits to users who adhered to better eating habits and physical exercise, factors considered essential and determinant in the control of the glycemic index, as already proven².

Moreover, a study⁽¹⁶⁾ showed that 70% of patients do not store insulin correctly. The discussion of this fact is relevant, whereas adequate conservation and storage are essential, since sudden temperature fluctuations, for example, can promote the denaturation of the protein structure of insulin, which compromises its effectiveness⁽¹⁶⁾.

Regarding the handling of insulin, there are difficulties due to complications from the disease, such as diabetic retinopathy. One study⁽¹⁶⁾ discussed the involvement of this condition in one in three patients with DM. These visual limitations, as well as motor and cognitive limitations, may compromise the technique of insulin self-application, a limiting factor for adherence to treatment⁽¹⁷⁾.

The participants are also concerned with the care of the feet, fact that diverges from the study⁽¹⁸⁾, in which the patients did not know or did not care about the risk of foot problems associated with DM, as they considered this factor with less priority when compared to the use of drugs and the verification of capillary blood glucose. Foot care is considered indispensable, since it prevents the development of vascular problems and diabetic foot, which often cause impairments in functional capacity, increased risk of amputations, hospitalizations and death⁽¹⁹⁾.

Regarding eating habits, considering the reports, people recognize their importance, although a study⁽¹⁴⁾ shows that most patients with DM have already received some kind of guidance from health professionals about food care, and yet, do not follow the recommendations properly. The findings show that, even with guidelines, most patients do not follow the recommendations properly, which reinforces the need for greater awareness of this public in addition to the information provided on the care measures related to DM.

Therefore, it is essential to clarify the advantages of the therapeutic process for glycemic control and to carry out educational interventions aimed at patients and family members that take into account level of education, purchasing power, culture and belief, in order to avoid clinical emergencies and undesirable hospitalizations, high costs for the health system and adverse effects⁽²⁰⁾.

There is a need for actions aimed at patients with DM in PHC from the weaknesses present in services. This unveils the importance of monitoring

patients with DM continuously and longitudinally in all segments of care in PHC, from consultation to home visit, as well as the planning of interdisciplinary educational actions in the scope of building knowledge and encouraging self-care practices⁽²¹⁾.

Educational actions are considered more effective when carried out in groups, since such strategy allows the exchange of experiences, as well as the discussion of doubts and feelings about living with this condition, in addition to allowing users to obtain knowledge, awareness of their state and of the behaviors necessary to control DM^(3,4). Moreover, group empowerment for adherence to user self-care is a foundation for the control and treatment of DM, and has the potential to contribute to the improvement of psychological and clinical results, since it influences and promotes the change of behaviors, as the autonomy of the user increases concerning the management capacity of their condition increases⁽¹⁶⁾.

In this context, countries that have developed expert patient schools as an aid to strengthening the self-management of chronic diseases stand out. In a study⁽²²⁾ conducted in Spain, after training for patients with chronic conditions, there was a more active performance of users and a positive impact on the health professional-user relationship, which caused the reduction of attendance of this public in emergency services and hospitalizations.

On the other hand, users' dissatisfaction with the service offered in the health unit they attend is notorious, especially in the relationship with the multiprofessional team, which meets studies⁽²³⁾ that reinforce the importance of listening in a qualified way, which is considered an essential tool in creating a bond between professional and user.

In addition, active listening enables a better understanding of patients' complaints and doubts, as well as enables dialogue and favors the provision of necessary and problem-solving information/guidance⁽²⁴⁾. In line with the findings, a study⁽²⁴⁾ pointed out the prescriptive and hegemonic character of the guidelines provided to patients, according to which rules of conduct and behaviors should be followed without considering the singularity of the subjects, due to the fact that, most of the time in consultations, users are blamed for the losses in treatment before difficulties in performing any of the guidelines.

Therefore, understanding the needs and

anxieties, in addition to the encouraging aspects of patients, helps them to take responsibility for their treatment gradually. Thus, professionals are responsible for establishing a position of trust, in order to clarify that they are not only concerned with the disease and therapeutic effectiveness, but that they really care about the individual⁽²⁵⁾.

In this scenario, the importance of PHC to provide care to patients with DM in order to cover all their needs is strengthened, in addition to prioritizing health education concerning the empowerment of users regarding their health status, with support for self-care and acceptance of the disease with a view to continuous care, which can guarantee autonomy before their health condition, changes in their habits and better quality of life^(26,27).

Given the above, PHC is configured as a point of support for patients with DM and/or their families, since it aims to expand knowledge about the chronic condition and stimulate self-care practices, in order to promote greater control of the disease and, thus, a better quality of life⁽²⁶⁾.

Based on the similarity analysis, the absence of the word "self-care" was observed as one of the most cited by the study participants. This fact can be justified by the scarce use of this term among this public, due to the predominance of the search for care in health services for the management of the disease, and also by the lack of knowledge of self-care activities or their low adherence^(14,26).

The health unit being evidenced by users but not self-care may be associated with the low protagonism of people with DM in relation to the care of their disease, with a passive role, contrary

to the expert profile expected for the control of chronic diseases⁽²⁶⁾.

A limitation of the present study concerns the small number of participants, which is unable to originate generalizations, since it portrays the reality of only a portion of the BHU of a city, because, although this reflects other places, different results can arise. Another limitation is the online data collection, which brings restrictions, since some people do not have access to the internet, do not know how to handle devices or have changed the telephone contact.

FINAL THOUGHTS

After reflecting on the prospects of self-care of users with DM and/or their families, most participants understand the monitoring of blood glucose, the performance of physical activity, healthy eating and care for insulin therapy and feet as self-care actions.

Moreover, they recognize the importance of these practices and are aware of the complications that the chronicity of the disease can cause without proper care. Despite this, many do not properly perform these activities.

The understanding of the difficulties that permeate this theme contributes to greater attention by managers and health professionals in the planning of strategies and actions aimed at fostering the construction of activities aimed at this population in the context of PHC, being also necessary the development of studies that portray the importance of self-care and measures that encourage this practice.

COMPREENSÃO SOBRE AUTOCUIDADO DA DIABETES MELLITUS POR PACIENTES ATENDIDOS NA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: compreender a percepção do paciente com diabetes *mellitus* atendido pela Atenção Primária à Saúde acerca da necessidade do autocuidado. **Método:** estudo descritivo de abordagem qualitativa, realizado com 12 usuários com diabetes que participavam do programa HIPERDIA e dois familiares por meio de entrevistas telefônicas entre novembro e dezembro de 2021. As falas foram transcritas e analisadas lexicograficamente com suporte do software *Interface de R Pour les Analyses Multidimensionnelles de Textes et Questionnaires*. **Resultados:** a partir das falas dos entrevistados emergiram três partições de análise: Autocuidado do paciente com diabetes *mellitus*, que se refere à gestão do autocuidado e medidas de controle da DM; Aspectos necessários ao paciente com diabetes *mellitus*, que reflete acerca das ações de autocuidado necessárias em pacientes e unidades de saúde, e Atendimento ao paciente com diabetes *mellitus* na Atenção Primária à Saúde, que traz discussões acerca da autogestão, cuidado e atendimento. **Considerações finais:** os usuários em estudo reconhecem as ações de autocuidado relacionadas à sua doença. No entanto, apresentam dificuldades em aderir às recomendações para promoção do autocuidado.

Palavras-chave: Diabetes mellitus. Autocuidado. Atenção primária à saúde

COMPREENSÃO DO AUTOCUIDADO DE LA DIABETES MELLITUS POR PACIENTES ATENDIDOS EM ATENÇÃO PRIMARIA DE SALUD

RESUMEN

Objetivo: compreender a percepção do paciente com diabetes *mellitus* atendido por la Atención Primaria de Salud acerca de la necesidad del autocuidado. **Método:** estudio descriptivo de abordaje cualitativo, realizado con 12 usuarios con diabetes que participaban del programa HIPERDIA y dos familiares por medio de entrevistas telefónicas entre noviembre y diciembre de 2021. Los relatos fueron transcritos y analizados lexicográficamente con soporte del software *Interfaz de R Pour les Analyses Multidimensionnelles de Textes et Questionnaires*. **Resultados:** a partir de los relatos de los entrevistados surgieron tres categorías de análisis: Autocuidado del paciente con diabetes *mellitus*, que se refiere a la gestión del autocuidado y medidas de control de la DM; Aspectos necesarios al paciente con diabetes *mellitus*, que pondera acerca de las acciones de autocuidado necesarias en pacientes y unidades de salud; y Atención al paciente con diabetes *mellitus* en la Atención Primaria de Salud, que trae discusiones acerca de la autogestión, cuidado y atención. **Consideraciones finales:** los usuarios, en estudio, reconocen las acciones de autocuidado relacionadas con su enfermedad. Sin embargo, presentan dificultades para adherirse a las recomendaciones para promover el autocuidado.

Palabras clave: Diabetes mellitus. Autocuidado. Atención primaria de salud.

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