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ORIGINAL ARTICLE

EVALUATION OF A GROUP INTERVENTION: QUALITY OF LIFE AND AUTONOMY IN USERS WITH DIABETES MELLITUS

AVALIAÇÃO DE UMA INTERVENÇÃO GRUPAL: QUALIDADE DE VIDA E AUTONOMIA EM USUÁRIOS COM DIABETES MELLITUS

EVALUACIÓN DE UNA INTERVENCIÓN DE GRUPO: CALIDAD DE VIDA Y AUTONOMÍA EN USUARIOS CON DIABETES MELLITUS

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ABSTRACT

Objective: evaluating a group intervention potential for those with Diabetes Mellitus and family in the context of the Family Health Strategy, developing the independence and quality of life. **Method:** an exploratory descriptive study, of a qualitative approach with the data produced data produced by means of semi-structured interviews and documentary study with the people with Diabetes Mellitus and family, after approval by the Research Ethics Committee, CAAE: 02664012.0.0000.0104. **Results:** benefits were referred as exchange of experiences and knowledge about the disease and medications, improvement of body integrity and diet, as well as emotional support and ease of access to other health services. There were identified low effectiveness in developing autonomy and quality of life, and distant practice of precepts of Health Promotion. **Conclusions:** it is necessary to combining different technologies to strengthening the actions of health promotion in health services in Brazil, and family support. **Descriptors:** Health Promotion; Program Evaluation and Health Projects; Diabetes Mellitus.

RESUMO

Objetivo: avaliar o potencial de uma intervenção grupal junto às pessoas com Diabetes Mellitus e familiares no contexto da Estratégia de Saúde da Família, para o desenvolvimento da autonomia e da qualidade de vida. **Método:** estudo descritivo-exploratório, de abordagem qualitativa, com os dados produzidos por meio de estudo documental e entrevistas semiestruturadas, junto a pessoas com Diabetes Mellitus e familiares, após a aprovação pelo Comitê de Ética em Pesquisa, CAAE: 02664012.0.0000.0104. **Resultados:** foram referidos benefícios como troca de experiências e conhecimentos sobre a doença e medicações, melhora na integridade corporal e na dieta alimentar, além de apoio emocional e facilidade de acesso aos demais serviços de saúde. Identificamos baixa efetividade no desenvolvimento da autonomia e da qualidade de vida, além de práticas distantes dos preceitos da Promoção à Saúde. **Conclusão:** é necessário combinar diferentes tecnologias para fortalecer as ações de Promoção da Saúde nos serviços de saúde do Brasil, além de apoio familiar.

Descritores: Promoção da Saúde; Avaliação de Programa e Projetos de Saúde; Diabetes Mellitus.

RESUMEN

Objetivo: evaluar el potencial de una intervención de grupo a las personas con Diabetes Mellitus y su familia en el contexto de la Estrategia de Salud de la Familia, para el desarrollo de la independencia y la calidad de vida. **Método:** es un estudio exploratorio descriptivo, de enfoque cualitativo con los datos producidos por estudio documental y entrevistas semi-estructuradas con personas con Diabetes Mellitus y su familia, después de la aprobación por el Comité de Ética de la Investigación, CAAE: 02664012.0.0000.0104. **Resultados:** fueron referidos beneficios, como el intercambio de experiencias y conocimientos sobre la enfermedad y los medicamentos, la mejora de la integridad corporal y la dieta, así como el apoyo emocional y la facilidad de acceso a otros servicios de salud. Identificar baja efectividad en el desarrollo de la autonomía y la calidad de vida, y las prácticas distantes de los preceptos de Promoción a la Salud. **Conclusiones:** es necesario combinar diferentes tecnologías para fortalecer las acciones de promoción de la salud en los servicios de salud en Brasil, y el apoyo familiar. **Descriptores:** Promoción a la Salud; Evaluación del Programa y Proyectos de Salud; Diabetes Mellitus.

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INTRODUCTION

Chronic and non-communicable diseases (NCDs) have been of global concern in recent decades, whether in academic, political or social environment, considering their significant growth and the impact on morbidity and mortality and the implications on quality of life and autonomy of people affected by these diseases.^{1,2}

Diabetes Mellitus (DM) stands out as a chronic disease of global impact that affects the cardiovascular system and can occur at any age. In Brazil, it is estimated that over 5 million people are diabetic and that in 2025, there may be approximately 11 million individuals affected by this disease. Its prevalence reaches 5,6% of the adult population at 18 years old or older, being that, in the age group of 65 or over reaches 21,6%. Over 3 million diabetics are users of the Unified Health System (SUS) and almost half of these is unaware of the disease or does not follow an appropriate treatment.^{1,3}

This framework usually raises the public health system spending with hospitalizations for complications, early retirement for disability and promotes change in the quality of life and autonomy of people with diabetes and in the family. Thus, DM constitutes a public health problem that requires policy interventions in society, and special attention in health services; featured, Primary Health Care (PHC), where most of those affected can be treated.^{1,2}

Early diagnosis of DM has been a priority of the Ministry of Health under the NHS. Featured in "the development and implementation of effective, integrated, sustainable and evidence-based public policies on prevention and control of NCDs, their risk factors and strengthening of health services"^{2:7}. These strategies should be undertaken by Family Health Teams (FHT), involving the promotion of health, prevention and control of these diseases.^{1,4,5}

In the treatment of hypertension and diabetes, Health Promotion (PS) is valued in confronting the alarming picture of the increase of chronic diseases. It is a field consisting of practices and concepts that emphasize the multiple dimensions involved in the process of living that generally affect the health and lives of individuals, as well as the behavioral aspects of individual, family and community, especially those that take to risks and vulnerabilities.^{6,7}

The approach of risk factors in contemporary society becomes a challenge for

health services, considering the complexity of events, such as urban violence, the phenomenon of aging and lifestyle, for example. New ways of living and habits such as smoking, physical inactivity, excessive consumption of salt, alcohol and food industrialized, have leading role on the health of individuals and impact on chronic diseases.²

Nevertheless, the factors associated to poor adhesion of individuals to potentiate health behaviors, make the work of the teams complex, being a fragile and challenging point of PS.⁸ The group intervention has been considered an effective methodology, regarding the changes in behavior and lifestyles with potential for health. Thus, the participation of the individual with DM in groups is a potentiating alternative, because it provides the interaction between people in similar situation needs, emotional support and training for these acts as co-participants in control of your health and quality of life.⁹⁻¹⁰

Despite these findings, the development of PS in health services is still limited. It is a complex, polysemic and little known field. Generally, the difficulties for the operation of these actions are highlighted, as well as the assessment of their results, in that it identifies a several meanings, concepts and a multiplicity of actions of various actors with different backgrounds. Under these conditions, the need arises to consider methodological strategies to evaluate interventions in health promotion.¹¹

OBJECTIVE

- Assessing the potential of a group intervention for those with Diabetes Mellitus and their family in the context of the Family Health Strategy, to develop the independence and quality of life.

METHOD

This is a descriptive-exploratory study, of a qualitative approach.¹² The field study was a Health Unit of Primary Health Care (PHC) from Maringá / Parana, focusing on the healthcare scenario of a team of the FHS, in development of a group intervention, focused on patients with diabetes.

The data production was carried out in the period from June to August 2012, through desk study and semistructured interviews. At first, the researchers approached the health service, to select subjects through hospital records available in the electronic information system. Study informants were users with diabetes and family members who closely the experience of illness, totaling 34 subjects.



In the second phase, the semi-structured interviews were conducted in respondents' homes. These had an average duration of 40 minutes, being scheduled in advance and after permission of the participants, recorded on digital equipment. The interpretation from the perspective of the interviewees was founded based on the theoretical framework of health promotion and in dialogue with authors of Anthropology of Health.

The study was conducted in accordance with the guidelines of Resolution 196/96 of the National Health Council with the approval of the Standing Committee on Ethics in Research Involving Humans (COPEP), of the State University of Maringa (Opinion no. 29249) as well as the bodies responsible for health unit. The participants signed an informed consent and to ensure their anonymity was used the letters U for Users and the letters C for caregivers and an indicative number of the order of the interviews.

RESULTS AND DISCUSSION

The discourse analysis allowed identifying the diversity of practices in the group intervention team of the FHS investigated, which confronted with the guidelines of the National Health Promotion (PNPS), it is identified that the actions operated in this process are far from the precepts political and ideological health promotion, with a predominance of approaches to disease prevention.

The group process investigated structure with quarterly meetings, characterized by educational guidance on various topics, check weight and circumferences (waist, hip and abdominal), assessment of blood glucose, nursing consultation, medical consultation, dispensing recipes, control and drug delivery, as well as scheduling for the next group intervention.

The age range of users surveyed who participate in group meetings ranged from 44 to 82 years old and the family of between 22 and 64, with a predominance of females. As for education, most have incomplete primary education, are married, and divided between Catholics and Protestants. Following is the perspective of the suspect on the group process and the approaches and difficulties with the autonomy and quality of life.

♦ Benefits of group Intervention

The group approach has been encouraged by the Ministry of Health and adopted by the FHS, especially in chronic illness care. Activities with groups are incorporated by SUS

and stimulated as a model that extends the understanding of user about their health problems.¹³

Participation in the group approach was reported by users as an opportunity to exchange experiences and information between individuals who share the same health problem, about the disease, its treatment and how to manage their illnesses.

[...] the better control of the medication, the fact of knowing the right time and right to taking, administering insulin, the place to store in the fridge, several factors that help as well. (U12)

For people to be more informed, because we alone can take care of ourselves and not the people watching the group, we see where is hitting and where is missing. (U5)

We also noted some concerns of users regarding access to medications and other services developed at the Health Unit, as vaccination and checking of blood glucose levels, the group encounters a space that enables meet these needs.

[...] the benefit is because we are freer to be able to get insulin, people meds, to get easier. (U14)

[...] I need to go there to measure, see how it is (blood glucose). (U7)

[...] I took a flu shot, did my card that I use around the world, there is good for everything. (U6)

For proper control of DM, it should be noted that it is essential to know aspects of the management and conservation of prescription drugs. In this respect, the information received in groups contributed to medication adherence and disease control,¹³ however, there are unique aspects to observe these conditions. The actions of health promotion beyond the focus of the disease, being composed of guidelines aimed at improving the quality of life and health of people, aimed at reducing vulnerability and health risks and ways to live safer and healthier.

PS actions are planned and politically institutionalized in Brazil since 2006, through PNPS. Their guidelines aim to strengthen the work of teams of the Family Health in addressing the various risk factors, especially for chronic diseases, such as promoting physical activity, healthy eating habits, reduction of tobacco use and alcohol prevention violence prevention, obesity, and special care with the aging process.⁶

In this broad approach process, the autonomy is recognized as a central category of health promotion, with a focus on strengthening the capacity of individuals, for



taking measures for their health and community decisions. Requires support that goes beyond health services, such as implementation of healthy policies, supportive environments, strengthening community action, developing personal skills and reorienting health services.⁷

Health education appears as a suitable for the development of health promotion and autonomy technology, since organized continuous, flexible and in dialogue with the broader aspects involved in living with the disease process forms, seeking to strengthen the capacity action for individuals living with the disease, but with quality of life.

One of the main problems confronting the DM is poor adherence to drug therapy users, as well as to promote the empowerment and autonomy is poor adherence to healthy behaviors of users. The participants in this study showed that participation in groups was beneficial for glycemic control, free drug access and information needed for drug therapy.

[...] I'm glad because I don't need to buy medicine, meds, all I caught there, insulin, so I don't pay anything. (U8)

The better control of the medication, the fact of knowing the right time and right to taking, administering insulin, the place to store in the fridge, several factors that help to control diabetes. (U12)

The search for free drugs has shown the situation of low socioeconomic level of SUS users, a factor that also interferes with adherence to healthy behavior. However, it is critical that the educational process or assistance, are considered broad health needs and overcome the reductionist view of disease and treatment, considering the user when seeking health services, brings diverse needs influenced by their social, cultural and subjective.¹⁴

The group interventions may have different approaches and goals. In this research we identified that the approach is close to what is defined as Therapeutic Group, which aims to improve specific diseases in individuals or the Group of Preventive Actions, based on classical informative education that seeks to reduce health problems under individual acts of self-care. However, in the context of FHS we highlight how important the alternative group is, Groups Health Promotion (GPS) by having the objective of strengthening the abilities, behavior changes and attitudes for the development of autonomy to face the harsh conditions of life.

Another benefit was that regarding the humane care perceived by users during the

group intervention, the appreciation of the emotional and subjective aspects.

[...] because they treat me well, they never treated me badly. (U3)

[...] Until the behavioral mode of treatment [...]. (U2)

[...] He (doctor) said that who has diabetes type 2 cannot get agitated, nervous, that he (diabetes) does not control. (U11)

Humanization has been recognized as an axis that allows bonds / bonding between the user and the health professionals, thus favoring the establishment of commitment and co-responsibility between them. The health team, in addition to providing information, can provide closer focusing and accompaniments changes in attitudes towards illness and condition in relation to the ways of dealing with the demands of treatment.¹⁵

The attention to humanized health affectively predisposes to coherent action with the affections and cognitions, favorable conditions for the development of autonomy, behavior change and consequent adherence.⁹

The reports also showed evidence other benefits such as improvement in symptoms of DM and further guidelines for body care, but linked to the effects of uncontrolled disease.

[...] because I had a lot of leg pain, [...] "the eyes" just stayed that way some clouds (blurred vision). (U5)

[...] being careful with your body, with your fingers, not hurt, because if hurt delay healing and the longer it takes to heal sometimes may have to amputate the finger, amputate an arm [...]. (U8)

With regard to food, care users have demonstrated adequate knowledge for good nutrition.

[...] do not eat food that is bad for diabetes don't go up; don't eat the sweet things for diabetes doesn't rise [...]. (U6)

[...] avoid things that get fat, seek to keep the weight to avoid diabetes. (U15)

Chronic illness DM is diffused in current society with a greater impact, leaving its effects in individuals affected by it, in the family, in society and in the health services.¹⁵ The manifestation of DM often leads to the need for adjustments in both the organization and the family dynamics, the need for continued use of medications, including insulin and restrictive diets, reflecting the quality of life and independence of people with DM and routine family.¹³

♦ Difficulties for the development of autonomy and quality of life

Despite reported with participation in group interventions benefits, the results showed that these do not guarantee



adherence to behavioral changes and some difficulties were identified as forgetting the date of the group and activities / various commitments on the same day and the difficulty in mobility probably related to the clinical course of DM, which emerged as barriers to participation in the group.

[...] We sometimes forget the dates. (U10)

[...] When I leave for work that falls on the day of the group, so the job gets in the way. (U6)

[...] to reach this group, because I don't have the ability, I don't have the strength for that, for walking, I need help. (U17)

Diabetic users experience daily conflicts involving constant food cravings, drugs, bodily integrity, emotional factors, among others, the fundamental being of the caretaker as support for adherence to practices that minimize the effects of the disease. Functional changes and chronic conditions impose constraints that lead the individual to become dependent on family care.¹⁶⁻⁷ This research verified the dependence of patients with diabetes in the care of family / caregivers.

The only thing I need [...] is my wife helping me apply insulin. (U14)

It is very important, she (the daughter) asks: have you taken your medicine? Have you taken insulin? Everything is taken care of. (U13)

[...] This (food) already belongs to my wife do, to do it in a way that does not affect diabetes. (U7)

[...] She lived far away, and came to live here close to me to help more. (C13)

Thus, the family is constituted as a support network and is essential for success in controlling and treating the disease, but can also help to promote the welfare and improvement in quality of life.¹⁸ The impact of DM in live mode of individuals and their families may be ameliorated when these guys reach physical, psychological health and reduce the level of dependency (on aspects of mobility, daily activities, medications, medical care and work capacity).¹³

The family is a care system characterized by the informal sector and the first healthcare provider, identifying and treating its loved one.¹⁹ This assistance takes place between people who are connected by family ties, friendship, neighborhood or religious organizations or professionals. Thus, caring involves an interactive action, have values and knowledge between caregiver and care subject subject.

In an anthropological perspective, "a person is defined as a patient if there is agreement between its own perceptions of

commitment to well-being and perceptions of the people around it"^{19:116}. In this sense, always getting sick is a social process that involves people other than the patient and the family who appears as the principal involved.¹⁹

The importance and the meanings given to the sick is a particular process and involves values and conceptions about life, health and disease. They are related to the experiences and experiences of each of the actors involved in the health-disease process. Thus, both ways of understanding health as practices vary among individuals, families, cultural groups and social classes.¹⁹⁻¹ Thus, poor adhesion can often be attributed to the fact that individuals feel sometimes sick, sometimes healthy. It is known that the effects of DM may be unnoticed and often absent, which leads the individual with diabetes to quit treatment and changes in lifestyle.

Individuals with diabetes should also be seen as participants in their care, and responsible for their own health, so the family participation is essential in this process.

[...] the participation of the family is a remedy, it is support. (C6)

In this aspect, the narratives of caregivers reflect concern and encouragement of the problems found with the disease.

[...] is more to stay on its feet, support [...]. (C6)

I can handle in relation to her feet when she goes to manicure. (C13)

[...] food at the right time, you can't be eating lots of food, lots of fat mass. (C14)

[...] looking for a meal that does not make to him much harm. (C11).

Within the field of health promotion, participation is regarded as a condition for the individual to take control of your health. In this sense, the family / caregiver is essential to assist in adapting to changing needs and coping process of DM.¹⁶

CONCLUSION

The anthropology of health has been useful for the understanding of an individual's health needs and difficulties for adhesion to healthy behaviors, by its focus on health/culture relationship. Individuals when they get sick, have an individual perception and particularly about the disease and respond to this situation from their subjective experiences. These responses are based on what represents the change in your body appearance, in the functions of your body, on loss or deficiency of movements and emotional changes. So there is a subjective response of this individual or his family, composed of private



meanings in relation to disease, which are influenced by culture, personality, cultural, social and economic context.

The relationship culture and health is a complex process and in the biomedical model we must consider the difficulties and the unpreparedness of health professionals in approaches that involve change of attitudes.

The health team can follow individuals with diabetes by knowing the behavior and meaning attributed to condition of illness, as well as its relation with the disease process, treatment requirements and with people who live with them. These elements contribute to the successful accession to a new lifestyle.

Analyzing the benefits cited by participants of group meetings, it identifies that these partially corroborated with health promotion and strategies for quality of life and autonomy. It was noted in the guidelines set forth by the users, the concern with adherence to drug treatment and prevention and control of diseases, shares characteristics of the biomedical model.

The group activity also used health education, but with traditional features and prescriptive. A group intervention that has as its goal, to promote health, should be developed to enhance the capabilities of subject to changes of behaviours directed to the development of autonomy. So, it has in the group activities a valuable tool to facilitate adherence, minimizing the occurrence of acute and chronic complications.

The analysis of the family perspective revealed that the autonomy and quality of life of its members with DM are not yet being widely achieved only with participation in groups, because they found that many tasks that could be developed by individuals with diabetes, are on behalf of the family, causing in this way, an overload on the same.

Individuals with diabetes require large, distinct interventions and constant, because there are various aspects present in living with diabetes that hinders the autonomy and quality of life. Factors such as the low level of schooling and age affect in this respect, taking into consideration that, when people have little knowledge about the disease and the dynamics of glycemic control, resist in incorporate self-care behaviors.

In view of the foregoing, it becomes apparent that the understanding of how the individual copes with his illness, coupled with information and knowledge about this, enhanced through the promotion of health

and for family care, are precious tools for the DM's approach.

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