



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

MALE PERCEPTIONS REGARDING MEDICAL TREATMENT WITH MEDICINES OR NOT FOR DIABETES MELLITUS TYPE II

PERCEPÇÃO MASCULINA QUANTO AO TRATAMENTO MEDICAMENTOSO E NÃO MEDICAMENTOSO DO DIABETES TIPO II

PERCEPCIONES MASCULINAS CON RESPECTO AL TRATAMIENTO MÉDICO CON MEDICAMENTOS O NO PARA LA DIABETES MELLITUS TIPO II

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ABSTRACT

Objective: recognizing the perception of men with diabetes mellitus type II regarding treatment. **Method:** a descriptive, exploratory study of a qualitative approach performed in the Family Health Strategy in Northern Minas Gerais/MG, with eight men with diabetes mellitus type II. The data were produced through individual interviews with a semi-structured script; they were fully transcribed, analyzed based on the technic of Analysis of Content, through the mode Thematic Categorization. The research project was approved by the Research Ethics Committee, CAAE 13340813.5.00005141. **Results:** three categories were identified: "Why diabetes is very dangerous for us" - Diabetes mellitus, "I take to know if it cures". The medication and non-medication treatment of diabetes and "The greatest difficulty mine, is the area of power supply" - Difficulties in treatment. **Conclusion:** men follow the drug treatment by obligation and consider the non-drug treatment as a restriction. **Descriptors:** Diabetes Mellitus; Gender and Health; Men's Health.

RESUMO

Objetivo: conhecer a percepção dos homens com diabetes mellitus tipo II quanto ao tratamento. **Método:** estudo descritivo, exploratório de abordagem qualitativa, realizado numa Estratégia Saúde da Família, no Norte de Minas Gerais/MG, com oito homens com diabetes mellitus tipo II. Os dados foram produzidos por meio de entrevistas individuais com um roteiro semiestruturado; os mesmos foram transcritos na íntegra, analisados à luz da técnica de Análise de Conteúdo, na modalidade Categorização Temática. O projeto de pesquisa teve a aprovação pelo Comitê de Ética em Pesquisa, CAAE 13340813.5.00005141. **Resultados:** foram identificadas três categorias: "Porque o diabetes é muito perigoso pra gente" - A diabetes mellitus, "Tomo pra saber se sara". O tratamento medicamentoso e não medicamentoso da diabetes e "A maior dificuldade minha, é na área da alimentação" - Dificuldades no tratamento. **Conclusão:** os homens seguem o tratamento medicamentoso por obrigação e consideram o tratamento não medicamentoso como uma restrição.

Descritores: Diabetes Mellitus; Gênero e Saúde; Saúde do Homem.

RESUMEN

Objetivo: conocer la percepción de los hombres con diabetes mellitus tipo II en respecto al tratamiento. **Método:** un estudio descriptivo, exploratorio de enfoque cualitativo, realizado en la Estrategia Salud de la Familia en el norte de Minas Gerais/MG, con ocho hombres con diabetes mellitus tipo II. Los datos se produjeron a través de entrevistas individuales con una guía semi-estructurada; los mismos fueron completamente transcritos, analizados a partir de la técnica de Análisis de Contenido, en el modo de Categorización Temática. El proyecto de investigación fue aprobado por el Comité de Ética en la Investigación, CAAE 13340813.5.00005141. **Resultados:** tres categorías fueron identificadas: "Debido a que la diabetes es muy peligrosa para nosotros" - Diabetes mellitus, "Tomo para saber hay curación". El tratamiento medicamentoso y no medicamentoso de la diabetes y "Mi mayor dificultad es en respecto a la alimentación" - Dificultades en el tratamiento. **Conclusión:** los hombres siguen el tratamiento farmacológico por obligación y consideran el tratamiento no farmacológico como una restricción. **Descriptores:** Diabetes Mellitus; Género y Salud; Salud de los Hombres.

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INTRODUCTION

The chronic non-communicable diseases (NCDs) are listed on the agenda of priorities of most countries, due to their impact on mortality, morbidity and health care costs. In Brazil, the NCDs correspond to higher expenses for medical attention in the Unified Health System (SUS), according to Ministry of Health data.¹

The main cause of the epidemiological growth of NCDs in Brazil are demographic, related to the growth and aging of the population, and to a greater urbanization, as well as changes in eating behavior and the adoption of lifestyles each time less healthy.¹

Among the NCD stands out diabetes mellitus (DM), characterized by a chronic hyperglycemic state, followed by metabolic disorders of carbohydrates, proteins and fat, characterized by hyperglycemia resulting from a deficiency of insulin secretion by the beta cells, peripheral resistance to insulin action or both, whose chronic effects include damage or organ failure, especially kidneys, nerves, heart and blood vessels.²⁻³ The types of diabetes are: Type I and Type II, specific types of DM and Gestational diabetes. In type II DM, the main pathophysiological phenomenon is the action of insulin resistance and the presence of modifiable and non-modifiable risk factors.⁴

Among the modifiable risk factors are overweight and/or the total obesity, central obesity, sedentary lifestyles, impaired glucose tolerance, metabolic syndrome (hypertension, decreased HDL and increase of triglycerides) and nutritional factors.²

There are 12,5 million diabetics, many of them without diagnosis⁵ and, according to the Ministry of Health of Brazil, from 1980 to 2005, mortality among men with diabetes increased from 9,6% to 19,5%, with a range of 103,6%, the highest among the 34 causes of death recorded in the country.¹

Faced with such information the reasoning arises: if a larger amount of men with DM die relating to women, would be for reasons of difficulties of men to recognize their needs, cultivating the magical thought that rejects the possibility of becoming ill, for issues of deficiencies in the health system that focus in health care for children, adolescents, women and the elderly and so the men got used to avoid contact with health services.¹

Also contributing, the fact that the functioning of health services is able to hinder the access for men, especially in primary care, since some aspects related to the hourly

labor, accessibility, the specificities of professional teams and to the structure of health services functioning, are influential elements of a lower demand by men for health assistance.⁶

Based on the identification of this problem and trying to correct a historical mistake, the Ministry of Health launched, in August 2009, the National Policy for Integral Attention to Men's Health - the PNAISH, to assist the men between 25 and 59 years old.⁶

The PNAISH searches for the qualification of health care of the male population in the care perspective that can safeguard the comprehensive care. Understanding that men only seek health care through a specialized attention, being necessary to create mechanisms that strengthen and qualify primary care, so that attention to men's health is not restricted to recovery, but ready to promotion and prevention of health and prevention of avoidable injuries.¹ Based on the above, this research aims to:

- Meeting the perception of men with diabetes mellitus type II regarding treatment.

METHODOLOGY

This is a descriptive and exploratory study of a qualitative approach. According to Silva and Menezes⁷, the qualitative-descriptive research is nothing but a dynamic relationship between the real world and the subject, that is, an inseparable connection between the objective world and subjectivity of the subject that cannot be explained by numbers. It is a descriptive survey, because researchers tend to analyze their data inductively, with the process and its meaning the main focus approach.

The scenario referred to in the study was a Family Health Strategy in the municipality of Montes Claros/MG. The research subjects were men with diabetes mellitus type II that have been inscribed in the Registration and Monitoring System of Hypertensive and Diabetics - HIPERDIA/2012. The number of participants was defined by theoretical saturation and there were interviewed eight men with DM type II.

The survey of research subjects occurred through the records of HIPERDIA of the year 2012, there were selected those that met the study inclusion criteria, being them in clinical conditions to respond to interview and accept participating. Once given the required characteristics and accepting in participate, the interview started in the participant's residence.

The instrument for data collection was a semi-structured script of questions, namely: What do you do to treat your diabetes problem?, 2) What do you consider important for diabetes treatment? Why?, 3) What do you think about the treatment of diabetes (diet, physical exercise and medication)?, 4) What are your difficulties in performing the treatment? and 5) Did you have any problem or got ill because of diabetes? Why do you think this happened or why your diabetes / glucose increased?

The interviews were recorded with MP3 player after explaining to participants the objectives and purposes of the study. To ensure the confidentiality, individuals are represented by the letter H (man) and the Arabic numerals determine an assigned code by the researchers, and signature of Informed Consent term and by them according to the National Health Council Resolution 466/2012⁸ The data collected were transcribed and later analyzed in the light of the technic of Analysis Content with thematic categorization. According to Bardin⁹ criteria is the set of analysis techniques of communications, which seeks, by systematic and objectives procedures of description of the content of messages, indicators (quantitative or not) that allow the induction of knowledge relating to production conditions/reception of these messages.

The project was submitted to Soebras Research Center / FUNORTE seem embodied with number 235147, CAAE No. 13340813.5.00005141.

RESULTS AND DISCUSSION

There were interviewed eight diabetics, of whom four older than 60 and four younger than 60 years old. About the marital status six were married and two were singles, seven had children. Regarding the occupation, five were retired, one student, one trucker and one farmer, about monthly income five earned minimum wages, one had no income and two earned more than a minimum wage, seven lived at home itself. Regarding the diagnosis time one had less than a year, four over one year, two over twenty years and one could not specify the time. After reading and analyzing the reports, three categories were identified: "Why diabetes is very dangerous for us" - Diabetes mellitus, "I take to know if it cures". - The pharmacological and non-pharmacological treatment of diabetes and "The greatest difficulty mine, is the area of power supply" - Difficulties in treatment.

♦ "Why diabetes is very dangerous for us" - Diabetes mellitus

The fact that diabetes is a chronic disease and its control requires the presentation of various types of behaviors are the main peculiarities associated with decreased adherence to treatment. Upon receiving the diagnosis of diabetes, the subject must change his way of life, which is the most complicated behavior change to be achieved. The diabetes treatment interferes with the routine clashes with social activities related to eat and drink and does not follow a set of fixed rules. In addition, treatment may produce side effects and associated risks, ie, weight gain, hypoglycemia, etc., it has a high financial cost and the diabetic need to spend time out of his day to day, taking care of.¹⁰

In this way, information about diabetes and the importance of self-care process allows to increasing the need to raise awareness about the risk factors for its development as well as its chronic complications among diagnosed.¹¹ We can see this in the phrase following on the perception of the risk of diabetes, where the interviewee says what he thinks about the disease:

[...] Because diabetes is very dangerous for us [...]. (H1)

The way a person sees the difficulties related to diabetes may also intervene in his adherence to treatment. If the person hides his condition, he can hardly present the conduct of self-care in public. In addition, only if the person trusts the benefits of treatment and in the probability of controlling his illness will present an active behavior in its treatment.¹⁰

The peculiarities of the treatment play a key role in adherence. The specifics of the therapeutic regimen, including its complexity, duration and side effects seem to assume a stronger role for membership than the particular characteristics of the individual.¹²

When including the patient's behavior to obtain information about diabetes and its treatment and the acquisition of specific skills, such as self-monitoring of blood glucose, self-giving injections, handling an insulin infusion pump and management of situations that differ from the routine constitute a prerequisite for self-care.¹⁰ Speeches below show insight about treatment adherence:

You have to deal with to heal. [...]. (H1)

[...] You control making the treatment within the patterns just right; you have an almost normal life. (H6)

It's cool, I feel good when I take the tablet [...]. (H7)

It is understood that, although healthy, diabetic patients are afraid of future complications and at the same time that the fear is a negative feeling, it can stimulate self-care positions. Such fears "the possibility of amputation, self-administration of insulin, the extreme dependence on care provided by others and, ultimately, death" are part of a natural process, inherent in the disease, as they are included to the new identity, which is acquired with the diagnosis of DM.¹³ Information described in the following quote:

[...] If you are [...] to the treatment you have a normal life, you will live normal, now if you do not do the treatment you will have complications, loss of limbs, you will only evolving the frame, there becomes more difficult for you to control [...]. (H6)

Diabetics suffering from the disease sequelae show greater adherence to treatment than those whom the chronic complications were undiagnosed. It is possible that the confrontation with the diagnosis of chronic complications increases the perception of vulnerability and severity of the disease and its sequelae, and the perceived benefits associated with adherence to self-care and consequently, improve the adherence to treatment.¹²

"I take to know if it cures" - Pharmacological and non-pharmacological treatment of diabetes

When referring to factors related to treatment, the prevalence of adherence to drug therapy is higher in patients who mention the need for changes in routine of daily life and those who did not present side effects related to medication to control diabetes. In the knowledge that the patient has about the medicine, the prevalence of adherence is higher in subjects who presented more informed.¹⁴

Thus, the control method includes the need for change in lifestyle and ideal weight maintenance, non-pharmacological measures are directed to all patients, the use of antidiabetic agents are directed to some patients. The choice is made on the basis of their mechanism of action, pathophysiology characteristics of each case of side events, ease to the patient and cost. For patients with DM type II, the advantages must be considered for each specific medication and which ones are best suited.¹⁵⁻¹⁶

As diabetes is a progressive disease, with the proceeding years, almost all patients require pharmacological treatment, in their majority with insulin, because the beta cells of the pancreas tend to progress to a state of partial or total failure over the years.²

Therefore, the reports below show that respondents are making use of drug treatment, expectantly waiting for improvements:

[...] I take to know if it cures. (H1)

Taking medicine to see if gets better [...]. (H4)

[...] Control it, taking the pills every day. (H7)

There are several classes of oral antidiabetics available for DM II, they improve glucose metabolism by different mechanisms and their results are additive. Not only the change in lifestyle and diet allow the patient reaching the established targets, it needs the use of medications alone or combined. A more rational approach combining drugs with different mechanisms seem to be more appropriate in most episodes.¹⁵

As regards the DM II patients assisted in primary care, the identification of personal responses facing drug taking must be continuous, so that we can know the factors involved in non-medication compliance and consequently intervene.¹⁷ Speeches below show the membership about the use of drugs by DM:

[...] Every day it is taken; every day we have to take it. (H5)

[...] I take the pill every day. (H7)

It is important, because it is remedy [...]. (H5)

Treatment adherence is a complex phenomenon and is influenced by many factors, and the diabetic belief about the medicine could be the key in relation to adherence to drug therapy. Often, patients adopt decisions about taking or not a medicine based on information received about them.¹⁴ You can understand the context in the following phrase when respondents cite drug therapy:

I take medicine! Some pills. (H1)

I take; we take because it is obliged to take, if you do not take the disease progresses. (H6)

It is of paramount importance to recognize the measurement of the adhesion of diabetic patients in drug treatment for diabetes control, by health professionals, in the presence of poor glycemic control and alleged failure in the therapeutic regimen instituted. The need for change in the daily routine of life of diabetic patients is related to the type of drug prescribed. The initiation of certain medications, such as insulin, requires the patient to adjust some of his daily habits, especially mealtimes and physical exercise.¹⁴

Because the drug treatment is of high cost and present contraindications and problems in

understanding about the appropriate dosage, the Brazilian Diabetes Society (SBD) has no drug intervention strategies that should be adopted in the first instance, and drug treatment started when changes of lifestyle (dietary control and physical activity practices) are not satisfactory to control the disease.¹⁸ The respondent expressed the fact in the following report which relates the change imposed to the same:

Diet! Ah, the diet has the role that the doctor gave, she does for me, the whole diet, I can't eat, I can't. The role I know what I can eat. (H1)

Some people can identify the change of eating habits as re-education and thus seek the balance between will and moderation, understanding this as positive change in their lives, emphasizing its benefits to the body and recognizing that the lack of control can be harmful.¹³ You can see some positive changes in the lives of patients:

What I do is eating fewer things that do wrong [...]. (H2)

First step is the power supply, because through the power supply you control the glucose. (H6)

The need for changing habits is perceived by most diabetics as an essential part of the treatment, but it is difficult to make this passage. Sometimes, the type of work of the person may be an obstacle to a more suitable power.¹⁹ You can see that in the accounts:

I do a diet like that, but it is not very well done. [...]. (H2)

Not 100%, more so trying to make functional diet so we know that there's still something missing. [...] Pasta, sugar, fat... people eliminate as much as they can. (H6)

[...] No, I eat everything that I can. (H8)

Even with all the barriers in adhering non-pharmacological measures by men, the nutritional treatment should be the main part of the therapeutic plan and may reduce glycated hemoglobin between 1-2%; it is based on the same basic principles of a healthy eating.²

We also emphasize that regular physical activity is recommended for all patients with diabetes; therefore, improves metabolic control, reduces the need for hypoglycemic agents, helps promoting weight loss in obese patients, reduces the risk of cardiovascular disease and improves the quality of life. Thus, the promotion of physical exercise is considered a priority.²

Some effects of physical exercise are well placed in the literature as increasing peripheral glucose uptake and increased insulin sensitivity. It is true, too, that physical

activity influences positively on cognitive function, mood disorders and sleep, bringing sensation of wellness. These variables together may account for the reduction in medical consultations, since patients have a self perception of improvement with exercise and start to look for medical services only when it is really necessary.²¹ The main practices reported were walking and cycling:

What I do, what I do is cycling, every day, it's hard not to cycling a day. (H2)

I go cycling about half an hour. (H4)

[...] I walk a lot; here and there. (H7)

Only walking. I walk every week. (H8)

Thus, the positive changes in life habits (food and physical activity) are of vital importance in achieving the goals of the treatment which are the relief of symptoms and prevention of acute and chronic complications.²

♦ "The greatest difficulty mine, is the area of power supply"- Difficulties with treatment

Due to the number of lifestyle changes that are imposed on people living with type II DM, a stage in life where their customs are already well consolidated, adherence to treatment of these has been a great challenge.¹⁹

The discrepancy between the habits adhered to by patients, social network and eating habits "prescribed" by the professionals to the DM carrier is named as a factor of complicating adherence to rehabilitation eating goals.¹³ It is noticed in the following account:

The difficulty I have is that I want to eat a lot of things and I can't eat. (H2)

You have to go on a diet, but this I little do, because I eat everything. (H4)

The simple episode of someone imposing changes in routine feeding may lead diabetes carrier to abandon the nutritional treatment. Thus, by proposing a new type of diet, it is important to know his eating habits, creating alternative proposals that help in the changes, avoiding deprive him of his eating habits.²²

The eating habits of people are built over a lifetime and are influenced by social and family life. The need for restructuring of the eating habits of diabetics becomes an even more comprehensive attitude, because it realizes that in order to have an effective change on the part of sick people, it is necessary that the environment in which they are inserted also passes through transformations.¹⁹ What can be seen in the following quote when the interviewee describes his difficulty in feeding area:

The greatest difficulty of mine, is in the area of food, because when you're at home you eat every three hours, looking for eat more things so that's inside. And when you're not at home eat what's on the street. It is more difficult. (H6)

The term "diet", often employed by both the respondents and by health professionals, in general, carries a connotation of constraint.¹⁹ That was realized in the following accounts:

[...] You can't eat a lot; you have to eat very little. More is green, you have to eat. (H1)

I control my mouth [...]. (H3)

It needs making a diet [...]. (H4)

These lines indicate the essential complexity to the modification of eating habits, keeping in view the variety of factors involved. When one thinks of the eating habits of a population, there are difficulties changes included, such as the conditioned habits, routine schedules, the cultural value attached to food, as well as socio-economic issues.²⁰

Chronic or long-term treatments, in general, have lower adherence, since treatment regimens require a large commitment of the patient, in some circumstances, need to modify their lifestyle to meet their treatment. For men, the qualitative research suggests several reasons, but in general, you can group the causes of low compliance in two main groups of determinants, namely: socio-cultural barriers and institutional barriers. In this way, the sense of 'loss' of force and the difficulty of access to services can explain this situation.²³

With respect to human health, there are historically established barriers, strongly evident in the work process of nurses when the patient does not adhere to treatment, does not participate in educational meetings and minimally seeking health services for preventive measures. This gap should be the focus of attention of professionals.

Diabetics should be asked about the presence of problems that hinder the adhesion due to the complexity of drug or non-drug treatment. The health care provider can offer simpler treatments adjusted to the patient's needs, in order to help him better understand the therapeutic regimen.²⁴

Nurses cannot take the position of indifference to a public health problem as relevant as it stands, representing a significant cause of morbidity and mortality. The prevention of risk factors is a signed challenge, aspiring help win a state of health and a better quality of life.²⁵

FINAL REMARKS

Diabetes mellitus is a disease that affects a large portion of the population, it is understood with this study that men are strongly predisposed to the complications of type II DM, since this group has greater difficulties in treatment adherence, including the reasons to recognize their needs along the culture that rejects the possibility of becoming ill, even for reasons of deficiencies in the health system that focus in health care for children, adolescents, women and the elderly, and men accustomed themselves to avoid contact with health services and for being the man often the head of the family, the work of time coincides with the health service, hindering the access, and the tertiary health service the demand, often late.

It can be seen in this survey where the men reported that they follow the medical treatment by obligation, and does not consider drug treatment as a constraint thus changing their habits and customs. It becomes imperative to differentiated approach to this genre, as there are often neglected their condition, not adhering to the treatment, and when they decide to treatment, complications already signed or have spread.

It is hoped that this study advances in knowledge in the care of human health, generating subsidies for development programs and other researches related to this topic.

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Submission: 2014/12/29

Accepted: 2015/07/04

Publishing: 2015/05/15

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