HEALTHCARE DEVELOPED BY PEOPLE WITH DIABETES MELLITUS AND SYSTEMIC ARTERIAL HYPERTENSION

CUIDADOS EM SAÚDE DESENVOLVIDOS POR PESSOAS COM DIABETES MELLITUS E HIPERTENSÃO ARTERIAL SISTÉMICA

CUIDADOS EN SALUD DESARROLLADOS POR PERSONAS CON DIABETES MELLITUS E HIPERTENSIÓN ARTERIAL SISTÉMICA

Mariane da Silva Barbosa1, Maria de Lourdes Denardin Budó2, Raquel Pötter Garcia3, Bruna Sudré Simon4, Margrid Beuter5, Lilian Medianeira Coelho Stekel1

ABSTRACT
Objective: to know the healthcare developed by people with diabetes mellitus and systemic arterial hypertension hospitalized in a medical unit. Method: this is an exploratory study with a qualitative approach, developed with eight people with diabetes mellitus and systemic arterial hypertension. The data production took place between April and June 2014 through narrative interviews and the analysis developed by the Minayo operative proposal. Results: the categories were grouped as: “Food always has, health not always”: nutritional care; “Care that I had to always have”: care relationship with the popular and professional sectors of assistance; and “Health is something that you can not neglect”: aid in the realization of care. Conclusion: the healthcare developed by users were related mostly to food. Still, other cares developed by users were found, conducted in the popular sector on influence of the professional sector.

Descriptors: Hypertension; Diabetes Mellitus; Nursing.

RESUMO
Objetivo: conhecer os cuidados em saúde desenvolvidos por pessoas com diabetes mellitus e hipertensão arterial sistêmica internadas em uma unidade de clínica médica. Método: estudo exploratório com abordagem qualitativa, desenvolvido com oito pessoas com diabetes mellitus e hipertensão arterial sistêmica. A produção de dados ocorreu entre abril e junho de 2014 por meio de entrevistas narrativas e a análise desenvolvida pela proposta operativa de Minayo. Resultados: as categorias foram agrupadas como: “Alimento sempre tem, saúde nem sempre”: cuidados com a alimentação; “Cuidados que eu tinha que ter sempre”: relação do cuidado com os setores popular e profissional de assistência; e “Saúde é uma coisa que não dá para descuidar”: auxílio na realização dos cuidados. Conclusão: os cuidados em saúde desenvolvidos pelos usuários estavam relacionados em sua maioria com a alimentação. Ainda, foram identificados outros cuidados desenvolvidos pelos usuários, realizados no setor popular sobre influência do setor profissional.

Descriptors: Hipertensão; Diabetes Mellitus; Enfermagem.

RESUMEN
Objetivo: conocer los cuidados en salud desarrollados por personas con diabetes mellitus e hipertensión arterial sistémica internados en una unidad de clínica médica. Método: estudio exploratorio con abordaje cualitativo, desarrollado con ocho personas con diabetes mellitus e hipertensión arterial sistémica. La producción de datos ocurrió entre abril y junio de 2014 por medio de entrevistas narrativas, el análisis desarrollado por la propuesta operativa de Minayo. Resultados: se agruparon las categorías: “Alimento siempre tiene, salud no siempre”: cuidados con la alimentación; “Cuidados que yo tenía que tener siempre”: relación del cuidado con los sectores popular y profesional de asistencia y “Salud es una cosa que no es para descuidar”: auxilio en la realización de los cuidados. Conclusion: los cuidados de salud desarrollados por los usuarios estaban relacionados en su mayoría con la alimentación. Además, fueron identificados otros cuidados desarrollados por los usuarios, realizados en el sector popular sobre influencia del sector profesional.

Descriptors: Hipertensión; Diabetes Mellitus; Enfermería.

1Caring Nurse of the of the Santa Casa de Caridade São Gabriel Fraternity, São Gabriel (RS), Brazil. E-mail: marianedasilbarbosa.enf@gmail.com; 2Nurse, Ph.D. in Nursing Philosophy, Nursing Department/Postgraduate Nursing Program, Federal University of Santa Maria/PPGEnf/UFSM. Santa Maria (RS), Brazil. E-mail: lourdesdenardin@gmail.com; 3Nurse, Nursing Master’s Professor, Federal University of Pampa, Ph.D. in Sciences, Federal University of Pelotas/UFPEL. Pelotas (RS), Brazil. E-mail: raquelpottercara@gmail.com; 4Nurse, Master’s Degree in Nursing. Professor of the Federal University of Pampa, Campus Uruguaiana. Uruguaiana (RS), Brazil. E-mail: enf.brusimon@gmail.com; 5Nurse, Ph.D. in Nursing, Nursing Department/Postgraduate Program in Nursing, Federal University of Santa Maria/PPGEnf/UFSM. Santa Maria (RS), Brazil. E-mail: margridbeuter@gmail.com; 6Caring Nurse, Radiotherapy Sctor, University Hospital of Santa Maria. Santa Maria (RS), Brazil. Master’s Degree in Nursing. E-mail: lilianstekel@gmail.com.
INTRODUCTION

Diabetes mellitus (DM) and systemic arterial hypertension (SAH) are diseases that have been prominent among the population, as currently are part of the reality of most users and health services, as the DM associated with SAH is considered the first cause of mortality and hospitalizations in Brazil.1

Diabetes mellitus is characterized by being a “metabolic disorders group having in common the hyperglycemia, resulted from defects in insulin action, insulin secretion or both.”2,5 Estimations approach that the world population with the disease is 382 million, with the possibility, in 2035, to reach 471 million. DM interferes in the quality of life of people and their families and can lead to systemic involvement2, and primary prevention focused on the people lifestyle that must be a global political priority to reduce new cases.3

Worldwide, the SAH in 2012 reached 600 million people, of which 24.3% were part of the Brazilian population. It represented 26.9% in women and 21.3% in men. In the range of 65 years, 59.2% were diagnosed with the disease, 3.8% in the range of 18 to 24 years and 8.8% from 25 to 34 years.4 It is a disease that hampers the adherence of people to treatment, especially because their course is asymptomatic.5

Non-adherence to treatment may be due to lack of patient’s knowledge about SAH, lack of motivation for the treatment of an asymptomatic and chronic disease, low socioeconomic status, low self-esteem, relationship difficulties with the health team, problems in scheduling consultations, high cost of medications, adverse effects, and changes in quality of life resulting from treatment initiation.5

Complications that occur for loss reason of these diseases can lead to hospitalization, and among the main complications of DM it highlights the commitment of the eyes, kidneys, nerves, brain, heart and blood vessels and SAH of cerebrovascular disease, coronary heart disease, heart failure, chronic kidney disease and peripheral arterial disease.1,6 To avoid these complications, patients with DM need to be oriented to develop personal care, physical activity practice, food planning, medications control, monitoring blood glucose levels, foot care, among others.2 The healthcare for SAH can be developed through changes in lifestyle and drug therapy.5

In this sense, the care provided for the DM and SAH treatment may involve several aspects, which permeate the three healthcare sectors, which are superimposed and interrelated.7 The informal or popular sector is characterized by the layman domain, self-treatment or self-medication, where healthcare is provided based on advice or treatment recommended by family, neighbors....

Moreover, the informal sector includes a set of beliefs concerning the maintenance of health. The main healthcare in this sector is developed by the family.4 In popular or folk sectors healers are present, which occupy an intermediate position between the informal and professional sectors. And finally, the professional sector comprises the professions of health treatment.7

Based on these considerations, this work is justified because, with the performance of searches in databases, it was observed that few published studies9–10 address the healthcare developed by users related to chronic illness, before the hospitalization. In some studies, issues related to the process of taking care of professional nursing11 and meaning of life experience were found.12

Thus, the present work has as object: How people with DM and SAH, hospitalized in a medical unit develop healthcare? To answer this question, the objective is to meet the healthcare developed by people with diabetes mellitus and systemic arterial hypertension hospitalized in a medical unit.

METHOD

This is an exploratory study with a qualitative approach, developed with eight people with DM and SAH, who were hospitalized in a medical unit, located in a university hospital in southern Brazil. These were selected through access to medical records, featuring an intentional search of those with DM and SAH.

The study included patients admitted to the medical clinic hospital II in question, with DM and SAH diagnosis, confirmed in medical records, older than 18 years and those with limitations for verbal communication and difficulty getting around due to the need to displacement to a unique room, located on the floor of the unit, to perform the interview, were excluded.

Data collection was carried out from April to June 2014 through narrative interviews.13 Interviews had guiding principles, being: illness: how it happened (from the beginning to the time of the interview); care: how is the
care provided in the disease process; care learning: people and institutions that are part of the context and assist in care.

The interviews were recorded on a digital recorder with the prior consent of the participants, transcribed and saved to the computer for data analysis. The data collection phase was completed when the study objectives were achieved. The process of data analysis, after transcription, was composed by the Minayo14 operative proposal, consisting of three stages: pre-analysis, material exploration, and treatment of results and interpretation. In the pre-analysis, the analyzed information was organized, the initial goal was resumed, and indicators were elaborated to assist in the interpretation of data. In the material exploration, the clipping text, classification and data association, and select categories were held. In the treatment of the obtained results and interpretation, the division of the results was performed, highlighting the obtained information and after the data interpretation.14

Participants were informed about the study and signed a Consent Form. To preserve the anonymity of the respondents, the letter I was used, which means “interview”, and sequential numbers identifying the order in which these were held, for example, I1, I2. The research followed the ethical principles recommended by Resolution 466/1215 of the National Health Council, which guides and protects the participants of scientific research involving human subjects and was approved by the University’s Ethics Committee linked to the project under the opinion number 556,349.

RESULTS

Initially, the characterization of study participants is exposed, which was elaborated from socio-demographic information, containing items such as age, gender, marital status, education, occupation, religion, history of illness in the family, disease diagnosis, reason for hospitalization and time of diagnosis, according to information reported by respondents (Figure 1). Of the eight participants, most were female (five), aged between 42 and 72 years, average 61.5 years; four of the participants were married, three separate and one widower; five participants had not completed elementary school, two had incomplete high school, and one had completed elementary education; occupations were varied, for example, farmer, agriculture, mason, housewife, housekeeper, retired and three participants performed more than one job; the Catholic religion was predominant in seven participants and one evangelical; six participants had a history of non-transmissible chronic diseases in the family, being stroke, SAH, and DM; the reason for hospitalization in three participants was due to cardiovascular problems and other by lung problems, decompensated DM, kidney problems, and biopsy. Through the history of the disease discovery and age of patients, according to literature2, they have type II DM, which can not be exactly confirmed in this research because this information is not clear in the medical records of patients and they also were not aware of the type of DM when asked.

<table>
<thead>
<tr>
<th>PART</th>
<th>Socio-demographic data</th>
<th>AG</th>
<th>GE</th>
<th>MS</th>
<th>ED</th>
<th>OCUP</th>
<th>REL</th>
<th>DHF</th>
<th>DP</th>
<th>HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>59</td>
<td>M</td>
<td>Divorced</td>
<td>IES</td>
<td>Farmer Mason Housewife</td>
<td>Evangelic</td>
<td>CVA</td>
<td>SAH, DM, Angina, CSWST</td>
<td>SAH, DM, CHF, RI</td>
<td>Cardiovascular problem</td>
</tr>
<tr>
<td>E2</td>
<td>55</td>
<td>F</td>
<td>Married</td>
<td>CES</td>
<td>Farmer Housewife</td>
<td>Catholic</td>
<td>SAH</td>
<td>SAH, COPD, DM, Hyperthyroidism</td>
<td>SAH, DM, MRS, AMI</td>
<td>Cardiovascular problem</td>
</tr>
<tr>
<td>E3</td>
<td>72</td>
<td>M</td>
<td>Married</td>
<td>IES</td>
<td>Retired</td>
<td>Catholic</td>
<td>-</td>
<td>SAH, COPD, DM, Hyperthyroidism</td>
<td>SAH, DM, MRS, AMI</td>
<td>Cardiovascular problem</td>
</tr>
<tr>
<td>E4</td>
<td>71</td>
<td>M</td>
<td>Married</td>
<td>IES</td>
<td>Retired</td>
<td>Catholic</td>
<td>-</td>
<td>S, DM, Strange endobronchial body</td>
<td>S, DM, Strange endobronchial body</td>
<td>Biopsy</td>
</tr>
<tr>
<td>E5</td>
<td>71</td>
<td>F</td>
<td>Widower</td>
<td>IHS</td>
<td>Farmer Housekeeper</td>
<td>Catholic</td>
<td>SAH</td>
<td>DM</td>
<td>S, DM, Strange endobronchial body</td>
<td>S, DM, Strange endobronchial body</td>
</tr>
<tr>
<td>E6</td>
<td>42</td>
<td>F</td>
<td>Divorced</td>
<td>IHS</td>
<td>Housekeeper</td>
<td>Catholic</td>
<td>DM</td>
<td>SAH, DM, Bronchitis, Asma</td>
<td>SAH, DM, Bronchitis, Asma</td>
<td>Decompensated DM, lung infection</td>
</tr>
<tr>
<td>E7</td>
<td>71</td>
<td>M</td>
<td>Married</td>
<td>IES</td>
<td>Housekeeper</td>
<td>Catholic</td>
<td>SAH</td>
<td>COPD, SAH, DM</td>
<td>COPD, SAH, DM</td>
<td>Renal problem</td>
</tr>
<tr>
<td>E8</td>
<td>51</td>
<td>F</td>
<td>Divorced</td>
<td>IES</td>
<td>Housekeeper</td>
<td>Catholic</td>
<td>SAH</td>
<td>DM</td>
<td>SAH, DM, Dyslipidemia</td>
<td>SAH, DM, Dyslipidemia</td>
</tr>
</tbody>
</table>

Figure 1. Characterization of interviewed participants. A Municipality of Rio Grande do Sul, 2014.
Subtitle: PART- Participants; AG - Age; GE - Gender; MS - Marital Status; ED - Education; OCUP - Occupation; REL - Religion; DHF - Disease History in the Family; DP - Diagnosis Pathology; HR - Hospitalization Reason; F - Female; M - Male; IES - Incomplete Elementary School; CES - Complete Elementary School; IHS - Incomplete High School; CVA - Stroke; SAH - Systemic Arterial Hypertension; DM - Diabetes Mellitus; CSWST - Acute Coronary Syndrome Without ST-segment elevation; CHF - Congestive Heart Failure; RI - Renal Insurgency; COPD - Chronic Obstructive Pulmonary Disease; MRS - Myocardial Revascularization Surgery; AMI - Acute Myocardial Infarction.

English/Portuguese
1741
The categories organized by the data analysis were: “Food always has, health not always”: nutritional care; “Care that I always had to have”: care relationship with the popular and professional sectors; and “Health is something that you can not neglect”: aid in the realization of care.

Food always has, health not always: nutritional care

We will discuss in this category the healthcare of patients related to food, such as those that were necessary with DM and SAH appearance, those involving questions about the disease and also habits acquired after the illness situation.

For most respondents, one of the main reasons that led to the emergence of DM and SAH was the food.

There are three years that Diabetes appeared. I think it was, at least the doctor there thought it was because of the food. I was exaggerated, I do not deny. I will say that the mouth takes many good things, but also kills easy right […] Because we, I ate only strong thing […]. (I1)

One day I went to the doctor, and he said it would be OK, if you do everything right with food […] Then I put in my head that would not be the food that would hurt me, then I began. (I7)

In I1 testimony, there is a concordance with the conclusion obtained by health professionals related to the appearance of the disease, recognizing that their eating habits were excessive. In contrast, it was found that the I7 user goes beyond recognition because food always has, health not always: nutritional care; “I never liked sweet, doctor? It is something that you can not neglect”.

On the other hand, in a participant declaration is possible to identify the performance of nutritional care, but appear questions that relate them to the development of the disease.

For example, in the coffee and stuff, I can not eat a lot of sweetness, I never ate sweet […] I told the doctor […] how I got diabetes? If I never liked sweet, doctor? It is funny that everyone says does not eat sweet because of diabetes, and I never ate, how it got diabetes? (I4)

It can identify that the cause for the emergence of DM generates questions since it is often specifically related to sweet intake. This situation can be detected both in the hospital and in the community since this doubt it is still very strong in the general population. Thus, it is a cultural issue that influences the way that care is established, as diabetes is a disease that can be caused by some factors including not only consumption of the “sweet.”

A study performed with DM patients pointed out that most of them had partial knowledge about the development of the disease and the issues related to glucose control and food.18 Accordingly, in the guidance of health professionals for this population, one should advocate an approach that includes dietary aspects, physical activity practice, medications, psychosocial issues, risk factors and previous history of diseases, among others.1 Referring specifically to food, the available information can be better articulated with the social, cultural and economic development of people1, promoting their autonomy and adaptation within their possibilities.

Still, the routine of respondents has changed after the discovery of the disease, since they now have greater attention to diet.

On the one hand, changes, changes a little, having to take more care, knowing that you are with that there you need to be careful because has not healed. Then you know you have to take care, […] sometimes you exaggerate and eat because eating every day is worse, then once another you eat something else. (I4)

Everything is controlled, it is now controlled, because we used to buy lard, but now had to change to oil, less fat, less salt and those spices that we used a lot […] The poor always buy the most cheaper […] but when we cannot, the cheaper becomes more expensive, which is our health […] great care is […] The health of the person

This situation can be detected both in the hospital and in the community since this doubt it is still very strong in the general population. Thus, it is a cultural issue that influences the way that care is established, as diabetes is a disease that can be caused by some factors including not only consumption of the “sweet.”

A study performed with DM patients pointed out that most of them had partial knowledge about the development of the disease and the issues related to glucose control and food.18 Accordingly, in the guidance of health professionals for this population, one should advocate an approach that includes dietary aspects, physical activity practice, medications, psychosocial issues, risk factors and previous history of diseases, among others.1 Referring specifically to food, the available information can be better articulated with the social, cultural and economic development of people1, promoting their autonomy and adaptation within their possibilities.

Still, the routine of respondents has changed after the discovery of the disease, since they now have greater attention to diet.
is in the first place, that food always has and health not always. (16)

(Professionals) Do not want me to mix the food, for example, pasta, rice, potatoes, have to eat only a delicacy. (13)

Concerning the declarations, it was observed that the routine of people changes. It appears that they now have greater care with their health and especially with food trying to eat products with less sodium and more varied. Nevertheless, even if they know about the need to control sometimes exceed the limits, as in the case of 14 testimony, however, says to be aware that this can not be done daily.

Chronic diseases affect the routine of people in their way of life and their relationship with the environment. Individuals experience different situations and need to adapt.19 If the user feel's that their freedom is threatened, i.e., with the presence of restrictions imposed by the disease, the more they will have to reacquire it, and may lead to opposite answers20 not beneficial to their health.

Reflecting about that category, it can be said that the food was identified as the main triggering factor of diseases such as DM and SAH. Participants mostly reported that who committed exaggerations and often had no control because they did not know the risk of developing a disease for life, a chronic disease. However, from the moment they were faced with this reality, they decided to change, to do something for their health by entering care into their routines, such as control of salt and fat, paying attention to the limits imposed by the experienced condition.

Still, at various moments during the interviews, respondents were able to do an analysis of how was routine before the illness and how has become after reflecting about the importance of healthcare.

Care I always had to have: care relationship with the popular and professional sectors

In this category we will discuss the care in health developed by people in addition to the food, care arising from the experience in the popular and professional sector and the relationship of these sectors.

After the discovery and early treatment for DM and SAH, in addition to food, people have come to include other care into their routine.

What I cared was the lift, in the walk, and if I felt bad I stopped [...] So it were such care that I had to always have. (11)

Some care as not lifting much weight, do not walk too far, look walking around, most often, more times, and when felt tired, sit down, take a deep breath, used a bottle of water always together, day by day. (16)

It is possible to identify that participants now include simple care, in their routine, arising from experiences of the popular sector. However, those are classified as important and as care that should be continuously performed due to requirements imposed by the disease.

Care is defined by people according to the needs of each situation, considering the prior experiences and resources available for the moment.21 Thus, it can be said that people care according to what seems most appropriate to address the everyday adversities.

Still, as a specific influence of the popular sector, certain care were learned to live with parents, as we can identify in this statement:

For the pressure [...] when I was O I was taking lemon juice, I saw when I was OK, I was really dizzy [...] then I took the lemon juice [...] My mother said, the cane sugar sheet lows pressure, lemon juice lows pressure, those with low pressure can not take the lemon juice, it goes very down [...] When I'm with high pressure I squeeze a lemon or suck a lemon, you'll see the difference. (18)

Although the identification of signs is a feature of the professional sector, some respondents use their care of the popular sector to treat them. The user started to identify when her pressure was altered using signals, which shows the influence of the professional sector. However, one realized this situation, and she was using knowledge shared with her mother, who also had high blood pressure and makes use of lemon juice.

The study showed that lemon has pharmacological properties for HAS22 treatment; however there are few studies focused on this theme. Thus, it is evident the influence of the popular sector in the routine of respondents.

In this sector, the healthcare is performed based on advice or treatment recommended by family or neighbors. In addition, the popular sector includes a set of beliefs concerning the maintenance of health.8 It is necessary to understand the view that the user has about SAH, taking into account their beliefs, values and the environment in which it is inserted because these interfere in their attitudes and choices.23

Besides the presence of specific features of the popular sector, were also detected care that is characterized by the interrelation of popular and professional sectors of care.
I see the pressure at home, in winter the pressure is always a little higher and in the summer it changes [...] So if I cannot eat very sweet, I do not eat, sometimes I have to eat, you know what diabetes is, if you do not eat a sweet, it goes down a lot [...] then you have to go there in the fridge and take a sweet there [...] it rises again, and diabetes rises. (I4)

And we [...] anything, ah, I'm dizzy, then if you do not take the pressure medicine, it varies. Because the pressure as is good it can give you a tumble and hurt you. (I1)

In these statements, one can see the care that people develop are related, in most cases, to the professional sector, mainly because although they perform these practices in their daily lives and away from health services, there is an influence of biological knowledge originated from the health professionals. The participant has the device and check the pressure and can observe values, but may also have been oriented thereby, showing the relationship between the sectors. About DM, when the participant realizes is hypoglycemic eat a sweet, knowing that through the way the glucose levels tend to normalize. In this case, the relationship of the popular sector and professional is affirmed, since this is care that the person has at home, however, was probably guided by a health professional and with the disease convivial it was incorporated into their experience.

People with health problems move between the popular and professional sectors, and can use them together.7 8 The care is related to healthcare sectors, which are cultural systems interconnected using interpersonal relationships.7

Health is something that you can not neglect: aid in the realization of care

Healthcare developed will be discussed by respondents in this category with the doctors help, health workers and spouses.

Concerning the professional assistance they receive for the development of healthcare, people reported receiving support from doctors and community health workers (CHW).

This is the doctor, and there are several there (health unit). Ones stay two months, other three months [...] They help telling we need to take care in the food [...] To not exaggerate, because if it is a rice spoon of rice, is a spoon rice [...]. (I1)

I already got the pressure device, and glucose also, is the family health (FHS) that we have there [...] Health Agent (ACS), which goes in homes, and has a monthly meeting of hypertensives also, they guide us a lot. (I2)

There is one time a month he comes at home, the health agent, then she asks if you measured glucose, blood pressure, and she said that I must be more careful [...] We have to be careful because health is something that you can not neglect (I5).

As I1’s testimony, who assists in the achievement of healthcare is the doctor, especially in the establishment of the diet. In the testimony of I2 and I5 users, the support received comes from CHW, which conducts home visits and guidelines about blood pressure, diabetes, nutrition, and others care. It is noteworthy that despite the present study is developed in the hospital, it was possible to identify that the main support offered to these people comes from primary care, and in this context they receive guidelines about DM and SAH, actually considered beneficial to the current health model in Brazil, which should be called the basic attention to the healthcare of these illnesses. Also, health workers, to conduct home visits, enable maintained the bond between the service and the user.

These findings can be justified by that given in the policy of primary healthcare, which defines as a strategic area the control of DM and SAH.24 Also, the CHW aid is fundamental for the organization of healthcare, as well as qualification of access, hosting, link establishment and care longitudinal.25 CHW acts as a mediator, contributing to the interrelationship of popular and professional knowledge26 and for being a resident of the place, has cultural elements similar to those of users, such as their living conditions, ethnic aspects, territorial, knowledge and popular practices of care, the imaginary and the representations.27

It is noteworthy that, although the nurse is part of the health team, was not mentioned in the interviews. It is known that CHW home visits do not replace the visit of nurses, though it was possible to identify in this research, that these professionals are not present in the guidance provided to participants, which leads to the following question: Is the CHW or the doctor are assuming the role of nurses? What about the health education group with hypertension, which was cited by some participants, who would be performing? Why the presence and importance of nurses are not being considered? The nurse both in primary as hospital care should work directly with the patient, being one of the main responsible for the construction of care to the disease process.
However, in addition to assistance in these environments, the nurse performs activities related to management, bureaucratic and administrative issues, a fact that might be interfering with the recognition of the professional by the user. The activities performed by nurses are associated with the idea that this professional develops many activities, which leads them to the removal of their role in the full care and close to the patient. In addition to the health team support, participants revealed that also receive help from their families at home, especially their partners.

My wife. At home is with her, she always takes care […] After I joined this woman I never needed to go to the doctor because of pressure. (I1)

My wife. We both take care. Then if we go on a birthday, I go, but if I eat little I will not go, then she sees if I eat more and says, you ate two, three, now is enough, do not advance very much. (I4)

In the testimony of I1 and I4, it is possible to identify that is the wife who helps in achieving healthcare. It can be said that family participation in care is important, since it seeks to maintain the well-being of all, and can be fundamental to the continuity of care. When you have a chronic disease, it is possible that mainly the closest members of the patient, as wife’s, become involved in this context, since the care require changes in lifestyle, especially food, interfering in their routine.

Affective support functions, socialization, and care are performed in the family system. In this relationship of support, the family named for the exchange of information are those who have closer emotional ties, being especially represented by partners, which can be confirmed by the testimonies of this study. Historically, women are, in large part, responsible for family care, even after their insertion in the labor market.

CONCLUSION

It was observed that most of the participants in this study had more than one chronic disease, which increases the risk for the development of possible complications such as heart failure, chronic kidney disease, ocular compromising, nerve, kidney, brain, among others, as some already present. Also, most of the participants had a history of family members with DM and SAH, which can be related to the development of the disease, although they have not verbalized this relationship.

Concerning healthcare developed by the interviewees, it was found that they were associated mostly with food and that most of them believed that it was one of the main reasons that led to the development of DM and SAH. Still, the daily routine has changed after starting the healthcare with food, as become to control the salt, sugar, among others.

Besides food, other care could be identified developed by respondents, which are mostly made in the popular sector influenced on the professional sector. The care they develop were adequate to their reality, and can be verified that the popular and professional sector work together. Still about the care sectors, any interviewed talked about practices related to folk, a fact that could be related to the hospital setting and would be better revealed in research that would focus on this sector as an object of study.

Concerning the support received for the realization of care, they mostly reported having support especially from physicians, community health workers and their companions. In this research, the nurse was not mentioned, which demonstrates the need for attention to these professionals and approach to these people, who need guidance and health education practices. Nursing, knowing how the care is developed, can assist in work strategies planning with these people in the future, thereby facilitating a better quality of life and contributing to the reduction of complications of DM and SAH.

REFERENCES


Barbosa MS, Budó MLD, Garcia RP et al.

Submission: 2015/07/17
Accepted: 2016/04/04
Publishing: 2016/05/01

Corresponding Address
Raquel Pötter Garcia
BR 472 - Km 592
Caixa Postal 118
CEP 97508-000 – Uruguaiana (RS), Brazil