DIFFICULTIES EXPERIENCED BY DIABETES MELLITUS CARRIERS RESIDENTS IN RURAL DISTRICT

LAS DIFICULTADES EXPERIMENTADAS POR EL PORTADOR DE DIABETES MELLITUS RESIDENTE EN DISTRITO RURAL

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ABSTRACT
Objective: Identifying the difficulties experienced by diabetes mellitus carriers living in rural district. Method: a qualitative approach study with 12 people with diabetes mellitus registered in a Health Family Unit of a rural district. The production of data was carried out through interviews recorded with the following question << What are the difficulties that you find by experiencing diabetes mellitus residing in a rural area? >> The interviews were transcribed and analyzed by the technique of thematic content analysis. Results: the reports expressed difficulties regarding the geographical distance of the Family Health Unit, the need to taking many medications and their side effects, limitations and impediments to work, presence of alcohol and tobacco addictions and the gene pool as a family legacy. Conclusion: primary care needs to promoting actions and educational strategies that allow the DM patients getting the knowledge to prevent and minimize the signs and symptoms of chronic manifestations of the disease. Descriptors: Diabetes Mellitus; Lifestyle; Health of The Rural Population; Nursing.

RESUMO
Objetivo: identificar as dificuldades vivenciadas por portadores de diabetes mellitus residentes em distrito rural. Método: estudo de abordagem qualitativa com 12 pessoas com diabetes mellitus cadastradas em uma Unidade de Saúde da Família de um distrito rural. A produção de dados foi realizada por meio de entrevistas gravadas com a seguinte questão << Quais as dificuldades que você encontra por vivenciar o diabetes mellitus residindo em uma área rural? >> As entrevistas foram transcritas e analisadas epla técnica de análise temática de conteúdo Resultados: os relatos expressaram como dificuldades a distância geográfica da Unidade de Saúde da Família, a necessidade de tomar muitos medicamentos e suas reações adversas, limitações e impedimentos para o trabalho, presença dos vícios do álcool e do tabaco e a carga genética como um legado familiar. Conclusão: a atenção básica necessita promover ações e estratégias educacionais que possibilitem ao portador de DM obter o conhecimento para prevenir e minimizar os sinais e sintomas das manifestações crônicas da doença. Descritores: Diabetes Mellitus; Estilo De Vida; Saúde Da População Rural; Enfermagem.
INTRODUCTION

Diabetes mellitus (DM) is in a heterogeneous group of metabolic disorders characterized by hyperglycemia. It is associated with complications, dysfunction and failure of various organs that are the result of defects in action and/or secretion of insulin.1

DM has a high morbidity and mortality among the population, with significant loss in quality of life for patients with this disease. It is a leading cause of kidney failure, lower limb amputations, blindness and cardiovascular disease.2

Education for self-care constitutes a fundamental strategy for the treatment of the person with DM. There has been a significant lack of knowledge and ability to manage the disease in 50%-80% of diabetics.3

This situation is even worse for DM rural residents who suffer from the unavailability of health services near the area they reside and/or reduced access to these institutions.4

It is necessary developing educational strategies that enable the person with diabetes, and get the knowledge to manage the disease, can incorporate it into their daily lives. Therefore, it is necessary to recognize the individual as body and mind inserted in a social and cultural context for proper sizing and targeting health actions, especially the establishment of primary and secondary prevention measures.5

The difficulties that people with DM living in rural areas face because of disease is of paramount importance to establish a treatment plan that minimizes complications of the disease and improve the quality of life of these individuals.

Driven by this problem this study aims to:

- Identify the difficulties experienced by people with diabetes living in a rural district.

METHOD

A descriptive study of a qualitative approach conducted in rural district of a medium-sized city located in the north of Parana State, Brazil. The study population consisted of patients with type 2 DM, aged between 40 and 60 years old, enrolled in a Family Health Unit (FHU) of the district. For selection of respondents participants proceeded to a draw among the 43 patients of type 2 DM users registered on that drive.

The total number of participants was defined according to data saturation method and convergence of information, which occurred in the 12th interview.3
emergence of a disabling disease is an especially critical moment of facing up to the family, since it affects all members.  

The diabetic patient’s treatment, as in any chronic condition, should consider the provision of a planned care, involving time, health providers and scenarios, training for self-care at home, support of social facilities and comprehensive policies for their effective management. To accomplish this care education programs in diabetes have added the family as a unit of treatment.

However, knowing how to live with the disease also depends on the individual characteristics of the individual acceptance and their expectations about life. Attitudes triggered in patients are rich in emotional content related to non-acceptance of disability and loss of autonomy. Awareness of the changes caused to you and the family leads to intolerance reactions, impatience, nervousness and frequent emotional lability.

In this sense the family structure influences the behavior of its members and the health status of each individual, in turn, also influences the functioning of the family unit. Studies show that the family is an institution that has a strategic importance in the sense that it can help or not a person with diabetes to properly manage the illness and achieve treatment goals.

Difficulties experienced by diabetes mellitus does not show up in clinical consultations to monitor the disease.

In addition, the availability of health services near the place of residence, including primary care health units and pharmacies, or reduced access to these types of care may be important factors for the lower consumption of essential medicines for treatment and control of disease.

Complications of diabetes mellitus often arise

Complications of diabetes are classified into acute and chronic. Among the acute complications are diabetic ketoacidosis, hypoglycemia and coma hyperosmolar non ketogenic. These complications are easy to clinical management, but can have serious consequences if not treated in time.

I had a lot of headaches, I was and I fall and I ended up in the ICU, when I saw was already dying, just after ICU that I discovered it was diabetes. (E6)

I feel pain in the legs, feet, and body; have bad sight when diabetes rises. (E10)

DM carriers with acute complications require urgent medical attention. A fact that represents a difficulty to residents of rural areas, since the distance and the bad road conditions for ambulance access delay medical care.

Respondents also expressed the presence of chronic complications related to DM in the following reports:

In addition to diabetes, have heart problems, high blood pressure and kidney problems. (E9)

I am awaiting a kidney transplant, because mine are stopping. (E4)

Diabetes is a terrible thing, you lose your toes, legs, kidneys, goes blind, imagine being with a handbag stuffed belly to pee, my God it is very difficult, brings a very great anxiety. (E9)

All study participants had DM complications, the most common diabetic retinopathy, chronic renal failure and diabetic foot. The interviewees’ statements also show the feelings of anxiety and fear of losses that the disease can cause.

Chronic complications arise from macrovascular and microvascular changes and manifest in coronary, cerebral and peripheral arteries of the lower extremities. There are the main causes of kidney failure, lower limb amputations, blindness and cardiovascular disease.

The emergences of chronic complications are the leading causes of mortality and worsening of the patient’s quality of life with diabetes. These chronic manifestations are...
frequent causes of disability in people in productive period.10

In a study of DM patients seen at a FHU in Fortaleza users also reveal that the chronic condition of diabetes is a threat to life, showing the fear that the disease evolve with complications and lead to death. This morbid thought leads us to understand a little more about the feeling of anguish expressed by respondents and how the multidisciplinary team should approach the social and cultural reality.11

Add to ace DM complications arterial hypertension (AH) and obesity, comorbidities frequently found in the same patient.12

The statements following the people of E2 and E9 demonstrate the difficulty in maintaining weight, both suffer with obesity:

My difficulty is to lose weight, my blood pressure is too high, and the time I resolve will become a bird. (E2)

I need to lose weight because of heart. I have a hard time even to talk, I stop eating I step down, and I get up three hours in the morning to eat, because of diabetes. I weight 116 kg. (E9)

Obesity, like HA, becomes a major diabetic and severity syndrome. Both affect the majority of people with diabetes and are important risk factors for coronary heart disease and microvascular complications such as retinopathy and nephropathy.2

The emergence of chronic complications often brings on an emotional shock to the person who is not prepared to live with the limitations arising from the clinical condition and need to change your lifestyle, generating feelings of anguish and anger.

Physical limitations that the diabetes mellitus causes impeding the exercise of work

Although the work is a great means of social development and human personnel to the diabetic complications of the disease hinder their work activities, which cause discomfort and suffering:

I got to lose service, lost a firm. (E2)

Working cannot even dream, because I spend very badly, I have to take care of kidney problems and am managing diabetes. (E4)

It's difficult! Six months ago I was still quite a lot, but got worse and now I cannot do anything; badly do lunch, supper for me and for my husband. (E10)

The chronic nature of diabetes, the severity of its complications and the means for its control has high costs for individuals, families, community and society. Disease progression can lead individuals to abandon the work activity or present limitation in their professional performance.13

Work activities are important to human existence and its relationship with the material world and psychic because, through them, the human being lives and relates to the external environment; individuals seek to satisfy their needs, that is, seek pleasure and avoid suffering.14

The statements show the various impediments to work resulting from the effects of DM. The loss of motor strength, weakness and physical fatigue are prohibitive or restrictive to perform the simplest tasks such as care home.

Difficulties experienced by diabetes mellitus...

In the account of respondents noticed the difficulty of abandoning tobacco addiction and alcohol:

What scares me is not being able to quit smoking. (E1)

Beer is needed, but it's better than dying sweet, but it's hard. (E2)

The association between tobacco and DM treatment worsens the prognosis seen acting in target organs worsening oxygenation levels in these and causing ischemia and premature aging of the entire circulatory network. It is estimated that in the world one billion and 300 million smokers, of which 80% live in developing countries and Brazil is the seventh largest number of smokers in the world.15

Another destructive factor in quality of life DM carrier is alcoholism. Excess alcohol prevents the release of glucose stored in the liver which can result in hypoglycemia, sometimes severe. This situation is even more common among people treated with insulin or oral hypoglycemic.2

Despite the risk to life, caused awareness for association of these addictions and the DM, respondents express fear and anxiety cannot abandon them. One E2 presents in his speech the concern with drinking, understanding that it is associated with your disease will take you to death.

Impediments to change eating habits

The speech of respondents reveals the struggle between what needs to change in the feeding and the desire of what likes to eat.

I had to think about what I can eat, I was eating too many candies. (E5)

It was difficult because we can't eat anything, especially the sweet and pasta. I had to change the feed at all. (E7)

Study of 150 adults living in rural areas showed that the eating habits found (habitual...
consumption of simple and complex carbohydrates, especially sugar, rice, bread and flour, fats, especially animal and margarine) contributes to the increase in frequency obesity, diabetes mellitus and hypertension.  

The change in eating habits DM Carrier is one of the first aspects to be modified to control the disease. However, giving up eating food that like in the desired quantity is one of the points of greatest significance for the person with diabetes as expressed in the following statement:

I like a lot of pasta, but it all turns into sugar and this does harm. We do a little diet, lose and gain weight. Sometimes you regret eating, get the pleasure of people.  

(E11)

The interviewee speaks of proper diet, often far from their experience expressing frustration and anguish to the uncontrolled disease. In their placements to E11 person lives the dilemma between weight changes, irregular diets, guilt and the desire of food.

The sudden dietary modification affects the way of life of people with DM, as a new routine is needed that involves rigorous discipline of meal planning. Often no need to get in touch with feelings, desires, beliefs and attitudes so that there are changes in lifestyle that were once consolidated.  

The DM results in significant changes in the relationship that the person affected has with his own body and the world around, and the restrictions on feeding behavior to become more aware of their limitations. For this reason, the conflict between the desire to eat and the pressing need to contain it is always present in the person’s daily life with diabetes.  

♦ Difficulties of drug treatment

In the speech described, the respondents demonstrate their difficulties in medical treatment due to the use of insulin and oral hypoglycemic agents. These difficulties are mainly related to the continued use of medications and their side effects.

Taking medication, insulin, do not know until when will this, there is no cure yet, a final medication, has to control, it is difficult!  

(E1)

We take medication; others take insulin, but only help a little. I take a medicine for diabetes that gives me diarrhea. When I'm bored, sad. (E10)

Almost all DM patients require drug treatment, many with insulin, since beta cells of the pancreas tend to progress to a state of partial or of total failure.  

Although hypoglycemic agents emerge as a great resource in the management of diabetes, for respondents medication use for an indefinite time brings anxiety and anger.

Study of diabetics showed that most patients (58%) reported the presence of side effects as a limiting factor to treatment adherence as can be seen in the speech of E11. In addition, one must consider that the side effects may remain for a long time which interferes with patient adherence to drug therapy.  

♦ Aspects of heredity of the disease and the feelings of being sick

DM brings to its carrier many existential questions, intense emotions, negative feelings. Respondents associate the cause of the disease with heredity and express a feeling of revolt.

Diabetes runs in the family, my mother, three brothers and I have diabetes.  

(E5)

My mother died of diabetes; she died young, 64 years old. Now see, I have my sister and my daughter who have diabetes. It’s not easy; no one asked to have diabetes.  

(E8)

The strength of heredity is more impactful in DM type 2. There are some subtypes of this classification in the hereditary factor is a dominant trait, involving three or more consecutive generations.  

In the statements the lines denote the feelings of being sick, denial of illness, anxiety and sadness generated by this condition:

My God of Heaven, it is very difficult, brings a very large anxiety, I was happier; it seems that I became more bored, sad.  

(E10)

Note the anguish and the person revolt E10 and the difficulty in taking on this new identity. The DM ported condition brings with it the renunciation of pleasure, self-discipline, have a responsibility to one’s life and self-care practices.

Addressing the DM is a daily invitation to your carrier to rethink life, even with physical and dietary limits. You need to set goals for the future every day, and value the adaptations that help in daily activities and become small achievements for those who have a chronic disease that does not allow the withdrawal, does not accept the bad old habits, or hopelessness.

Disadvantaged populations are most in need of public policies that aim the improvement of their living conditions, creating scenarios to establish new health paradigms. Impaired health practices that are in accordance with established scientific knowledge and their correlations with the
inadequate conditions must be understood to be modified. 18

Any intervention to modify health habits and lifestyles of chronic disease patients implies in changing individual, cultural, social and community behavior and that this change occurs is essential that there is skill. 19 This sense stands out the importance of constant support from the FHS and its multidisciplinary team providing knowledge and attitudes encouraged to provide the appropriate management of the disease and thus preventing chronic and disabling manifestations of DM.

CONCLUSION

The family dependence for performing self-care becomes a negative moment for the diabetic, but can be less painful if the family and patient receive support from the multidisciplinary health team.

Noteworthy is the distance from urban centers, which concentrate specialized outpatient and emergency services, lack of transportation and financial resources among the difficulties to access and continuity of care.

The clinical complications of the disease and result in important vital physical limitations and hindrances such a situation brings to work. This finding confirms the epidemiological data on DM is a highly disabling disease.

Another challenge for health services that assist this population is to find strategies for DM patients fight the vices, especially, alcohol and tobacco. These defects result in worsening of the clinical picture of diabetic and work directly in the chronic complications, such as stroke, amputations, kidney disease, and blindness, among many others.

The use of multiple concomitant medications to treat the disease has also become an obstacle for the diabetic. Take the knowledge of drug effects, their daily and continuous needs as well as their indications, is working to empower the patient to self-care.

In the universe of the difficulties of DM the last barrier to be identified is the inheritance of the disease. Entire families carry the genetic load and such perception can guide preventive actions in the household is stimulated by the health team.

You need to establish educational strategies that allow the DM patients get the knowledge to prevent and minimize the signs and symptoms of chronic manifestations. Management of the disease should be progressively incorporated into their daily lives and brought its cultural and socio-economic reality.

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