Health care praxiology men living with diabetes and hypertension

Praxiologia do cuidado de saúde homens que convivem com a Diabetes e a Hipertensão Arterial

Hombres de praxiología de la salud que viven con diabetes e hipertensión

Anderson Reis de Sousa[1], Andrey Ferreira da Silva[2], Fernanda Matheus Estrela[3], Helder Pereira Bonfim[4], Tamires Jesus Sousa[5], Leilane Nascimento da Conceição[6], Álvaro Pereira[7]

How to cite: Sousa AR, Silva AF, Estrela FM, Bonfim HP, Sousa TJ, Conceição LN, et al. Health care praxiology men living with diabetes and hypertension. REVISA. 2021; 10(2): 320-35. Doi: https://doi.org/10.36239/revisa.v10.n2.p320a335

1. Faculdade Nobre de Feira de Santana. Feira de Santana, Bahia, Brazil. https://orcid.org/0000-0001-7286-0315

2. Universidade Federal da Bahia, Nursing School. Salvador, Bahia, Brazil. https://orcid.org/0000-0001-8534-1960

3. Hospital Geral Roberto Santos e Obras Sociais Irmã Dulce. Salvador, Bahia, Brazil. https://orcid.org/0000-0003-2161-7563

4. Hospital Geral Cleriston Andrade. Feira de Santana, Bahia, Brazil. https://orcid.org/0000-0002-5236-3933

5. Faculdade Nobre de Feira de Santana. Feira de Santana, Bahia, Brazil. https://orcid.org/0000-0002-3815-3083

6. Faculdade Nobre de Feira de Santana. Feira de Santana, Bahia, Brazil. https://orcid.org/0000-0002-3901-8721

7. Faculdade Nobre de Feira de Santana. Feira de Santana, Bahia, Brazil. https://orcid.org/0000-0002-1351-1278

8. Universidade Federal da Bahia, Nursing School. Salvador, Bahia, Brazil. https://orcid.org/0000-0003-4141-9097

Received: 12/01/2021
Accepted: 29/03/2021

RESUMO

Objetivo: Aprender as práticas de cuidado de saúde exercitadas por homens em situação de adoecimento crônico. Método: Estudo qualitativo realizado com 38 homens idosos que conviviam com a Diabetes e a Hipertensão Arterial Sistêmica em um município da Bahia, Brasil. Realizamos entrevista individual submetida à análise pelo método do Discurso do Sujeito Coletivo, suportado pela Teoria das Transições. Resultados: A praxiologia do cuidado de saúde dos homens esteve configurada pelo desenvolvimento de aprendizados e aquisições de habilidades específicas sobre a doença crônica; reeducação familiar; adesão às terapêuticas tradicionais face a utilização dos fitoterápicos, de saberes ancestrais e populares; a promoção de atividade física e repouso; o controle de modificações nos órgãos e no corpo e a promoção do bem-estar psicológico e a superação do sofrimento. Conclusão: As práticas de cuidado estão constituídas a partir das vivências masculinas na experiência do adoecimento crônico pela Diabetes Mellitus e a Hipertensão Arterial, que ao seu modo, implicam em mobilizações das masculinidades ao encontro de atos, atitudes, ações direcionadas à convivência com a doença, o seu enfrentamento e a significação a partir das oportunidades e dos acessos que estão disponíveis no território.

Descritores: Praxiologia; Cuidados de Enfermagem; Adoecimento crônico; Saúde do Idoso; Saúde do Homem.

ABSTRACT

Objective: Objective: To learn the health care practices exercised by men in a situation of chronic illness. Method: Qualitative study carried out with 38 elderly men who lived with Diabetes and Systemic Arterial Hypertension in a city in Bahia, Brazil. We conducted an individual interview submitted to analysis using the Collective Subject Discourse method, supported by the Transition Theory. Results: The praxiology of men's health care was shaped by the development of learning and the acquisition of specific skills about chronic disease; family reeducation; adherence to traditional therapies in view of the use of herbal medicines, ancestral and popular knowledge; the promotion of physical activity and rest; the control of changes in organs and body and the promotion of psychological well-being and the overcoming of suffering. Conclusion: Care practices are constituted from male experiences in the experience of chronic illness due to Diabetes Mellitus and Arterial Hypertension, which, in their own way, imply mobilizations of masculinities to meet acts, attitudes, actions directed to living with the disease, its confrontation and the significance from the opportunities and accesses that are available in the territory.

Descriptors: Praxiology; Nursing care; Chronic illness; Health of the Elderly; Men's Health.

RESUMEN

Objetivo: Conocer las prácticas asistenciales que ejercen los hombres en situación de enfermedad crónica. Método: Estudio cualitativo realizado con 38 hombres mayores que vivían con Diabetes e Hipertensión Arterial Sistémica en una ciudad de Bahía, Brasil. Realizamos una entrevista individual sometida a análisis utilizando el método del Discurso Colectivo del Sujeto, apoyado en la Teoría de la Transición. Resultados: La praxiología del cuidado de la salud de los hombres fue moldeada por el desarrollo del aprendizaje y la adquisición de habilidades específicas sobre enfermedades crónicas; reeducación familiar; adherencia a las terapias tradicionales en vista del uso de hierbas medicinales, conocimientos ancestrales y populares; la promoción de la actividad física y el descanso; el control de los cambios en los órganos y el cuerpo y la promoción del bienestar psicológico y la superación del sufrimiento. Conclusión: Las prácticas de cuidado se constituyen a partir de vivencias masculinas en la vivencia de enfermedad crónica por Diabetes Mellitus e Hipertensión Arterial, que, a su manera, implican movilizaciones de masculinidades para enfrentar actos, actitudes, acciones encaminadas a convivir con la enfermedad. , su enfrentamiento y la trascendencia de las oportunidades y accesos que se encuentran disponibles en el territorio.

Descriptores: Praxiología; Cuidado de enfermera; Enfermedad crónica; Salud de los ancianos; Salud de los hombres.

ORIGINAL

Introduction

Chronic Noncommunicable Diseases (CNCDs) are responsible for more than 41 million deaths annually and are major factors for the emergence of disabilities and premature deaths in society worldwide. To cope with this, the use of health interventions, especially in Primary Care, with the promotion of adherence to treatments and improvement of actions that guarantee the adoption of healthy habits that stimulate the control of these diseases, are mostly quite effective.[1]

The impacts generated by the CNCDs are observed in several areas and range from family issues due to inability in provision to the emergence of economic imbalances resulting from high costs with ends in treatments.[2] Faced with this problem, the World Health Organization (2014), [3] defined some global goals to be achieved by 2025. These goals converge with disease control and include improving eating habits, reducing obesity and encouraging therapeutic measures.

In this area that involves the context of chronic illness in the experience of health and illness, they are confronted with gender relational issues, which highlight the social constructions of masculinities.[4] It is based on the understanding of this intersection that the National Policy was instituted in Brazil of Integral Attention to Men's Health.[5] Thus, this normative mark of the development of a focal health policy for the male population has triggered attention to contexts such as the perception of invulnerability, resistance in the search for institutional health services, concern reduced with the health situation, exercise of normative gender standards - position of provider and the culture of carelessness that permeate much of the male construction in Brazil, which can occur with elderly men.[5-8]

In view of this scenario that raises visibility in relation to the way men conceive and exercise health care, attention is paid to practices. In this light, it is essential to recognize that such practices have their own political ontology, which structures the logic of care.[9] In this way, it is increasingly necessary to work with health professionals with a focus on health care practices. and in the planning and execution of promotion, education, prevention, control, coping, treatment and rehabilitation actions, which include nursing professionals.

In view of the presented scenario, this study was guided by the research question: How to configure a health care praxiology for men who live with Diabetes and Arterial Hypertension? This article aims to learn the health care practices exercised by men who live with Diabetes and Arterial Hypertension.

Method

Qualitative study, structured on the socio-anthropological bases of health and nursing. The research was carried out in two scenarios: a Family Health Unit and a Diabetic and Hypertensive Care Center - CADH, located in a municipality in the state of Bahia, Brazil. 38 elderly men participated in the study, who attended health services in the Primary Care network and in Medium Complexity in the Unified Health System.

The data were collected using an instrument previously prepared and validated by researchers with expertise in the area, applied to the participants in

the facilities of the health services surveyed, at previously scheduled times, under the availability of the participants and the organization of the services. The instrument used was composed of closed questions, which dealt with sociodemographic, clinical, therapeutic and related to chronic illness and open questions about the empirical object, namely: Tell us about your experience of health care in the context of chronic illness?

For data collection, the study followed the application of a semi-structured form, composed of guiding questions regarding the proposed theme and sociodemographic issues, health conditions and chronic illness, in addition to the use of herbal medicines.

As a way of approaching the participants, they were accessed by a trained researcher, who performed observation strategies not participating in the service, and made the invitation to participate in the study, considering the ethical and bioethical requirements for conducting research involving human beings, as recommendations proposed by Resolution 466 of 2012 from the National Health Council. Therefore, the Free and Informed Consent Term (ICF) was presented, which was read, explained and signed in two copies, considering the digital signature, for those who did not. were literate

The methodological analysis of the data was performed using the Collective Subject Discourse - CSD, an inductive method, which enables the organization of qualitative data to locate phenomena of social representation. From the accurate systematization and standardization of convergent discourses, Key Expressions and Central Ideas / Anchorages emerged that theoretically support the synthesis discourses of the investigated object.[10]

The interview was conducted individually in order to guarantee the reliability and confidentiality of the data, with an average duration of approximately 30 minutes, being guided by the pre-established script, being recorded in a single recorder, later transcribed under a reliable record of the empirical material collected. , for further organization, coding and analysis, in compliance with the criteria established by the Consolidated Criteria for Reporting Qualitative Research (COREQ), in order to guarantee rigor in qualitative research.

Through the process of organization and subsequent initial categorization of the transcribed material, developed through the NVIVO 11® Software, analysis and interpretation was carried out, which was guided by the Collective Subject Discourse (CSD) method proposed by Lefèvre and Lefèvre10, which made the in Key Expressions, later, Central Ideas, and the Synthesis Speeches.

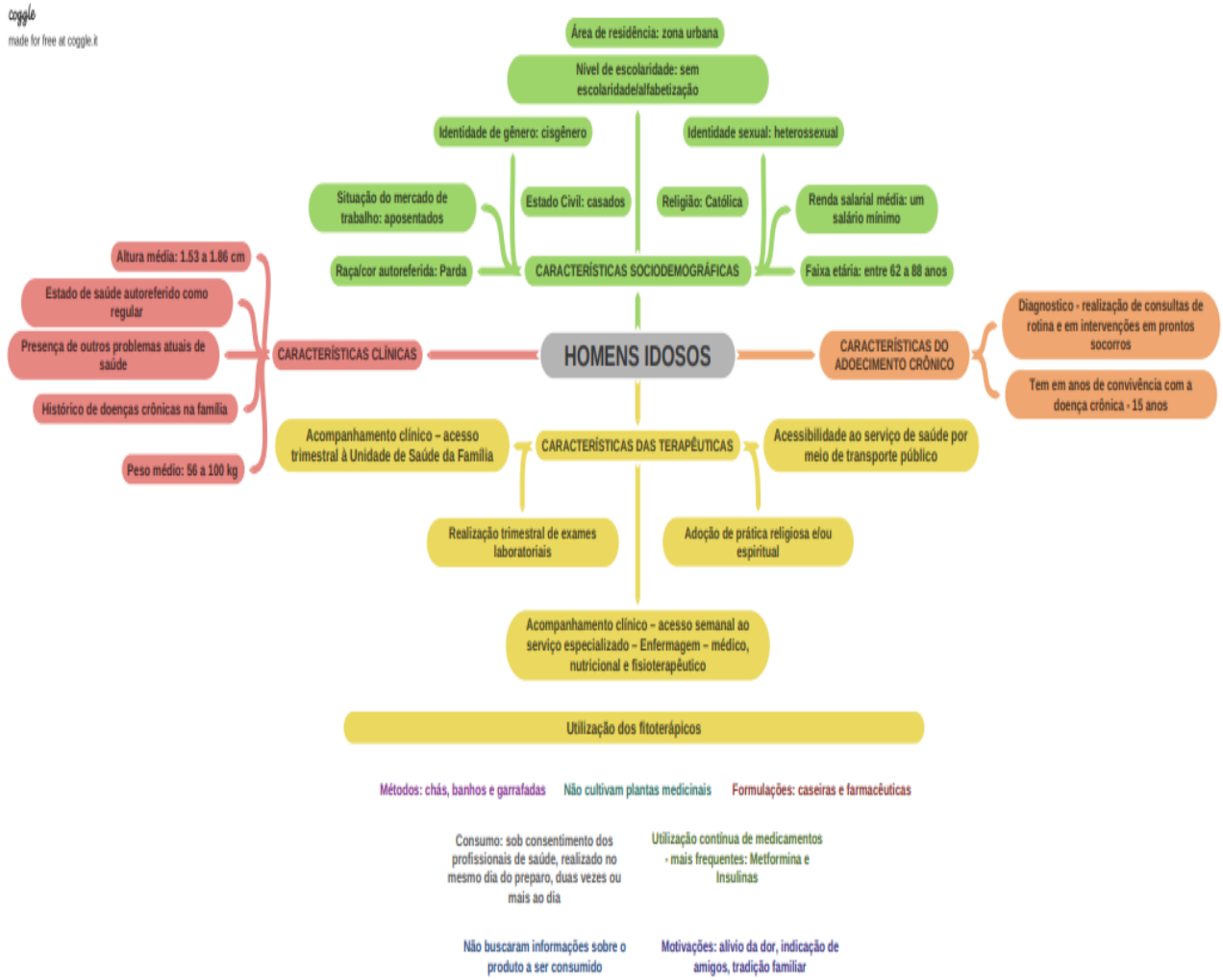
Social representations are socio-cognitive schemes that people use to make judgments or opinions in their daily lives; they are a form of knowledge, socially elaborated and shared, of a reality common to a social group.[10] The interpretation of the findings was structured in the theoretical framework of Anne Marie Mol from concepts such as ontology, the logic of care and practices in given praxiology exercise employed by the author.[11-14]

The ethical aspects of research have been fulfilled in all stages of research development. The project was approved by the Research Ethics Committee under the opinion of: CAAE: 83710017.8.0000.5654 and n. 2.518.617.

Results

The study consisted of 38 elderly men experiencing chronic illness due to Diabetes Mellitus and Arterial Hypertension. The sociodemographic, labor and clinical / health characteristics are presented in the infographic below:

Figure 01 – Characterization of participants. Bahia, Brazil. 2017.



The speeches-syntheses and their respective Central Ideas that support the knowledge of the phenomenon, exposes the typology of care practices adopted by elderly men experiencing chronic illness due to Diabetes and Arterial Hypertension. The praxiology of care of the investigated public takes place in the daily routine of health services, especially within the scope of the specialized care of the Unified Health System, and reveals the centrality of practices aimed at approaching, knowing, negotiating and incorporating the dynamics presented by illnesses , and the path in the search for support, support, intervention, monitoring, adaptation and repairs.

Synthesis 1: response patterns

This category of discourse-syntheses expresses the collectivity of elderly men in the face of care practices that are directed to the experience of the disease due to Diabetes and Hypertension. They denounce the development and

acquisition of learning about the disease, the changes imposed by the repercussions and the construction of adaptive and coping strategies.

Central Idea 1A: Development of learning and acquisition of specific skills on chronic disease

The development of the development of care practices based on learning and the acquisition of specific skills on chronic disease, constituted the type of care by this group. In addition, perceptions about their social constructions of masculinities are elucidated in the discourse of men and interface this care:

[...] women are more concerned with health, they are more prudent. Men tend to be more relaxed with their health care. I did that too. I lacked interest, but it wasn't because I didn't like taking care of myself, it was carelessness and ignorance, laziness and lack of motivation. In addition, there was also prejudice, which was great and shame. I also lacked guidance, as I started looking for care after 65 years old. The discovery of the diseases generated a lot of precaution, after all nobody wants to have Diabetes, nor Hypertension, because it is terrible, it is a negative subject, something bad, a hindrance, they are the worst diseases that exist, mainly for not allowing me to carry out the activities that I did before. However, even living with this situation, I started looking for improvements and even though I'm slowly trying to face it, wanting to live better, overcome difficulties, learn more about the disease, learn more with the professionals, especially about the side effects that these diseases bring , and applying the teachings in my daily life, because today I understand that taking care of health is fundamental to avoid future complications for men and health care cannot wait. (CSD de homens idosos).

Ideia Central 1B: Mudanças de hábitos, novas formas de ser e adoção de comportamentos saudáveis

As práticas de cuidado direcionadas às mudanças de hábitos e a adoção de atitudes positivas e comportamentos saudáveis se dão face a necessidade da interrupção de práticas danosas à nova condição de saúde, especialmente, as doenças crônicas. Destarte, também implicou em novas formas de ser, na busca por restabelecer sua condição saudável. Tais mudanças ocorrem mobilizadas pelos impactos deletérios e incapacitantes do adoecimento crônico:

> *[...] após o surgimento da Diabetes e da Hipertensão as preocupações aumentaram. Tive que mudar muitas atitudes na vida, e eliminar comportamentos que eu realizada antes. Agora eu não faço mais o que fazia: beber cerveja, fumar, comer de forma desregrada e tudo isso por conta dessas doenças e também por conta da idade que já está ficando avançada. Também estou tendo dificuldade para andar sozinho, pois estou começando a perder a visão e tive que amputar um pé. Por conta disso, a minha família já comentou até de adquirir um andador, o que não me agrada. Agora já tenho consciência de que não pode só pensar em se cuidar só quando os problemas na saúde chegam, mas quanto antes melhor.* (DSC of elderly men).

Central Idea 1C: Adaptations and coping strategies to the new therapeutic / medication routines

Care practices aimed at adaptation and coping strategies performed by elderly men are directed towards adherence to new routines, compliance with drug therapies, glycemic control, and whether they are influenced by changes in work capacities and the exercise of activities of daily living in your daily life:

[...] before I was a more active man, I didn't care much about health, but today I am a cautious man. The routine of life was totally changed after the appearance of diseases. I stopped working because of the fluctuation of blood glucose. I started to use several medicines daily, I follow the prescription that the doctor gave me and I had to stop performing some daily activities because I lost a little bit of capacity. (DSC of elderly men).

Central Idea 1E: Adaptations and coping strategies to affective and sexual changes

The fragments of the speeches of elderly men reveal that there are impacts on the dimension of family, affective and conjugal life and on sexual performance. In view of this experience, men seek to establish new socio-affective bonds, which take place in the institution of new conjugal relationships, in the exercise of fatherhood in the old age phase and in the search for knowledge and professional support to deal with the present sexual dysfunction:

[...] I have tried to be closer to the family, because I know that even after illnesses, our relationship has not changed, they are always supporting me, but the sex life changes. I have sexual impotence, I am no longer the man I used to be. The marital relationship has also changed. I separated from my first wife because of the illness. She didn't want to stay with me. I am now married and have two more children with my second wife. She is younger and old enough to be my daughter, but she takes care of me. Now I have been trying to start the approaches again and to overcome the difficulties in relation to sex, seeking to know more and carry out the treatments in the health service. (CSD of elderly men).

Central Idea 1F: Adaptations and coping strategies to changes in work and finances

Adaptations and coping strategies to the changes caused by chronic illness to the dimensions of the world of work and financial relationships emerged as care practices among men, and are structured through the experience of impacts, such as deprivation, income decline, loss the productive capacity for work, the removal of poses, the change of place of the man-product, for the man - "disabled", through the advent of retirement, the increase in the costs of maintaining therapies and the need for financial support by fostered by the children:

[...] *Since I started to suffer more with the advance of Diabetes and Hypertension, I went through a lot of difficulties, especially in financial terms. I had difficulty accessing the sickness allowance, I had to stop working and I was retired due to disability, and from then on my financial life changed completely, because for those who earned a lot and today living with retirement money is bad. Working I lived in a good situation, but without*

working it is another very unpleasant one, mainly because I am no longer exercising what I used to do before. Even though I am retired, the expenses with the disease are large and the value of the pensioner is small, which made me need to do some activity to earn more money. I also had to count on my children's financial support, which has helped me with some monthly bills. I had to sell some poses that I had, for not having anyone to take care of. (CSD of elderly men).

Central Idea 1D: Food reeducation

The care practices directed to food take place through the restrictive measures recommended by health professionals in the service that elderly men attend and perform specialized monitoring, especially those of nutrition, approaching a food reeducation. Among the components of this practice, there is a change in eating habits, the restriction of consumption of processed foods, with high glycemic and lipid content. It was noted the presence of health professionals and family members as agents to support compliance with dietary diets and the positive perception of the investigated regarding the improvement of the clinical condition and the distance from practices considered "harmful":

[...] I had to change my diet because of illness, and now I can't eat everything. I stopped drinking beer and drips and also eating some foods, especially fatty and industrialized ones, besides sweets and breads. I have followed a diet where I cannot eat everything, it is well regulated, because the nutritionist, professionals and my family are always supervising me. I then had to undergo a dietary reeducation and started to eat better, to eat less and several times a day, through a varied diet and avoid everything that harms. (CSD of elderly men).

Central Idea 3A: Adherence to traditional therapies - use of herbal medicines

Mobilized by the desire to cure Diabetes and Hypertension, elderly men used care practices anchored in traditional medicine, especially in the use of herbal medicines:

[...] I have used plants, herbs and natural products. I also looked for information in the book "Plants heal". Use not only for Diabetes and Hypertension, but for other diseases, such as pain, flu and stuck intestines. To lower the sugar level and consume "cow leg", "stick lieutenant", "stick iron", "jamelão", "juá de boi", "juá mirim". I make tea from plants such as "graviola leaf", "quina-quina", "okra", "chia" and "moringa". I consume "alumã" and "boldo", whenever the belly is bad and tea of "stone breaker" for the kidneys. I use "aroeira" to bathe my leg when it hurts, and also to heal the wound and "lemongrass" and "capim santo" and "chayote" tea to calm down, lower the pressure and make me sleep well. I have been looking for plants and herbs in a store that sells natural products and also in my backyard or in the fields, on a farm or in the neighbor's yard and even on the curb of the street. (CSD of elderly men).

Central Idea 3B: Adherence to ancestral and popular knowledge

Care practices linked to ancestry and popular knowledge constitute the repertoire of the typification of care for elderly men. The findings showed the rescue of maternal knowledge acquired in childhood, the search for information

and advice provided by friends and older people and accumulation of experience on the management of chronic diseases, the consumption of teas, medicinal drinks, access to popular fairs and the search for healers:

[...] after I found out I had Diabetes and Hypertension, I started taking information with older people, to find out with more experienced people. I remembered my mother's guidelines, that since she was a child, she used to make teas and we drank, and now I'm doing the same. I sought information from friends about the disease and how I could improve it, and the advice was important. Friends have also been using teas, and they told me to do it because it was good. I looked for people who had more knowledge about herbs and baths, and started to go to places to buy, which are usually in the street markets, there I received guidance on what was good, which could bring relief. It was easy to buy and quick to use. I also started to take medicinal bottles that are made by a healer and also to seek guidance from people who live in the fields and in the bush. (CSD of elderly men).

Central Idea 1D: Promotion of physical activity and rest

Motivated by the need to maintain body functionality, mobility, and motor performance, male discourse revealed the practice of promoting physical activity and rest. In the use of these care practices, the therapeutic participation of the physiotherapy professional stands out:

[...] I miss the physical activity I used to do, now as I'm old I no longer have the same disposition, but still, because of the diseases I have, I walk in the yard and on the street during the day, and sometimes I do activity I do physical therapy at the health unit in my neighborhood, because of the leg I had to amputate and also rest and rest during the day. (CSD of elderly men).

Central Idea 1D: Control of changes in organs and body

When suffering from the impacts of organic and bodily deterioration, elderly men performed repairing, restored and rehabilitation care practices, such as in the search for and carrying out surgical interventions, access to medical therapies:

[...] Diabetes and Hypertension deformed me and because I was in an advanced stage I had to seek medical help and health service professionals. When going through medical consultations, evaluations, performing various exams, I needed to perform surgery for amputation of the leg and foot. I also had problems with my hearing and I had a stroke. Because of that today I do medical monitoring and follow the recommendations that are passed on in the service. I still face problems with circulation, and I started to use a kind of boot to facilitate the circulation of blood and prevent it from generating a new wound on the other leg. I lost a lot of weight, the body is not developed as it was, I feel very tired, I feel very dizzy when the sugar level drops and I no longer have the same disposition as before. Now I have to weigh myself and take the pressure measurement every week, to prevent me from weakening. (CSD of elderly men).

Central Idea 1D: Promoting psychological well-being and overcoming suffering

Although in a discreet way the male discourse revealed that elderly men when they are experiencing disruptions in psychological well-being, seek to employ positive care practices aimed at promoting physical rest, stress control:

[...] sometimes I feel a little down, sad, discouraged, nervous and uneasy in the face of the complications that diseases bring, but I try to rest, to distract myself to relieve the mind. There are days that are really bad, but I make teas to calm down and prevent me from being shaken. I seek to improve my relationship of pleasure in living, and not complaining, always saying it is good, because if I say it is bad, it gets worse and all I want is to face and live better, as much as I can. (CSD of elderly men).

Discussion

The findings of this study are able to show how praxiology of care operates with elderly men in chronic illness experiences, from the experience of the disease and the development of care strategies for adaptation and coping. Thus, the results show that there are care practices centered on the disease and others that are transposed to the different dimensions of life and health that were affected by the repercussions of the chronic illness of men. Thus, the data also allow to identify the expressions of attributes of masculinities self perceived by elderly men, which permeate their constructions and ideas in relation to the relationship with care, thus revealing their originality.

As a practice to deal with and cope with chronic illness, men developed certain learnings along the clinical trajectory and experience of the disease and acquired skills that conferred specificities to the disease in its chronic character. Such practices provide advances in health and disease knowledge, drug therapies, treatment modalities and lifestyle habits.[15] In this regard, differences between genders are identified in a study on women and men with Diabetes Mellitus and lifestyle and showed that men like unsatisfactory hygiene and inadequate nail cutting. They also presented less practice of scalding feet, the use of inappropriate shoes, less healthy behaviors, less food control and laboratory tests to monitor the recommended lipid profile.[16]

It is important to emphasize the performative character of the practices, which configure the ways of being, knowing and intervening in the face of male health care.[15] The scope of the notions of ontological policy present in the way men exercise self-care of health must be part of of professional health care from a social perspective.[11-12]

Family reeducation has become a health care practice adopted by men when living with Diabetes and Arterial Hypertension, especially with regard to the male approach to the family, and their participation and support offered. In a mutual relationship, it is possible to recognize the emergence of tribes that establish themselves in the care practice of those who are in contexts of chronic illness.[2,4] Furthermore, family support has made a significant contribution to the self-management of chronic disease, as revealed by the theory's assumptions. of Self-management.[17]

Adherence to traditional therapies, especially those derived from plants, medicinal knowledge that cultivates herbs and promotes herbal medicines. In this light, it is relevant to infer that most of the participants in this study are located in a rural territorial context, and are residents of a municipality whose

popular free markets have an expressive historical and cultural demarcation and, therefore, are already part of the everyday life of men, which can strengthen the use of herbal practices along with the health and disease process that permeate the experience of Diabetes Mellitus and Arterial Hypertension. In addition, it is necessary to understand the belief systems present among men regarding the concepts attributed to chronic diseases and the stories they build about the disease process, the causes, prevention, the link that is established with the diagnostic strategies and with health services, such as, for example, the bond that is built with health professionals. [18]

In line with herbal health care practices, men also incorporate ancestral and popular knowledge into their experiences, which are influenced by the age and generation categories, especially the popular sayings of the elderly and religion, based on religious teachings linked to recovery and healing. Such practices make up the social representations of men about chronic diseases with regard to causes, concerns, recognition of signs and symptoms, and the adoption of care practices - purchase of medicines and other medicines, food, treatment, which are intertwined in the practices popular health and common sense knowledge so peculiar to the informal care network and ruralities.[19-20]

Although representative among the study group, it was not possible to evidence whether such practices are oriented, if they follow expert recommendations, if they were proposed by health professionals, or if they are used in isolation without correlation with the therapies instituted in the services. What was observed was a variety of herbs with which men manipulate and make use, especially in the formulation of teas, with direct purposes in the management of chronic diseases, but also of other associated clinical conditions.

Given the context of the use of herbal medicines in the context of chronic diseases with Diabetes Mellitus and Arterial Hypertension, attention is drawn to their empirical use, and the existing concern with the use, cultivation, access and manipulation of herbal medicines, the dosage, and complicating factors such as intoxications and the phenomenon of self-medication, which is expressive among the male population.[21-22]

The promotion of physical activities and rest were present among male care practices. Such practices are positive because they give men aspects of improvements in sexual functioning, metabolic control and quality of life.[23] It was not possible to deepen the investigation plan to find out whether such practices were already considered to be common among men in their daily lives. What was possible to learn is that they started to incorporate such practices after experiencing Diabetes Mellitus and Hypertension. These aspects are being placed to draw the attention of what puts Mol[11-14], when he recommends that we make a turn to the field of research on practices, and that we investigate daily practices, as it did in its research paths on practices of living with diabetes and arteriosclerosis.

In turn, the control of bodily and organic changes generated by the investigated chronic diseases, such as dysfunctionality, disabilities, deformities, mobilize men to exercise their health care. Mol in her investigations about the coexistence of people with Diabetes Mellitus and Arterosclerosis, brings significant contributions to the recognition that care emerges as a broader dimension such as citizenship, and that it would not necessarily be linked only to the logic of choice individual, but of conjunctural opportunities,

such as access to services, socioeconomic status, health literacy and more.[12,14]

In addition to the dimension of physical health, the men surveyed revealed from the collective discourse the practices of mental health care, especially those aimed at promoting psychological well-being and minimizing the suffering related to the experience of chronic illness by Diabetes and Arterial hypertension. It is known that chronic conditions have important relationships with the onset of psychic disorders, especially due to the production of stress, psychosomatic effects that, in a progressive and chronic character, generate harmful effects to the subject's mental health situation.[24-27]

Given the possibility already evidenced in the literature of psychological distress associated with the experience of chronic illness, it is necessary that health professionals, such as those in nursing, are attentive and trained to recognize signs suggestive of mental disorders, such as imbalances and / or mood disorders, anxiety, depression, post-traumatic stress disorder, as well as those that imply a higher level of complexity such as suicidal behavior. In addition, it emphasizes the essentiality that the professional team is able to identify and value the positive individual, singular and autonomous practices that are employed by men.

When considering the social construction of masculinities, which in a great way can be structured in hegemonic molds, which does not prioritize health care for themselves, delays the search for help in health services, accesses the medium and high complexity of care more, hides emotions and feelings, including those related to the clinical contexts of chronic disease, it is essential that the health team is well positioned to support men in coping with the negative circumstances that may be generated by the development of the disease.[28-29] Thus, the masculinity marker needs to be inserted in the daily routine of the clinical conduct adopted by the health professional, being the same analyzed with sensitivity, free of stereotypes, in order to collaborate with the more harmonious experience of men with the illness.

Even elaborating an assumption that the men investigated are circumscribed in a normative pattern of construction of masculinities, when analyzing the practices they exercise, it is important to know that they are inserted in multiple realities, as well as being multiple and heterogeneous bodies the articulations between the different human and non-human actors in the social network.[14-15] Thus, it is relevant to know the appropriate ways to infer about the practices adopted by men with regard to the context of chronic non-transmissible illness.

In the context of mental health, paying attention to the relationship that may exist between men's masculinity constructs with the psycho-emotional and mental context, may lead professionals to early identify existing vulnerabilities, such as suffering - their level of intensity and complexity , and later, find

the best and most coherent mental health interventions to be applied to the male population within the scope of health care practices in the face of chronic illness. Such aspects reinforce the need for men's health to be a real priority within the scope of public policies, management of services and assistance and in the daily practice of professional care production, with the awakening to the multiple dimensions of health care. health - physical, mental, spiritual, religious, bioenergetic, social, work and other.[30]

In a study carried out with a similar population, however, at the Family Health Unit, male experiences in the context of chronic illness found findings that outlined health care practices, such as health control, the disposition for self-care and for spiritual well-being and the improvement of family processes.[31] Such results reinforce the need to pay attention to the analysis of the praxeology of care[11-14] as a way of typifying, accurately knowing and being able to constitute more specific lines of care, design therapeutic plans and more personalized care, coherently adapted and compatible with the realities experienced by men in their territories and social, cultural, managerial and historical and political constructions.

From the results obtained, it is possible to advance the knowledge produced on the topic, especially in the field of science and nursing practice, in which the investigations involving the male audience are still discreet. Thus, there is relevance in the study insofar as a heterogeneous group is explored, but with presentations of care practices that are consistent and that may be demonstrating a response pattern, and even of performance, be it individual or also community, the which can imply ease in the management of nursing professionals in their daily work in services.

In addition, it is possible to condense substantial information for the progress of the nursing clinic in the care of elderly men, allowing to identify the specificities existing between the ways of being, the existing inter and cross-cultural relationships, the masculinity models of which men are circumscribed, the therapies that are more coherent and more easily accepted and the impacts, repercussions and difficulties that surround them, in the quest to live in a healthy and less harmful way possible with chronic diseases.

This study was carried out on the use of a unique data collection technique, which can limit the depth of the investigated phenomenon. Data collection occurred with the participants in different scenarios and at different levels of health care and complexity, which can also influence the apprehension of the empirical material, which configured in the limitations of this study.

The contributions of this study are focused on the prospect of advancing scientific knowledge and the practice of gerontological nursing, in the field of aging and health, as well as the approximation with the socio-pathological markers of the experience of the disease and masculinities, together with the production of nursing care men's health. The findings of this study may also contribute to: a) a deeper understanding of the typology of

male care practices in old age; b) redirection of lines of care in Nursing and health within the scope of Chronic Non-Communicable Diseases; c) in the design of clinical practice and the management of Nursing and health services in the health care network; d) in the expansion and strengthening of research and insertion of Integrative and Complementary Practices in Health - PICS, in making professional services and e) in directing the valorization of popular knowledge along with biomedical knowledge.

Conclusion

The praxiology of men's health care was shaped by the development of learning and the acquisition of specific skills about chronic disease; family reeducation; adherence to traditional therapies in view of the use of herbal medicines, ancestral and popular knowledge; promoting physical activity and rest; the control of changes in the organs and body and the promotion of psychological well-being and the overcoming of suffering.

Care practices are based on male experiences in the experience of chronic illness due to Diabetes Mellitus and Arterial Hypertension, which, in their own way, imply mobilization of masculinities to meet acts, attitudes, actions aimed at living with the disease, the its confrontation and the significance from the opportunities and accesses that are available in the territory.

Acknowledgment

The authors did not receive funding for this study.

References

1. WHO. Noncommunicable diseases: Key facts. WHO, 2020. Disponível em: https://www.who.int/en/news-room/fact-sheets/detail/noncommunicable-diseases

2. Santos Robson Nogueira Costa, Bellato Roseney, Araújo Laura Filomena Santos de, Almeida Karla Beatriz Barros de, Souza Ítala Paris de. Lugares do homem no cuidado familiar no adoecimento crônico. Rev. esc. enferm. USP, 2018; 52: e03398. https://doi.org/10.1590/s1980-220x2017046703398.

3. WHO. NCD Global Monitoring Framework: Ensuring progress on noncommunicable diseases in countries. WHO; 2020. Disponível em: https://www.who.int/nmh/global_monitoring_framework/en/

4. Separavich MA, Canesqui AM. Masculinidades e cuidados de saúde nos processos de envelhecimento e saúde-doença entre homens trabalhadores de Campinas/SP, Brasil. Saude soc. 2020;29(2)30.Doi: https://doi.org/10.1590/S0104-12902020180223

5. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas e Estratégicas. Política

Nacional de Atenção Integral à Saúde do Homem: princípios e diretrizes. Brasília: Ministério da Saúde, 2009.
6. Queiroz TS, Rehem TCMSB, Stival MM, Funghetto SS, Lima LR, Cardoso BG, et alComo homens idosos cuidam de sua própria saúde na atenção básica? Rev. Bras. Enferm. 2018; 71(Suppl 1): 554-61.Doi: https://doi.org/10.1590/0034-7167-2017-0131
7. Coelho JS, Giacomin KC, Firmo JOA. O cuidado em saúde na velhice: a visão do homem. Saude soc. 2016; 25(2):408-21. https://doi.org/10.1590/S0104-12902016142920.
8. Sousa AR, Vergara OJ, Mota TA, Silva RS, Carvalho ESS, Teixeira, JRB, Pereira A. Vivências de homens em adoecimento crônico no cuidado à saúde: implicações para a assistência de enfermagem. REVISA. 2020; 9(2): 212-21. Doi: https://doi.org/10.36239/revisa.v9.n2.p212a221
9. Martin D, Spink MJ, Pereira PPG. Corpos múltiplos, ontologias políticas e a lógica do cuidado: uma entrevista com Annemarie Mol. Interface comunicação saúde educação 2018; 22(64):295-305. Doi: https://doi.org/10.1590/1807-57622017.0171
10. Lefevre F, Lefevre AMCavalca. Discurso do sujeito coletivo: representações sociais e intervenções comunicativas. Texto contexto-enferm. 2014; 23(2): 502-7. Doi: https://doi.org/10.1590/0104-07072014000000014
11. Mol A. Ontological politics: a word and some questions. In: Law J, Hassard J. Actor network theory and after. Oxford: Blackwell Publishing; 1999.
12. Mol A. The body multiple: ontology in medical practice. Londres: Duke University Press; 2002.
13. Mol A. Who knows what a woman is...On the differences and the relations between the sciences. Med Anthropol Theory. 2015; 2(1):57-75.
14. A. The logic of care: health and the problem of patient choice. New York: Routledge; 2008.
15. Martin D, Spink MJ, Pereira PPG. Corpos múltiplos, ontologias políticas e a lógica do cuidado: uma entrevista com Annemarie Mol. Interface Com. Sau.Edu. 2018; 22(64):295-305.Doi: https://doi.org/10.1590/1807-57622017.0171
15. Queiroz DT, Oliveira AKA, Mota FGA, Esmeraldo GROV, Pedrosa GF, Farias GMN. Living with diabetes melittus: a man's experience. Braz. J. of Develop. 2020;(60):4,16731-16741. DOI: https://doi.org/10.34117/bjdv6n4-006
16. Rossaneis MA, Haddad MCFL, Mathias TAF, Marcon SS. Differences in foot self-care and lifestyle between men and women with diabetes mellitus. Rev. Latinoam. Enferm. 2016;24:e2761. https://doi.org/10.1590/1518-8345.1203.2761
17. Ryan P, Sawin KJ. The individual and family self-management theory: background and perspectives on context, process, and outcomes. Nurs Outlook. 2009;57(4):217–25. Doi: https://doi.org/10.1016/j.outlook.2008.10.004

18. Silva MGC, Domingos TS, Caramaschi Sandro. Hipertensão arterial e cuidados com a saúde: concepções de homens e mulheres. Psic.Saúde & Doenças. 2018;19(2):435-452. https://doi.org/10.15309/18psd190221 .
19. Becker NB, Heleno MGV. A eficácia adaptativa em pessoas com Diabetes Mellitus tipo 2. Bol. Psicol.. [internet]. 2016;(66):145,159-170. Disponível em < http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0006-59432016000200005&lng=pt&nrm=iso >. acessos em 28 dez. 2020
20. Burille A, Gerhardt TE. Doenças crônicas, problemas crônicos: encontros e desencontros com os serviços de saúde em itinerários terapêuticos de homens rurais. Saude soc. 2014; 23(2):664-76. Doi: https://doi.org/10.1590/S0104-12902014000200025.
21. Santos M.M, Nunes M.G.S, Martins R.D. Uso empírico de plantas medicinais para tratamento de diabetes. Rev. bras. plantas med. 2012;14(2):327-34. Doi: https://doi.org/10.1590/S1516-05722012000200012 .
22. Sousa AR, Alencar DC, Silva AMM, Souza CS, Barros JF, Álvaro P. Hombres, necesidades de salud y motivaciones para la automedicación. Cultura de los Cuidados. 2019;5.Doi: https://doi.org/10.14198/cuid.2019.55.12
23. Pereira MG, Rodrigues Â, Santos J, Pedras S, Costa V, Marques O et al . Funcionamento sexual, controlo metabólico e qualidade de vida em pacientes com Diabetes Tipo 1 e Tipo 2. Rev. SBPH [Internet].2014 [citado 2020 Dez 28]; 17(1):70-87. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1516-08582014000100005&lng=pt.
24. Viapiana VN, Gomes RM, Albuquerque GSC. Adoecimento psíquico na sociedade contemporânea: notas conceituais da teoria da determinação social do processo saúdedoença. Saúde Debate. 2018; 42(Esp. 4): 175-86. Doi: https://doi.org/10.1590/0103-11042018S414
25. Hiller M, Bellato R, Araújo LFS. Cuidado familiar à idosa em condição crônica por sofrimento psíquico. Esc. Anna Nery. 2011; 15(3): 542-9. Doi: https://doi.org/10.1590/S1414-81452011000300015
26. Becker SML, Silva ABB. Representações sociais da hipertensão arterial. Temas psicol. 2016;24(3):895-909.Doi: https://doi.org/10.9788/TP2016.3-07 .
27. Geremias LM, Evangelista LF, Silva RC, Furtado DS, Silveira-Monteiro CA, Freitas CF. Prevalência do diabetes mellitus associado ao estresse ocupacional em trabalhadores bancários, Minas Gerais, Brasil. Rev Cuid. 2017; 8(3):1863-74. Doi: https://doi.org/10.15649/cuidarte.v8i3.442
28. Sousa, AR, Queiroz, AM, Florencio, RMS, Portela PP, Fernandes, JD, Pereira, A. Homens nos serviços de atenção básica à saúde: repercussões da construção social das masculinidades. Rev Bai Enf.2016;30(3):1-10. Doi: https://doi.org/10.18471/rbe.v30i3.16054

29. Silva JC, Nasif SS, Sousa AR, Santos SD, Mota TN, Pereira A. Características clínicas de homens atendidos em unidade de pronto atendimento. Rev baiana enferm. 2020;34:e34702. Doi: https://doi.org/10.18471/rbe.v34.34702
30. Sousa AR. Produzir cuidado à saúde de homens e suas masculinidades: uma prioridade. REVISA. 2020;9(4):681-4. Doi: https://doi.org/10.36239/revisa.v9.n4.p681a684
31. Sousa AR, Vergara OJ, Mota TA, Silva RS, Carvalho ESS, Teixeira, JRB, Pereira A. Vivências de homens em adoecimento crônico no cuidado à saúde: implicações para a assistência de enfermagem. REVISA. 2020; 9(2): 212-21. Doi: https://doi.org/10.36239/revisa.v9.n2.p212a221

Correspondent Author
Anderson Reis de Sousa
Nursing School of Universidade Federal da Bahia.
241 Basílio da Gama St. ZIP: 40110-907. Canela.
Salvador, Bahia, Brazil.
son.reis@hotmail.com