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PERCEPTION OF THE EXPERIENCE AND SELF-CARE OF OLDER ADULTS WITH DIABETES MELLITUS

PERCEPÇÃO SOBRE VIVÊNCIA E AUTOCUIDADO DAS PESSOAS IDOSAS COM DIABETES MELLITUS

PERCEPCIÓN DE LA EXPERIENCIA Y AUTOCUIDADO DE LAS PERSONAS MAYORES CON DIABETES MELLITUS

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Objectives: to know the perceptions of older adults with Type 2 DM treated in primary health care regarding their experiences and self-care. Method: Exploratory research with a qualitative approach, conducted with 13 older adults undergoing treatment for Type 2 DM. Data were collected between March and June 2024 through semi-structured interviews based on Orem's self-care theoretical framework and content analysis. Results: older adults perceive the condition of being a person with diabetes as linked to the perception of living with the disease, particularly in their self-perception. Self-care was declared important in daily life, understood as an essential tool, with the following categories standing out: 1) Self-care is health and; 2) Self-care is attitudes of self-esteem and emotion. Conclusion:

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participants demonstrated awareness of their strengths and weaknesses in living with Type 2 DM, demonstrating self-care as an essential tool, linked to health, nutrition, self-esteem, and emotion.

Descriptors: Nursing. Type 2 Diabetes Mellitus. Older Adult Health. Self-Care. Primary Health Care.

*Objetivos: conhecer a percepção das pessoas idosas com DM Tipo 2, atendidas na atenção primária em saúde, sobre suas vivências e autocuidado. Método: pesquisa exploratória com abordagem qualitativa, realizada com 13 pessoas idosas em tratamento do DM Tipo 2. Os dados foram coletados entre março e junho de 2024, mediante entrevista com roteiro semiestruturado embasado no referencial teórico do autocuidado de Orem e análise de Conteúdo. Resultados: as pessoas idosas percebem a condição de ser pessoa com diabetes vinculada à percepção de viv*er com a doença, principalmente na autopercepção. *O autocuidado foi declarado como importante no cotidiano, compreendido como instrumento essencial, destacando-se as categorias: 1) Autocuidado é saúde e 2) Autocuidado são atitudes de autoestima e emoção. Conclusão: os participantes demonstraram ciência das suas potencialidades e dificuldades em relação à vivência com o diabetes mellitus tipo 2, evidenciando-se que o autocuidado como instrumento essencial, atrelado à saúde, alimentação, autoestima e emoção.*

Descritores: Enfermagem. Diabetes Mellitus Tipo 2. Saúde do Idoso. Autocuidado. Atenção Primária à Saúde.

Objetivos: comprender las percepciones de los adultos mayores con DM tipo 2 atendidos en atención primaria a la salud con respecto a su experiencia y autocuidado. Método: Investigación exploratoria con enfoque cualitativo, realizada con 13 adultos mayores en tratamiento para DM tipo 2. Los datos se recopilaron entre marzo y junio de 2024 mediante entrevistas semiestructuradas basadas en el marco teórico de autocuidado de Orem y análisis de contenido. Resultados: Los adultos mayores perciben la condición de persona con diabetes como vinculada a la percepción de vivir con la enfermedad, particularmente en su autopercepción. El autocuidado se declaró importante en la vida diaria, entendido como una herramienta esencial, destacando las siguientes categorías: 1) El autocuidado es salud y; 2) El autocuidado es actitudes de autoestima y emoción. Conclusión: Los participantes demostraron estar conscientes de sus fortalezas y debilidades al vivir con DM tipo 2, demostrando que el autocuidado es una herramienta esencial, vinculada a la salud, la nutrición, la autoestima y la emoción.

Descriptores: Enfermería. Diabetes mellitus tipo 2. Salud del adulto mayor. Autocuidado. Atención Primaria a la Salud.

Introduction

Diabetes is considered one of the main causes of morbidity and mortality due to its high incidence and prevalence. Worldwide, there are approximately 463 million people with type 2 DM, aged between 20 and 79 years. In Brazil, there are 16.8 million people diagnosed with Diabetes Mellitus, 14 million with Type 2 DM, and of these, 11.9 million are older adults[1,2,3].

To control this disease, it is necessary to have tools, strategies, and an adequate structure. Therefore, Primary Health Care (PHC) is the gateway for people with type 2 DM, with a strategy capable of preventing and effectively providing health care to older adults with type 2 DM[4,5]. Strategies such as self-care are developed in PHC, with emphasis on actions to help older adults with type 2 DM take the lead in their own care[4].

The term "older person" was used in this study, in accordance with Federal Law number 14,423/2022, which changes the use of the term "elderly" to the respective terms "older person" and "older adults"[6].

For this study, the theoretical conception of self-care, derived from Orem's theory[7], is defined as practices of maturation and improvement, based on dedicating time to self-care activities for one's own benefit, promoting healthy habits and maintaining well-being[7,8]. Self-care is a personal behavior, considered a broad concept, linked to the various factors that affect the individual in his lives, including health, well-being, self-learning, and survival, not limited to activities of daily living[7,9].

In this context, this research is timely for the field of geriatrics and gerontology, as it presents scientific evidence on the perceptions of older

adults regarding their experience with type 2 DM. These data are essential for developing strategies and action plans aligned with the desires, needs, and priorities for personalized health care, especially in PHC.

The specialty of geriatrics and gerontology values the heterogeneity of older adults, making it timely in health care planning. Therefore, information that identify the drivers of care are essentials, in order to present facilitators that can contribute to the self-care, well-being, autonomy, and independence of older adults with type 2 DM.

Thus, considering the importance of the topic, the health context, and the self-care strategies aimed at older adults with type 2 DM, the objective was to understand the perceptions of older adults with type 2 DM, treated in primary health care, regarding their experience and self-care.

Method

This exploratory research with a qualitative approach[10,11], was conducted with older adults who attended a Municipal Health Unit (MHU), considered a benchmark in PHC care for older adults in Curitiba, Paraná. Its development was based on the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist, aiming to demonstrate greater reliability in the process[12].

To recruit participants, posters inviting them to participate in the study were posted at the MHU. Those interested in participating completed a form with basic information (name, age, contact phone number, and address). The researcher contacted them for the first meeting, and at this time, the inclusion criteria were confirmed: age 60 or older; residing within the MHU area; having a medical record and diagnosis of type 2 DM registered with the MHU; and present preserved cognitive capacity, as per the Mini-Mental State Examination (MMSE) score, with cutoff scores based on education level: illiterate ≤ 13 points; 1 to 8 incomplete years ≤ 18 points; 8 years or more ≤ 26 points[13]. The total sample consisted of 13 older adults undergoing treatment for type 2 DM.

Data collection was conducted from March to June 2024, with interviews using a semi-structured script. Three 60-minute meetings were held with each older person. The interviews were audio-recorded and conducted face-to-face (researcher and older person) in a reserved space at the MHU. Prior to data collection, a pilot test was conducted to verify the structure and clarity of the questions in the semi-structured script, enabling modifications and improvements to the interview guide. The data from the pilot interview conducted with three older adults were not considered in the research results. The semi-structured questionnaire contained four parts:

1) Sociodemographic characteristics: name, sex, age.

2) Clinical profile: Time since diagnosis; Time of treatment; type of treatment; underlying diseases (comorbidity), complications of Type 2 DM, and knowledge about the health condition.

Regarding self-care, it was based on Dorothea Orem's theoretical framework of self-care[7], and the following questions were asked:

3) Condition of being a person with diabetes: A) Does living as an older person with Type 2 DM require daily challenges or changes? If yes, which ones? If no, explain. B) Did anything change before and after discovering the diabetes diagnosis? C) Did anything change before and after becoming a person with insulin-dependent diabetes? (Applied to interviewees currently undergoing this treatment); D) What are your thoughts about your condition today? E) Does having Type 2 DM change the way you live or perceive yourself in the world?

4) Self-care: A) What is self-care for you? B) Do you do anything for yourself? And for your self-care?

The interviews continued until data saturation was achieved, through repetition of content and ideas. After the interviews were completed, the data were tabulated and subsequently subjected to content analysis[14]. In the pre-analysis stage, the data were organized and systematized, removing free-text responses that did not add relevant

information for analysis. In the exploratory coding stage of the recording units, the resulting excerpts were coded according to convergent and divergent excerpts from the interviews. In the categorization stage, recording units emerged, represented by categories and subcategories, which guided the results processing stage. This stage consisted of reflective and critical inferences and interpretation of the data on the perceptions of older adults with Type 2 DM regarding their experience and self-care.

In compliance with ethical precepts of anonymity, the interviews were recorded and transcribed in full, with the older individuals identified by the codes PAT. 1... PAT. 13. The research was approved by the Research Ethics Committee of the Federal University of Paraná and the Municipal Health Department of Curitiba, according to the opinions substantiated: 6.195.537 and 6.064.240.

Results

Characterization of the Older Adults

Thirteen older adults participated in the study. Seven were female and six were male, ranging in age from 61 to 87 years, and the mean time since diagnosis and treatment of Type 2 DM was 30 years. The most common treatment options were dietary restriction (n=11), oral medication (n=11), exclusively oral medication (n=2), and oral and insulin therapy (n=5).

All participants reported having comorbidities, the most common being: systemic arterial hypertension (SAH) (n=12), hypercholesterolemia (n=4), chronic venous insufficiency (CVI) (n=1), and prostate cancer (n=1). Regarding complications resulting from Type 2 DM, difficulty healing stood out (n=6), followed by diabetic retinopathy (DR) (n=4), stroke (n=1), thrombosis (n=1), and other complications (n=1). Two older adults (n=2) reported nocturnal polyuria. Two older adults (n=2) stated that they did not have any complications related to Type 2 DM. All interviewees (n=13) reported having knowledge about their health condition, with no doubts.

Perception of Being a Person with Diabetes

Regarding perception of being a person with diabetes, five categories emerged, based on the interviewees' statements: 1) Self-perception: nutrition, outlook on life, and decision-making; 2) Being a person with diabetes: dietary changes, prevention of complications, active living; 3) Being a person with insulin-dependent diabetes: dietary changes, daily management; 4) Types of thoughts: Adaptation, Expectations, Fear; 5) Self-reflection: resignification and changes. Box 1 presents the coding of the testimonies and the reference code for older adults, as well as the corresponding emerging category of the *corpus* of analysis.

Box 1 – Possible domains of application of content analysis

Coding and reference code for older adults	Emerging categories
Nutrition (PAT. 2), (PAT. 7), (PAT. 8), (PAT. 11) Life Outlook (PAT. 4), (PAT. 6), (PAT. 9) Decision Making (PAT. 6), (PAT. 9), (PAT. 13)	Self-perception
Dietary Change (PAT. 2), (PAT. 3), (PAT. 6), (PAT. 9), (PAT. 10). Prevention of Complications (PAT. 3), (PAT. 6), (PAT. 9) Active Living (PAT. 3), (PAT. 6), (PAT. 9)	Condition of being a person with diabetes
Dietary Change (PAT. 4), (PAT. 5), (PAT. 6), (PAT. 10). Daily Control (PAT. 5), (PAT. 6), (PAT. 10)	Condition of being a person with insulin-dependent diabetes
Adaptation (PAT. 1), (PAT. 2), (PAT. 4), (PAT. 5), (PAT. 6), Expectations (PAT. 4), (PAT. 5), (PAT. 6), (PAT. 12) Fear (PAT. 10), (PAT. 12)	Types of thoughts

Resignification (PAT. 1), (PAT. 6), (PAT. 13) Changes (PAT. 2), (PAT. 5), (PAT. 9)	Self-reflection

Source: Own elaboration (2024).

The first clear category was self-perception, considered the way in which an individual perceives his individual strengths and weaknesses. Within this category, the following subcategories emerged: nutrition, the process by which the human body obtains and assimilates food and nutrients to perform its vital functions; life outlook, considered the way of thinking, feeling, and interpreting events and decision-making, the process inherent in choosing actions and attitudes to achieve a specific goal.

> *I need to have a balanced diet with little sugar* (PAT. 2).
>
> *I often don't travel, preferring to stay home because of my diabetes* (PAT. 4).
>
> *I have to take many medications daily and end up living around them* (PAT. 6).
>
> *I need to restrict many foods and take many medications* (PAT. 7).
>
> *I need to watch my diet and take my medications* (PAT. 8).
>
> *I take care not to injure myself; I'm afraid I won't heal and I'll lose a finger or foot* (PAT. 9).
>
> *Because of my diabetes, I haven't left the house much, not even to visit relatives' houses* (PAT. 13).

The second category "The condition of being a person with diabetes corresponds to the lifestyle" that results from the circumstances in which the older adults with Type 2 DM find themselves. This category highlighted aspects related to dietary changes (a resource applied to assist in glycemic control and reduce the risk of comorbidities for diabetics), prevention of complications (strategies and individual attitudes aimed at reducing the risk of complications from the disease), and active living considered in the implementation and adherence to practices that contribute to improving health and quality of life. Testimonies emerged on the issue involving changes that occurred with the discovery and/or diagnosis of diabetes.

> *Yes, it has changed! My diet* (PAT. 2).
>
> *After learning about diabetes, I'm always concerned about controlling my health and diet. I get tests and monitoring at the clinic* (PAT. 3).
>
> *It has changed my life! Before I had diabetes, I was sedentary!* [...] *Today, I exercise; I take care of my diet and health to prevent complications* (PAT. 6).
>
> *It changed when I learned I had diabetes; I had to change my eating habits* [...] (PAT. 9).
>
> *Yes, it has changed, I take care of my diet, I'm afraid of getting hurt, of my glucose levels rising and of losing my vision; I have a little anxiety, but I'm living my life with diabetes.* (PAT. 10).

For older adults undergoing drug treatment with insulin therapy, the category "condition of being a person with insulin-dependent diabetes" stood out, based on the definition of category two (way of living that results from the circumstances in which the older adults with Type 2 DM find themselves), with the subcategories: dietary change (resource applied to assist in glycemic control and reduction of the risk of comorbidities and daily control corresponds in this research as an integral part of the treatment for Type 2 DM aimed at insulin-dependent older adults.

> *Yes, it changed after I started taking insulin. My quality of life worsened. I can't drink and I eat very little sweets* (PAT. 4).
>
> *My life was better without diabetes. I need to monitor my health and diet, and I need to be careful every day* (PAT. 5).
>
> *Using insulin, I have to be careful to eat well to avoid hypoglycemia and serious complications* (PAT. 6).
>
> *It changed. I had to learn to control my blood sugar, take insulin daily, and there are still many trips to the doctor* (PAT. 10).

The fourth category highlighted "Types of thoughts", considered as the way of thinking of the older person about his/her condition of living with type 2 diabetes, with the subcategories: adaptation, based on the capacity and willingness that each person has to manage the internal and external demands in solving problems, expectation understood as the wait based on the probabilities of something happening in relation to Type 2 DM and fear considered the feeling in

relation to the disease, according to the following statements from the interviewees:

> *I think I need to act rationally; after all, my head goes, but my body doesn't!* (PAT. 1).
>
> *I think I always have to be mindful of taking care of myself* (PAT. 2).
>
> *I would like to go back many years, it's impossible, right? But life is good before diabetes, after, and always* (PAT. 4).
>
> *I think I would like to be cured of diabetes* (PAT. 5).
>
> *Today, diabetes is a disease of young people, children, and the older adults; I think it all depends on care* (PAT. 6).
>
> *I think diabetes brings many physical problems, especially vision problems* (PAT. 10).
>
> *I am afraid of going blind because of diabetes, so I do what people tell me to do to get better* (PAT. 12).

Changes in the way older adults with type 2 DM live and perceive the world were also evidenced, generating the category of "Self-reflection", understood as reflection on oneself. Within this category, aspects inherent to subcategories are allocated: resignification, understood as the older adults' ability to reorder and value something in order to alter the meaning of something; and changes, also based on Orem's theory, understood as changes made in relation to the experiential context in favor of living with type 2 diabetes, as can be seen in the testimonies presented:

> *Yes, I need to resignify my life daily* (PAT. 1).
>
> *I realize that the disease affects my diet, lifestyle, and health care. I had to change practically everything* (PAT. 2).
>
> *Having diabetes has changed things* […] *I don't go to dances anymore, I spend a lot of time taking care of my health* (PAT. 5).
>
> *It has changed; I realize that diabetes is a disease that requires a whole lot of treatment. I needed to find new meaning in my life* (PAT. 6).
>
> *It has changed my routine, as well as my life* (PAT. 9).
>
> *It has changed the way I live* (PAT. 13).

Older Adults' Perceptions of Self-Care

Regarding older adults' perceptions of self-care, two categories emerged: 1) Self-care is health; 2) Self-care is attitudes of self-esteem and emotion.

Box 2 presents the reference codes for older adults, coding, and categories, emerging from the corpus of analysis based on the older adults' testimonies, as can be seen.

Box 2 – Possible domains for applying content analysis

Coding and reference code for older adults	Emerging categories
Food (PAT. 8), (PAT. 9), (PAT. 10), (PAT. 13) Health care (PAT. 3), (PAT. 4), (PAT. 8), (PAT. 9), (PAT. 10), (PAT. 13)	Self-care is health
Self-Esteem (PAT. 2), (PAT. 5), (PAT. 8) (PAT. 12) Emotion (PAT. 2), (PAT. 5), (PAT. 8), (PAT. 12), (PAT. 13)	Self-care is about attitudes of self-esteem and emotion

Source: Created by the author (2024), adapted from Bardin[14]

The first category generated was self-care is health, based on the precepts of Orem's theory, which considers self-care as a set of actions a person performs for his/her own health. The emerging subcategories were "nutrition" (the process by which the human body obtains and assimilates food and nutrients to perform its vital functions), and "health care," considered in this research as an attitude of carrying out interventions seeking positive health outcomes, as can be seen in the following statements:

> *I think self-care is about loving yourself! Doing healthier things, in every way, be it physical, emotional, and social* (PAT. 3).
>
> *Self-care is truly taking care of yourself and doing everything possible to make everything work out, so that diabetes doesn't get worse* (PAT. 4).
>
> *Self-care is about paying attention to your diet, walking, and taking care of yourself* (PAT. 8).
>
> *Self-care is about taking care of yourself, such as your diet and health* (PAT. 9).
>
> *Self-care is about taking care of everything: your feet, your hands, your shoes, your diet, and your health (PAT. 10).*
>
> *Self-care is about taking care of myself, having discipline* [...] *it's about control* (PAT. 13).

The following category also emerged: "self-care is attitudes of self-esteem and emotion", considering the attitudes of the older person related to his/her self-esteem and emotion. The emerging subcategories involved: self-esteem, considered as a form of self-evaluation that supports attitudes and decisions, generating confidence in his/her actions and personal judgments[7]; and emotions, such as affective reactions related to health and life, as shown in the following statements:

> *I've been going to church, trying not to get nervous, and always thinking positive!* (PAT. 02).
>
> *I've been trying to take care of myself physically, emotionally, and for my family* (PAT. 05).
>
> *I'm trying to slow down, spend more time doing what I enjoy* (PAT. 8).
>
> *I've been doing everything* [...] *I do everything I'm told, I take medicine, tea, I cut out sweets, and I go to church. It's helped!* (PAT. 12).
>
> *I've been trying to take care of myself! I've stopped worrying about others* (PAT. 13).

Discussion

In line with the results identified in the study, a theoretical and scientific basis is presented, beginning with the characterization of the participants, with a predominance of females. The Surveillance System for Risk and Protective Factors for Chronic Diseases by Telephone Survey (Vigitel) indicates that the disease affects 11.1% of women, while the percentage for men is 9.1% [3]. Regarding age, data in the literature converge with the findings of this study, ranging from 61 to 87 years old, corroborating the diagnosis of type 2 DM in older adults in this age group[15,16]. Understanding the sociodemographic profile, such as the predominant characteristics of the participants, particularly gender and age, is relevant to understanding care management strategies and possible action plans.

Regarding the time since diagnosis and treatment of type 2 DM, data may be related to increased longevity and improvements in quality of life. In this regard, the Ministry of Health has been investing in PHC support tools, implementing the National Policy that guides actions developed and targeted at this population[4,14]. The treatment for type 2 DM stands out, including oral medications, dietary restrictions, and oral medications combined with insulin, as recommended by the Ministry of Health[3,4].

Another relevant aspect regarding older adults with type 2 DM is multi-morbidity, characterized by the presence of two or more chronic diseases in the same individual[17]. All interviewees reported having this condition, which can be explained by the greater likelihood of older adults developing chronic diseases[18,19].

This study also highlighted complications resulting from type 2 DM, including impaired wound healing and diabetic retinopathy. Most diabetes complications result from blood glucose levels that can remain elevated for long periods, gradually leading to or worsening complications related to type 2 DM. Slowing the healing process and vision impairment due to diabetic retinopathy are common[3]. Older individuals' perceptions of living with type 2 DM emphasized self-perception, particularly regarding nutrition, life outlook, and decision-making. This highlights the complexity of health in older adults, with multiple factors that facilitate and hinder well-being, quality of life, autonomy, and independence[16,20].

Healthy eating habits play an important role in the treatment of diabetes and are a factor in preventing and reducing comorbidities such as hypertension and cholesterol. Studies examining the eating habits of older adults with diabetes have demonstrated a positive association between eating habits and lifestyle. These results highlight the need to promote interventions focused on healthy eating guidelines, as well as health education specifically for people with diabetes, especially in primary care settings[20,21].

Interviewees highlighted the need for daily monitoring required for insulin-dependent older adults, reinforced by reports of the need for adaptations and incorporation of practices involving dietary changes, glycemic control,

frequent physical activity, and lifestyle changes after a diabetes diagnosis. Research has shown that being a person with diabetes encourages individual adaptation in aspects inherent to daily life and preventive care[22,23].

Furthermore, many factors may be related to the thoughts of older adults with diabetes, which influence emotional and physical well-being[22,24]. Among the thoughts listed by older adults in this study were adaptation, expectation, and fear, indicating motivational barriers for these individuals facing the disease.

Studies show that the complexity of type 2 DM and the need for consistency and monitoring of treatment can lead to negative emotions and self-care for older adults with diabetes. Understanding the feelings and behaviors of older adults with diabetes can guide and redirect health care provided in PHC[25].

In Brazil, the Unified Health System (SUS) establishes and reaffirms social rights to health, strengthening and intensifying the expansion of PHC to ensure universal and comprehensive care for the population. Thus, BHUs are gateways for older adults with DM and their function is to promote comprehensive health care, playing a key role in ensuring care and monitoring for individuals with NCDs[25,26]. In this sense, public health policies in PHC should be geared towards older adults, encouraging the creation of physical and social environments that enable improved health for older adults with type 2 DM.

Furthermore, it is essential to understand perceptions about changes, ways of living, and self-perception in the world as a person with diabetes. This demonstrates the desire to seek new meaning and changes for well-being, self-care, and living with diabetes. These attitudes have a positive impact on coping with the disease and support self-care[7,8]. Understanding the feelings and behaviors of older adults with diabetes by healthcare professionals can contribute to the effectiveness of current treatment[23].

The theoretical foundations of self-care emphasize restoring older adults' autonomy in decisions about their living conditions[7]. In this context, PHC nurses are strategic elements in assisting with the demands and self-care planning of older adults with type 2 DM[4,22], respecting individuality and unique needs.

Among the tactics developed by PHC nurses, encouraging self-care stands out; interviewees highlight this tactic as an important instrument for contributing to health and nutrition. The nurse's welcoming and bonding with the older person was considered important for fostering closer relationships and supporting self-care. When self-care is self-managed and supported effectively, these elements are crucial to the success of treatment for older adults with DM[2].

To achieve self-care, joint and continuous efforts are necessary between the nurses and the older adults with type 2 DM, through agreed practices for shared responsibility, especially in treatment and care, preventing health problems and complications for the older person with diabetes[22,23].

Respecting and understanding the individual needs and demands of older adults with type 2 DM requires a broad perspective, refuting a singular biological understanding and considering physical, psychological, social, and collective aspects, with an emphasis on individualized care that contributes to self-care, well-being, health promotion, autonomy, and independence[5]. Valuing the perceptions of older adults with type 2 DM about their experiences and self-care are the foundations for effective and sustainable care planning.

The limited number of participants (N=13 older adults) and the source (a single primary care unit) are among the limitations of this study, limiting the generalizability of the results.

Conclusion

The findings of this study demonstrated relevant arguments and contributions to nursing care for older adults with type 2 DM treated in PHC, strengthening the field of geriatrics and gerontology, the science of nursing. The evidence demonstrates the importance of self-care in

relation to the psycho-emotional aspects that influence the development of older adults with type 2 DM, including their self-care, well-being, health promotion, autonomy, and independence, as well as diabetes treatment.

Self-care emerged as an important strategy for preventing and rehabilitating the health of older adults with type 2 DM, highlighting the importance of identifying gaps in self-management and self-care commitment. Some weaknesses identified in this study include: difficulties living with diabetes, fear expressed as uncertainty regarding changes, difficulties with daily control regarding capillary blood glucose monitoring, and adaptation to care routines related to nutrition, healthy habits, and physical activity. The older adults with type 2 DM in this study demonstrated awareness of their strengths and weaknesses in living with the disease, highlighting the importance of self-care in daily life, understood as an essential tool, linked to health, nutrition, self-esteem, and emotions. Thus, these findings and contributions to the field of geriatrics and gerontology are important, particularly in identifying information that characterizes the heterogeneity of older adults with type 2 diabetes mellitus, as well as the key points that need to be addressed in care planning.

The emphasis on self-care, well-being, autonomy, and independence, as well as the context of PHC, are relevant to prioritizing action and public policies on the topic studied. Furthermore, the importance of future studies addressing this topic is highlighted, especially with in-depth analysis of psycho-emotional aspects.

Collaborations:

1 – Project design and planning: Alcione Oliveira de Souza;

2 – Data analysis and interpretation: Alessandra Amaral Schwanke and Denise Cristina Diniz Braga;

3 – Writing and/or critical review: Karina Silveira de Almeida Hammerschmidt, Jessika de Oliveira Cavalaro, and Barbara David Nascimento Aeroso;

4 – Final version approval: Neidamar Pedrini Arias Fugaça.

Conflicts of interest

There are no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available in the article itself.

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