Received: 22 February 2022 | Revised: 10 March 2023 | Accepted: 5 May 2023

DOI: 10.1002/nop2.1825

NursingOpen Open Access WILEY

RESEARCH ARTICLE

Narratives of type 2 diabetes mellitus patients regarding the influence of social issues on diabetes self-management: Implications for patient care

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Abstract

Aim: To explore the perspectives of individuals living with type 2 diabetes mellitus on the influence of social factors on diabetes self-management in Ghanaian context.

Design: Hermeneutic phenomenological approach to qualitative research was used.

Method: A semi-structured interview guide was used to collect data from 27 participants who were newly diagnosed with type 2 diabetes. Analysis of data was carried out by using content analysis approach. One main theme with five subthemes emerged.

Results: Participants experienced social stigma due to the changes in their physical appearance. Mandatory isolation was created by participants in order to manage the diabetes. The financial status of the participants was affected by the diabetes self-management. Differing from the social issues, the overall participants' responses to experiences living with type 2 diabetes mellitus culminated with psychological or emotional hassles, and therefore, patients resorting to alcohol consumption to deal with diabetes related stress, fears, anxiety, apprehension and pain among others.

KEYWORDS
diabetes mellitus, management, social

1 | INTRODUCTION

Diabetes is a global health issues and its impact on the wellbeing of mankind cannot be over emphasized. The number of persons with diabetes mellitus has almost increase fourfold since 1980. Prevalence is increasing globally, predominantly in low- and middle-income countries (World Health Organization [WHO], 2021). In Ghana, it is estimated that diabetes mellitus affects 6.3% of the Ghanaian population with type 2 diabetes accounting for 90%–95% of all cases of diabetes (WHO, 2020). It is a long-lasting disease that affect how the body turns food into energy (Centre for Disease Control and Prevention, 2021). Diabetes mellitus occurs when the body cannot produce enough insulin or cannot respond appropriately to insulin (Healthy people, 2020). Type 2 diabetes mellitus is one of the forms of diabetes mellitus aside the type 1 and gestational diabetes. Type 2 diabetes mellitus results from a combination of resistance to the action of insulin and insufficient insulin production (Healthy people, 2020). More than 95% of people with diabetes have type 2 diabetes mellitus (WHO, 2021). Diabetes mellitus has a devastating effect on the individual and can damage the heart, blood vessels, eyes, kidneys and nerves (WHO, 2021). Diabetes mellitus of all types can lead to complications in many parts of the body and increase the risk of dying prematurely (WHO, 2020).

2 | BACKGROUND

The management protocol of type 2 diabetes mellitus includes daily oral medications or insulin injections, regular blood sugar testing, frequent exercises and being selective in terms of food intake (International Diabetes Federation (IDF), 2018). It has been noted that social and economic issues impact health in general and have been identified as statistically significant factors, which influence diabetes outcomes in particular among persons living with the condition (Harwood et al., 2013; Solar & Irwin, 2010; Walker et al., 2014). Social determinants of health are the socio-economic conditions, which affect the health of persons and communities in general (Raphael, 2004). The literature mostly centres on the biomedical care, lifestyle modification including diet, regular exercises, blood glucose monitoring and some aspects of psychological issues such as anxiety and depression among individuals living with diabetes mellitus (Williamson et al., 2004), with diminutive consideration or attention given to the part played by social determinants of health in the prevention and control in addition to the management and treatment of diabetes mellitus (Pilkington et al., 2011). It has also been noted that social issues are connected with chronic conditions as some of them serve as barriers in managing these diseases (Blas et al., 2012; Raphael et al., 2010; Touma & Pannain, 2011). The idea of social issues in health care appears to be associated with health determinants framework (Dahlgren & Whitehead, 1993) as it is based on individuals or group of individuals, in addition to factors surrounding them. Persons are at the focal point of this layered framework who are impacted by their own environment and actions (Dahlgren & Whitehead, 1991), as demonstrated by Dahlgren and Whitehead (1993) who show the relationships between the person, disease and environment (WHO, 2011; Jack et al., 2012).

From the authors observation as professional nurses' with over 20 years' experience in clinical nursing practice, it has been noted that, our current healthcare services for individuals with diabetes mellitus centres mainly on organizing and conducting review clinics and meeting them on regular basis to deliver clinical care. Conversely, social issues confronting the affected persons are given limited attention. It is important to recognize that social perspectives around the care of patients with diabetes mellitus are worth noting as diabetes mellitus is considered a chronic disease condition (Silva et al., 2018). In this sense it requires extensive behavioural changes in the affected individuals in order to adhere to its treatment in general. Social issues are considered very essential and key factors for performing self-care and management among persons living with diabetes mellitus (WHO, 2021). In other words, social issues may affect disease control and outcome among individuals with diabetes mellitus. Examples of these factors may include the patient's income level, level of education, access to health care, access to nutritious diet, availability of public parks for exercises and social support in general to mention a few. This research is situated particularly in the areas of social inequalities and social stigma, and diabetes-distress related to diabetes care in the context of Ghana, where patients and their healthcare providers encounter unique challenges in self-care and management of diabetes mellitus. For example, in Ghana individuals living with diabetes mellitus encounter challenges including high cost of treatment of the condition and shortage of medications and stigmatization, and limited access to health resources in general, to mention a few. There is inadequate number of skilled healthcare staff especially in the rural areas to take proper care of persons living with chronic diseases such as diabetes mellitus. In addition, health system challenges such as the national health insurance scheme in Ghana does not function appropriately to cushion patients who have contributed to it, due to poor management. The healthcare providers also face similar challenges, which centers around patient care barriers such as limited resources and availability of equipment needed for adequate care of the condition. Staff are demoralized by the management's unwillingness to support them for innovative changes to patient care, increased burden of patient load without corresponding remunerations, and inappropriate cultural beliefs of patients, which militate against patient care. For example, individuals living with diabetes tend to ignore health professionals' advice due to patients' poor beliefs and perceptions, which in most cases result in poor patient and disease outcomes. It was on this basis that the researchers set off to explore the perspectives of individuals living with type 2 diabetes mellitus on the influence of social factors on diabetes self-management in Ghanaian context, in order to find ways to improve the lives of the affected individuals in a holistic approach. The research question, therefore, is what are the influences of social issues on diabetes mellitus self-management?

3 | METHODS

3.1 | Study design

The investigation employed hermeneutic phenomenological approach to qualitative research for the current study, which demonstrates that individuals cannot be disconnected from the world, which seems to explain the stand of the research investigators who could not separate themselves from the research participants in this study (Kafle, 2013; Reiners, 2012). The theoretical orientation upon which this study depends in terms of hermeneutic phenomenology, centres on the description of personal experiences of the individuals living with diabetes mellitus through understanding and interpretation of their experiences (Manen, 2014). These reflect on the basic assumptions of hermeneutic phenomenology, which indicates that humans seek meaning in their lives and that there are several realities in socially constructed meanings from individuals' lived experiences (Manen, 2014). Thus, hermeneutic phenomenology focuses on the idea that individuals make meaning of lived experiences (Gadamer, 1997; Kafle, 2013). This study employed 32 COREQ checklist for qualitative research developed by (Tong et al., 2007).

3.2 | Sample and sampling approach

In this study 54 patients, newly diagnosed with type 2 diabetes mellitus were invited to take part in this research, but 42 of them responded to the invitation letters, which were sent out. The names of the research participants were obtained from the diabetic clinic attendance register. The study was opened to patients with type 2 diabetes mellitus who were newly diagnosed within 3 months at the hospital. The study recruited persons diagnosed with type 2 diabetes mellitus within 3 months. This ensured that individuals diagnosed within this time frame would easily recollect their experiences living with the condition, as such experiences would still be fresh in their memories. Also being newly diagnosed patients with diabetes mellitus, it was imperative to find out their challenges at the initial stage of the condition in order to offer them the needed support such as counselling, social support and financial support among others, for them to come to terms with the condition at the primary stage of the illness. The context for this research in terms of how the care of patients newly diagnosed with diabetes mellitus occur focused on the fact upon diagnosis and commencement of treatment. Most patients are confronted with some challenges such as limited income, stigmatization by the public and even at the family level, emotional distress related to the diagnosis of a debilitating condition and social isolation for fear of being stigmatized. These social issues affect negatively the self-care and general management of individuals who are newly diagnosed with diabetes mellitus.

3.3 | Data collection

Data was collected by employing a semi-structured interview guide, which allowed the researchers to ask open ended questions to guarantee the conversation with the participants to centre on the key subject related to the influence of social factors on diabetes mellitus self-management (Stuckey, 2013). To ensure consistency of data collection, the lead author conducted all the audio-recorded interviews. This was to ensure that specific common words and sentences were used for participants' understanding in both English and Twi languages, which were employed for all interviews. This was to avoid variations in their meanings to the research participants, which could also affect meanings during analysis of data. Back translation of interviews from English to Twi was also done by a colleague researcher to ensure consistency and accuracy as part of strategies to guarantee trustworthiness. Additionally, to ensure methodological rigour, the research participants were interviewed extensively in order to get detailed information on the influence of social factors on diabetes self-management from their point of view. The semi-structure interview was composed of two main parts. These were part A and B. Part A of the interview guide was intended to collect data on socio-demographic information. Some of the question, which were asked in the part B included “In what ways do you think the management of your condition is affected?”. In some specific situations when responses were not forthcoming from the research participants questions such as “Tell me about how social factors such as your income level, stigma from people, and fear about the disease have affected the treatment of your condition?” were asked. In addition, probes were asked for expansion and clarification of their responses. These helped to expand on responses, which were unclear to the researchers. Each interview lasted between 45 min to 1 h, either in the local Twi language or English. Data collected in the Twi language were later translated into English language. Data collection occurred between August and October 2009 at a hospital in Ghana. Twenty-four of the interviews took place in the hospital where the researcher was allocated an office purposely for this research. The remaining three interviews were conducted in the homes of the research participants with their authorization. In all data saturation occurred at the 27th interview, when it was observed that no new information was forthcoming from the research participants (Fusch & Ness, 2015). Data collection and analysis proceeded simultaneously. This was done with the aim to ensure that pieces of information or findings, which emerged from the data analysis shaped the ensuing sampling and data collection.

3.4 | Data analysis

Analysis of data was carried out by using content analysis approach by (Creswell & Creswell, 2018), which was done simultaneously with data collection. Recorded data from the research participants was transcribed verbatim and printouts were read several times to acquire meanings emerging from them. The meanings were then generated to form the research theme, out of which the subthemes were identified (Mayan, 2009). The lead author carried out independent data analysis of all the audio-recorded interviews in this study to ensure uniformity of the processes involved. However, the second author was given the opportunity to conduct the second autonomous data analysis to authenticate, which was done by the lead author. This was done to compare and contrast the findings to settle on the mutually suitable research outcomes. The research participants were engaged for a prolonged period of time during interviews to ensure that questions, which needed clarification were asked in a form of probing. Additionally, piloting of the interview guide was done using two family relatives of one of the researchers who incidentally had type 2 diabetes mellitus.

3.5 | Ethics

Ethical and scientific approval for the study was obtained (REDACTED). Permission was given by the local Diabetes Patients' Association to interview its members who agreed to be part of the study. In this research, some of the ethical concerns that were taken into account were anonymity, confidentiality and informed consent among others. For instance, written informed consent was obtained willingly from each of the research participants. In addition, pseudonyms were given to research participants to obscure their real identity in this research. In the same vein, the biographic data of the research participants was detached from the research data to circumvent any linkages between them.

4 | RESULTS

The interviews were conducted among 27 patients newly diagnosed with type 2 diabetes mellitus. Their ages ranged between 38 and 63 years. In all, there were 12 females and 15 males. Twenty-six of the participants were affiliated with the Christian religious group whereas only one participant was a Muslim. In terms of employment, all the 27 participants were employed. Fifteen of the participants had attained basic education, seven with secondary education, two were professional nurses, one professional teacher and two participants had no education background.

One main theme with five subthemes emerged from the data analysis.

4.1 | The Main theme: Social experiences with diabetes mellitus self-management

The theme focused mainly on the participants' social experiences as persons living with diabetes mellitus having to manage the condition in relation to the challenges including low income of patients and associated high cost of treatment of a chronic disease, poor access to health care and resources, and scarce skilled healthcare staff. It is equally important to emphasize that persons with diabetes in Ghana are stigmatized when they have severe weight loss, which is perceived to be Acquired Immune Deficiency Syndrome (AIDS) related. Additionally, persons living with diabetes incline to disregard health professionals' advice due to patients' poor beliefs and values and perceptions, which in many situations lead to pitiable patient consequences.

The five subthemes which emerged from the social experiences with diabetes mellitus self-management are as follows: (1) Effects of stigma on diabetes management. (2) Impact of social isolation on diabetes management. (3) Financial conditions and circumstances on diabetes management. (4) Psychological/emotional effects on diabetes management and (5) Use of alcohol among the patients with diabetes mellitus.

4.2 | Subtheme 1: Effects of stigma on diabetes mellitus management

This subtheme centred on social stigma which participants experienced due to the changes in their physical appearance. They lost a statistically significant amount of weight due to the effect of the diabetes and that made them appear typically like a client diagnosed of Acquired Immune Deficiency Syndrome (AIDS). The participants recounted their stories of been branded as having AIDS. They alleged to have been abandoned and blamed by family members and community members as having AIDS, which is perceived by most people as deadly and without cure, although it can be managed. Hence nobody would want to be associated with a hopeless condition. A participant narrated her story this way:

> I have reduced in weight so people accuse me of having AIDS. The doctor at the hospital told me that I have diabetes but because of weight loss individuals are stigmatizing me with a different condition, which is very deadly.
>
> (P25)

The stigmatization and social rejection experienced by the participants made them felt troubled. Another participant who felt rejected by the community recounted her experiences below:

> When I am moving around, individuals just gaze at me as if there is something wrong with me. Probably, they have not seen someone with weight loss before. I am pretty disturbed because I feel rejected and unhappy in my community and everywhere I go.
>
> (P5)

It may be possible that participants such as those who experience stigmatization at the community and family levels may withdraw from social interactions in the course of their illness such as seeking health care and hence are less likely to receive the needed and expected treatment. The felt social stigmatization lead to social isolation of the participants.

4.3 | Subtheme 2: Impact of social isolation on diabetes mellitus management

This subtheme explored the mandatory isolation that the participants had to create in order to manage the diabetes. This was due to their unwillingness to disclose their status to others with the aim of circumventing other people to know that they have diabetes. It was identified that participants had to detach themselves from colleagues and friends at times in order to take their medications and to eat at specific times. One of them narrated his story as follows:

> There are times I have to isolate myself from other people, either to eat or to take my medication, to make sure that I am not identified as diabetic because of stigmatization of having diabetes.
>
> (P10)

Another participant also noted it this way:

> I have even stop going for reviews at the hospital because other people may spot me and I will feel

> embarrassed, because they will think that I have diabetes and that is why I am frequently being seen at the hospital, so I have to isolate myself.
>
> (P12)

The risk of social isolation in this sense is the possibility of the participants to isolate themselves from individuals who may offer them the care they deserve when the need arises. In circumstance that it becomes impossible for participants to isolate themselves socially to manage their diabetes, there is a potential of non-compliance to the management.

4.4 | Subtheme 3: Financial conditions and circumstances on diabetes mellitus management

The findings revealed that the financial status of the participants affected diabetes mellitus self-management. The interruptions to financial position of the participants focused on limited income due to financial burden on families, decrease in revenue, and amplified cost of overall diabetes management. One of the patients had this to say:

> I receive meager wage from my employers, so it is very difficult for me to buy all the drugs which the doctors prescribe for me at the diabetes clinic.
>
> (P22)

Similarly, a participant said:

> I have no work doing at the moment, so I find it difficult to pay my hospital bills and to buy drugs that are recommended by the doctors. (P6)

Due to ill health, it is imperative that patients do have money on them always to be able to safeguard against every unexpected situation. When there is no money, participants may have the tendency to live in anxiety and fear due to uncertainties around the disorders of diabetes.

4.5 | Subtheme 4: Psychological/emotional effects on diabetes mellitus self-management

Differing from the social issues, the overall participants' responses to experiences living with type 2 diabetes mellitus culminated with psychological or emotional expressions indicating fear, anxiety, stress, apprehension and feeling about ultimate death due to organ failure. Some emotional expressions were put forward by a participant in this way upon hearing the death of a colleague with diabetes mellitus:

> I become fearful and I think about myself when I hear the death of a diabetic and ponder over who may die next time because of diabetes mellitus. (P3)

Similarly, another participant noted:

> I do not know what will happen to me with this condition at long last as the outcome is always very bad based on my observations with individuals who have had the condition for some time.
>
> (P5)

Another participant, however, noted the stress associated with the condition in terms of economic challenges:

> As for this condition, it brings stress to the affected individuals because the recommended foods by the health professionals are very expensive and an ordinary person like me cannot afford.
>
> (P20)

Certainly according to this patient, diabetes mellitus is not for an ordinary person as cost of expenditure in terms of food recommended by doctors and health professionals in general is woefully exorbitant. However, vis-à-vis with these findings, respondents were able to move on in the phase of some challenges associated with the influence of social issues on diabetes self-management.

4.6 | Subtheme 5: Use of alcohol among the patients with diabetes mellitus

In their attempts to deal with the condition, some of the patients resorted to alcohol consumption to manage perceived stress, fear, apprehension and the anxiety related to the condition. Despite the detrimental effects of alcohol on diabetes in the affected individuals, the patients opted for it as evidenced in these accounts:

> I have been taking alcohol in order to forget about the stress and fears about this condition. With diabetes, if one does not take to alcohol the stress alone may kill you. I do not take too much of it because at the clinic we were told not to take alcohol.
>
> (P15)

> I know that the alcohol is not good for me, because we were told at the clinic during visits by the nurses and doctors not to take alcohol, however I take it to reduce the stress and physical pain with this condition.
>
> (P9)

The patients appear to know complications associated with the use of alcohol to manage perceived stress and other problems associated with the condition, nevertheless they resort to it, despite the health education given by the nurses and doctors during routine visits to the clinic.

5 | DISCUSSION

The findings indicated that the participants were stigmatized by the pubic both at the family and community levels because the diabetes patients had reduced in body weight, which was perceived to be AIDS associated. De Graft (2007) also noted that patients with diabetes in Ghanaian communities "face the risk of HIV/AIDS related stigma" as they experienced humiliation and degradation due to reduction in body weight. The concept of "social identification" related to body size and image is associated with beliefs on thinness of the body weight and are interconnected with personal predicaments and difficulties or diseases such as AIDS, which may influence the typical body weight of people (Block et al., 2009).

The study found that social isolation may have profound effect on health seeking behaviour as patients may avoid any form of interactions with other people including healthcare providers who may even offer them the needed care in critical situations. Similarly, (Chew et al., 2014) noted that self-isolation may lead to loneliness, fear of others and negative self-esteem in diabetes patients (Chew et al., 2014; Hjelm & Beebwa, 2013).

Therefore, ensuring behavioural modifications and providing the appropriate and required psychosocial support during the course of the condition may be one of the ways to reduce complications, optimize health and increase their quality of life. Other studies in Ghana such as that by (Bosu, 2012) have also indicated that due to financial dependence on other individuals such as friends, family members and other relations, it has also resulted in desertion and social isolation in patients living with non-communicable diseases such as diabetes mellitus. This phenomenon is common in Ghana as in most cases due to financial challenges relatives abandon their sick family members in which case the sick person experiences social isolation (Bosu, 2012).

In this study, the findings indicated that due to diabetes patients' poor financial circumstances, it affected the management of the condition. A study by (Aikins, 2006) had similar findings on the issues of National Health Insurance Scheme (NHIS) in Ghana, but her results specifically noted that treatments for individuals with diabetes mellitus becomes problematic when the patient has not registered with the NHIS, in which case the burden falls on the extended household members to bear the cost of health care of the family member with diabetes. A study in Ghana by (Kratzer, 2012) on structural obstacles on coping with type 1 diabetes mellitus among the youth and their family members showed that financial encumbrance on them was mainly owed to, delayed monthly salary payments, high cost of medications and medical appliances required for appropriate diabetes mellitus self-management, which are external factors or barriers to diabetes patients' self-care (Kratzer, 2012), compared with individualistic centered factors as noted in the current study.

The overall response to their experiences living with diabetes mellitus included stigma, social isolation and financial burden on patients with type 2 diabetes mellitus. In this current research were psychological or emotional issues such as depression, stress and anxiety, in which cases some of the diabetes patients began to take to alcohol to deal with the problem at hand. As much as (Chew et al., 2014) considered secondary appraisal in dealing with emotional strains by means of some of the diabetes patients taking to alcohol, which is detrimental to their health, (Stuckey et al., 2014) and (Chew et al., 2014) looked at the interactions between effects of emotional strains on diabetes mellitus treatment and subsequent quality of life (QoL) of diabetes patients.

The outcome of the current study points to the need for healthcare professionals and providers in general to consider rejuvenation of massive patient and in particular public education that weight loss in diabetes mellitus is not related to HIV. In this regard, the education may centre on the disease processes of diabetes mellitus. In this way, the public may not stigmatize the patients with diabetes mellitus in which case the affected patients may avail themselves in hospitals for treatment on regular basis for improved patient outcomes (Browne et al., 2013). The wider literature on health and disease related stigma indicates that individuals who experience stigma may decline to unveil their disease conditions or delay, reduce and even terminate medical treatments and management in general, which are likely to lead to poor disease and patient outcomes (Person et al., 2009). Other studies from high income countries have noted that individuals who perceive that they are stigmatized because of their type 2 diabetes report of amplified emotional distress, reduced social support and worse glycated haemoglobin levels (Browne et al., 2016; Gredig & Bartelsen-Raemy, 2017; Schabert et al., 2013). As part of treatment, these patients may also benefit from counselling to deal with the psychological distress related to unknown outcome of the condition. Nurses and medical doctors and other healthcare providers may spend some time in their interactions with these vulnerable patients to offer them these forms of emotional support. Botchway et al. (2021) have already noted that individuals diagnosed with type 2 diabetes who experience high self-stigma may have reduced social support, which, in turn, may lessen their capacity for disease management and self-care, therefore, such patients require emotional sustenance and care. Similarly, wider social networks and interactions may be beneficial for individuals diagnosed with diabetes mellitus in limited resource economy, and interventions, which increase network resources for individuals with diabetes, which may empower them as patients and ultimately may facilitate diabetes control and better patient outcomes (Browne et al., 2013). Equally, understanding the financial circumstances of these patients and looking for financial support for them may go a long way to ameliorate their financial stand to reduce the financial burden of diabetes mellitus care. There is positive association between network size and social support such as financial support that the patient may receive irrespective of the level of stigma (Seeman & Berkman, 1988). This is because larger networks may include various social ties, which may offer avenues for connections with patients and family members, and non-family members, friends and other distal social contacts who may serve as extra sources of social support, and access to assorted resources (Seeman & Berkman, 1988). In this vein, it may be noted that individuals with diabetes mellitus who are connected to various social groups may obtain support with diverse health-related needs from manifold sources including governmental and non-governmental organizations.

The government may also place subsidies on their medications to make them affordable, this may go a long way to increase attendance of patients with diabetes mellitus at the diabetes clinics across the country. At the hospital level, nurses, doctors, pharmacist and other healthcare providers may establish special fund for sick and poor patients including patients with diabetes mellitus to augment patients who may not afford payments for their medications. In this regard, funds may be solicited from benevolent and organized groups such as Churches, Muslim groupings, Members of Medical Doctors' Wives' Association, Hair Dressers and Beauticians Associations and similar groupings and even from individuals who may have interest to contribute to the fund. There is a saying in Ghana that "Each Person is Another Person's Keeper" and with this spirit individuals appear to be ready to support the care for others when it comes to soliciting for financial assistance for people in need. These and similar interventions may go a long way to augment the care of patients with diabetes mellitus.

5.1 | Limitations of the study

The study employed only patients with type 2 diabetes mellitus, newly diagnosed within a period of 3 months, excluding experiences of patients with type 1 diabetes mellitus and even patients with type 2 diabetes mellitus who have lived with the condition for many years. The qualitative nature of the study limits the findings to the setting. As noted already, the research participants were engaged extensively during the interviews to get detailed data and rich data from them; however, too long interaction could have resulted in interview fatigue of participants, which could have also reduced their responses to certain pertinent questions. In addition, back translation of interviews from English to Twi was also done by a colleague researcher to confirm consistency and accuracy as part of strategies to guarantee trustworthiness; however, translation as closely as possible did not occur possibly due to limited variations in the understandings of words by the lead researcher and the colleague researcher who performed the back translation.

6 | CONCLUSIONS

The study has noted some major challenges faced by patients with type 2 diabetes mellitus including stigmatization by the pubic associated with the body weight reduction perceived to be HIV/AIDS related among others. The inclusive effects of these challenges are their deleterious consequences on diabetes mellitus self-management among the affected persons. This study augments the body of knowledge regarding the influence of social issues on diabetes mellitus self-management in the context of Ghana, which has not been identified earlier.

AUTHOR CONTRIBUTIONS

KAK conceptualized the research, collected the data, conducted the data analysis and drafted the manuscript. JAY assisted in drafting the manuscript and finalizing the manuscript for publication.

ACKNOWLEDGEMENTS

The authors would like to acknowledge all the participants who shared their experiences in this study.

FUNDING INFORMATION

This research received no specific funding.

CONFLICT OF INTEREST STATEMENT

No conflict of interest declared by the authors.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

RESEARCH ETHICS COMMITTEE APPROVAL

Ethical and scientific approval for the study was given by the De Montfort University, Faculty of Health and Life Sciences Research Ethics Committee (Reference Number:347). Additionally, site approval for the study was given by the Health Management Team of the Holy Family Hospital, Techiman, Ghana. Similarly, permission was given by the local Diabetes Patients' Association of Techiman to interview its members who agreed to be part of the study. Written informed consent was obtained willingly from participants.

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How to cite this article: Korsah, K. A., & Agyeman-Yeboah, J. (2023). Narratives of type 2 diabetes mellitus patients regarding the influence of social issues on diabetes self-management: Implications for patient care. *Nursing Open*, *00*, 1–8. https://doi.org/10.1002/nop2.1825