

UNIVERSITY OF GHANA
COLLEGE OF HUMANITIES

BODY IMAGE, EMBODIMENT AND CHRONIC ILLNESS EXPERIENCE IN THE
GHANAIAAN CONTEXT: A SOCIAL PSYCHOLOGICAL STUDY

UNIVERSITY OF GHANA - LEGON

BY

VIDA ASAH-AYEH

10331990

THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES,
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF
DOCTOR OF PHILOSOPHY DEGREE IN PSYCHOLOGY



NOVEMBER, 2024

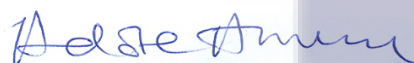
DECLARATION

Except for references to other people's work, which have been duly acknowledged, I declare that this thesis is the result of my own research. It has neither in part nor in whole been presented for another degree in this institution or elsewhere.



VIDA ASAH-AYEH
(PHD CANDIDATE)

29/11/2024
DATE



PROF. ADO TE ANUM
(PRINCIPAL SUPERVISOR)

29/11/2024

DATE



PROF. AMA DE-GRAFT AIKINS
(CO-SUPERVISOR)

29/11/2024

DATE



DEDICATION

To my beloved husband whose unwavering support and encouragement have been my foundation throughout this journey.

To my beautiful children, who have shown such patience and joy along the way, this work is as much yours as it is mine.

In loving memory of my father, my number one cheerleader, who passed away this year, I dedicate this work to your memory, knowing you would have been immensely proud. May your soul rest in peace.

If you set your mind to a goal everything is possible, yes! Just trust God!!!



ACKNOWLEDGEMENTS

I wish to express my profound gratitude to all the research participants who generously shared their experiences and insights with me. Their voices are at the heart of this study. Your insights, openness, and readiness to share have enriched this study and contributed to furthering knowledge in this field. This work would not have been possible without your vital contributions.

I am also deeply thankful to my supervisors, who have gone above and beyond in their support. Your guidance has been incredible significant from the onset. Prof. Adote Anum, thank you for being such an amazing person. Your extensive knowledge and innovative ideas have guided me throughout this journey and brought me this far. I am particularly appreciative of the calls and unwavering assistance throughout this project; it has yielded significant impact. Thank you!

I would like to say a very big thank you to Prof. Ama de-Graft Aikins, my mentor and supervisor. Our journey began a long time ago during my MPhil days, and you have been a blessing, offering unwavering support and opening doors that have shaped my path. The opportunities you have granted me have paved the way for growth and success, and I am deeply and sincerely grateful. You took a genuine interest in my academic journey, ensuring I learned the rigours of research and developed a deep understanding of what it means to engage in substantive work. Your mentorship extends beyond academics, helping me navigate challenges and personal matters with wisdom and kindness. You have been a remarkable source of guidance and I am eternally grateful for your faith in me.

I would also like to extend my gratitude to the teaching and non-teaching staff of the Psychology Department, University of Ghana. Your support and dedication have enriched my learning experience and made my journey smoother.

To my PhD classmates, the 12 disciples, we have truly come far together. The knowledge we shared, the countless hours of discussions, the peer reviews, and the insights were all invaluable.

To Prof. Ama de-Graft Aikins' mentees — Dr. Francis Agyei, Dr. Leonard Baatiema, Dr. Mawuli Kushitor, Dr. Paapa Yaw Asante, and Jemima Okai — every bit of your assistance, advice and encouragement have meant the world to me. Dr. Francis Agyei, may God bless you for the endless calls, directions, and unwavering support.

To my cherished friends, the PADA Girls, thank you. To the “Three Musketeers”, Rachael Hansen-Garshong, Lilian Efua Phillips-Kumaga and myself (Department of Psychology), the love for you is big and deep. May we continue to soar higher and higher together.

To all my friends and loved ones, although I may not be able to mention each of you by name, please know how deeply I appreciate your support. Special thanks to Joycelyn Kalitsi Vogelsang, Irene Botchway, Pious Affum and Solomon Alhassan Yabila.

Now, to my family, I am very grateful. My heartfelt appreciation goes to my mother and siblings.

To my in-laws, Georgina, Irene and especially Mrs. Joyce Mensah, my cheerleader who will call to find out how things are going and encourage me, I am thankful to God for bringing you my way.

To my beloved family, my deepest thanks to my husband and children for their understanding and patience throughout this journey. I know there were times when they wished to have me around more, but they gave me the space I needed to pursue this goal. I promise to make it up to you, my people.

I would like to express my heartfelt gratitude to everyone who has been a constant source of support throughout my PhD journey.

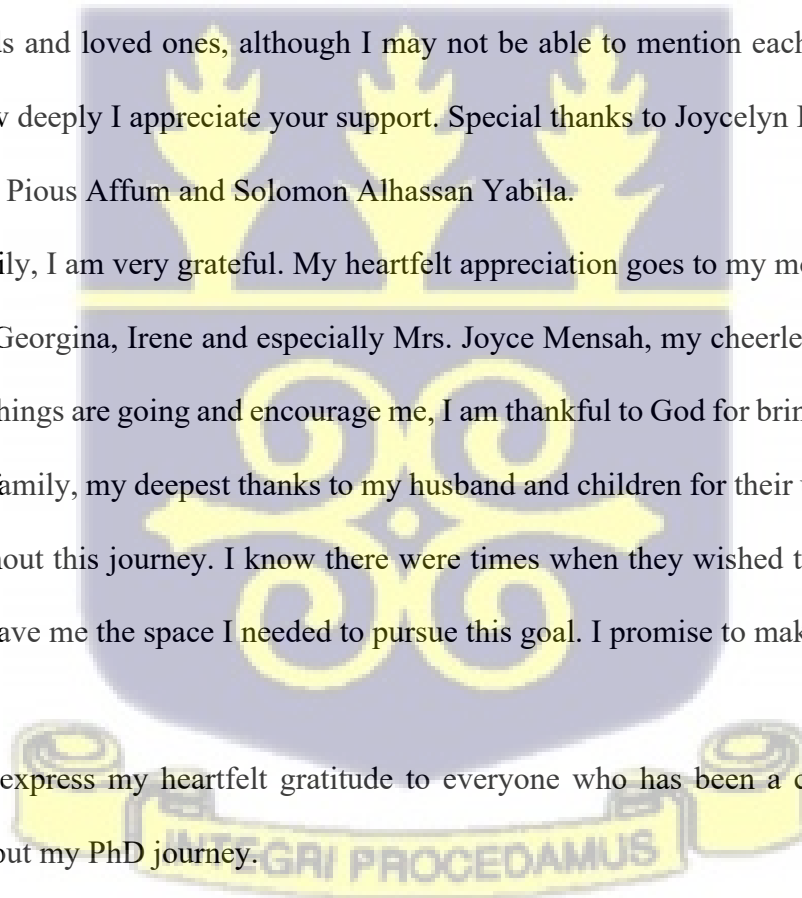


TABLE OF CONTENTS

DECLARATION	i
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	v
LIST OF TABLES	ix
LIST OF FIGURES	x
LIST OF ACRONYMS	xi
ABSTRACT	xii
CHAPTER ONE	1
INTRODUCTION	1
1.1 Background to the Study	1
1.2 Problem Statement	8
1.3 Aim and Objectives	10
1.4 Research Questions	10
1.5 Significance of the Study	11
1.6 Organization of Chapters	13
CHAPTER TWO	16
LITERATURE REVIEW	16
2.1 Introduction	16
2.2 Theoretical Framework	16
2.3 Conceptual Framework	23
2.4 Empirical Review	28
2.4.1 Individual Level Experiences of Chronic Illness, Body Image and Embodiment	28
2.4.2 Interpersonal Level Experiences of Chronic Illness, Body Image and Embodiment	32
2.4.3 Group Influences on Chronic Illness Experience, Body Image and Embodiment	34
2.4.4 Societal Influences on Chronic Illness Experience, Body Image and Embodiment	37
2.5 Summary of Literature Review	40
CHAPTER THREE	42
METHODOLOGY	42
3.1 Introduction	42

3.2	Research Setting.....	42
3.3	Research Paradigm	45
3.4	Research Design	47
3.5	Study Participants and Segmentation Plan.....	48
3.6	Recruitment of Research Participants	63
3.7	Procedure and Data Collection	65
3.8	Data Collection Tools	65
3.9	Ethical Considerations	72
3.10	Data analysis.....	75
3.11	Reflexivity, Trustworthiness and Rigor	81
CHAPTER FOUR.....		85
FINDINGS ON SOCIAL REPRESENTATIONS OF BODY IMAGE		85
4.1	Introduction.....	85
4.2	Content of Representations of the Ideal Body	86
4.2.1	Representations of Ideal Body	86
4.2.2	Gender and Age-based Nuances in Representations of the Ideal Body	94
4.2.3	Ethnic differences in perspectives on body sizes	100
4.2.4	Representations of Fatness and Thinness	103
4.3	Sources of Knowledge on Ideal Body	109
4.4	Discussion	115
4.4.1	Content of Representations of the Ideal Body.....	115
4.4.2	Sources of Knowledge on the Ideal Body Image	118
4.5	Conclusion	120
CHAPTER FIVE.....		122
FINDINGS ON SOCIAL REPRESENTATIONS OF BODY IMAGE IN CHRONIC ILLNESS		122
5.1	Introduction.....	122
5.2	Embodiment and Chronic Illness Experience	122
5.2.1	Pre-diagnosis Representations of Body Image	122
5.2.2	Post-diagnosis representations of body image.....	127
5.2.3	Changes in pre-diagnosis and post-diagnosis body image.....	133
5.3	Causal attributions of changes	144
5.4	Implications for everyday body image management and embodiment	156
5.5	Discussion	159

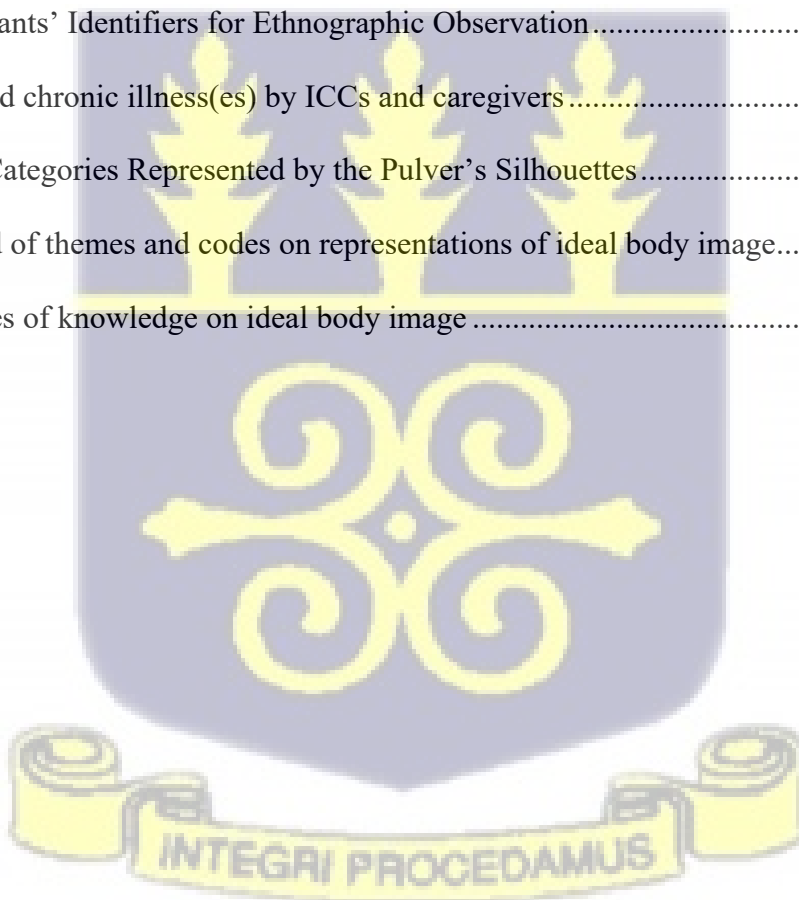
5.5.1	Embodiment and Chronic Illness: pre-diagnosis, post-diagnosis and changes	159
5.5.2	Causal attributions for body image changes	162
5.5.3	Implications for everyday body image and embodiment	163
5.6	Conclusion	165
CHAPTER SIX.....		166
FINDINGS ON BODY IMAGE, EMBODIMENT AND CHRONIC ILLNESS MANAGEMENT		166
6.1	Introduction.....	166
6.2	Chronic illness management	166
6.3	Sources of Information for Treatment and Management of Chronic Illness.....	168
6.4	Challenges with treatment and management	175
6.5	Discussion	181
6.5.1	Chronic illness management.....	181
6.5.2	Sources of Information for Treatment and Management of Chronic Illness	183
6.5.3	Challenges with Treatment and Management	185
6.6	Conclusion	187
CHAPTER SEVEN.....		189
FINDINGS ON CARE NEEDS, EXPERIENCES AND IMPROVEMENT		189
7.1	Introduction.....	189
7.2	Care Needs.....	189
7.3	Care Experiences	197
7.4	Care Improvement.....	203
7.5	Discussion	208
7.5.1	Care needs	208
7.5.2	Care experiences	210
7.5.3	Care Improvement.....	212
7.6	Conclusion	215
CHAPTER EIGHT.....		216
SYNTHESIS AND GENERAL DISCUSSION		216
8.1	Introduction.....	216
8.2	Body Image, Embodiment and Chronic Illness Experiences	216
8.3	Implications for Chronic Care and Management	219
8.4	Contribution of the Study to Knowledge	221
8.5	Limitations of the Study	224

8.6	Recommendations for Future Research.....	225
8.7	Conclusion	227
APPENDICES		258
APPENDIX A – DATA COLLECTION TOOL.....		258
APPENDIX B – PARTICIPANT PROFILES		272
APPENDIX C – CODING FRAMEWORK.....		283



LIST OF TABLES

Table 1: Segmentation plan for participant recruitment	49
Table 2: Sociodemographic profile of individuals with chronic conditions (N = 31)	51
Table 3: Sociodemographic profile of caregivers of chronic patients (N=15)	53
Table 4: Sociodemographic characteristics of healthcare providers (N=8).....	55
Table 5: Sociodemographic characteristics of Focus Group Discussion participants (N=33)	57
Table 6: Sociodemographic characteristics of ethnographic participants (N=4).....	59
Table 7: Participant identifiers.....	60
Table 8: Participants' Identifiers for Ethnographic Observation.....	61
Table 9: Reported chronic illness(es) by ICCs and caregivers.....	62
Table 10: BMI Categories Represented by the Pulver's Silhouettes.....	68
Table 11: Spread of themes and codes on representations of ideal body image.....	88
Table 12: Sources of knowledge on ideal body image	110



LIST OF FIGURES

Figure 1:Multilevel representations of body image, embodiment, and chronic illnesses.....	27
Figure 2: Silhouettes for women's body sizes.....	69
Figure 3:Silhouettes for men's body sizes.....	70
Figure 4:Themes of Body Image Prior to Diagnosis	123
Figure 5:Themes of Body Image after Diagnosis	128
Figure 6:System Map of Information Sources for Treatment and Self-Management of Chronic Illness	175



LIST OF ACRONYMS

Body image – BI

Body size – BS

Caregivers – CG

Chronic Condition – CC

Chronic disease – CD

Chronic illness – CI

Healthcare Providers – HCP

Healthy Lay Individuals – HLI

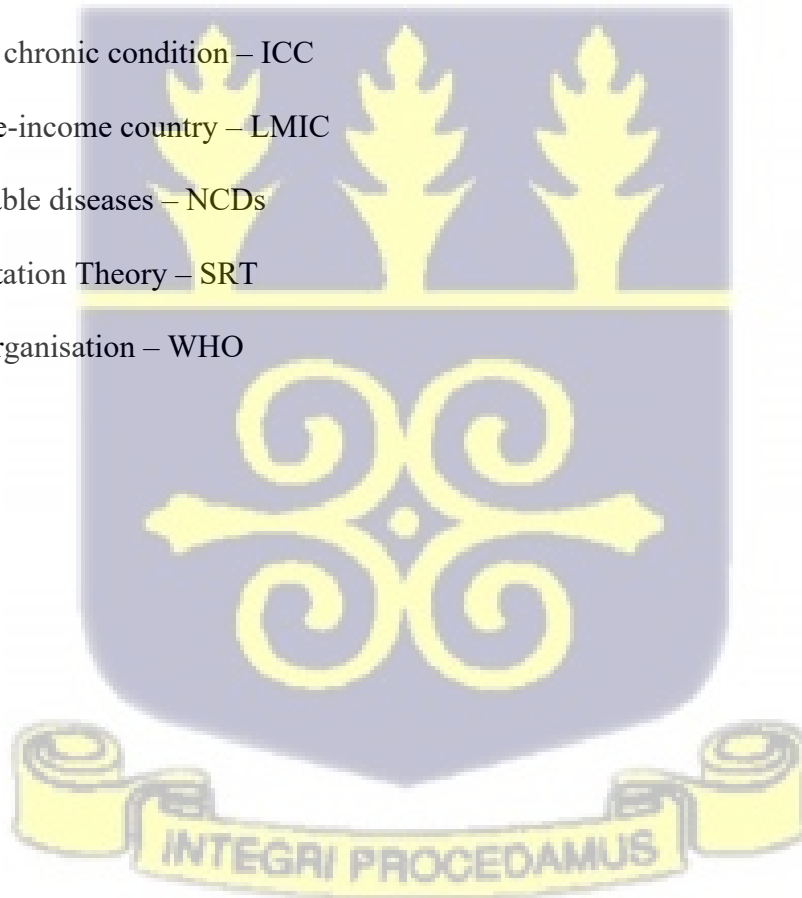
Individuals with chronic condition – ICC

Low- and middle-income country – LMIC

Non-communicable diseases – NCDs

Social Representation Theory – SRT

World Health Organisation – WHO



ABSTRACT

Individuals living with chronic illness experience changes to their body image and sense of embodiment. These changes significantly impact individuals' physical, psychological, and social well-being. Understanding these changes, particularly within the socio-cultural context of Ghana, is critical for developing effective care strategies. Despite growing interest in the interplay between chronic illness and body image, limited research has examined these issues, particularly in African contexts. This study applied a social psychological approach to explore the social representations of body image among individuals living with a range of chronic illnesses in Accra, how these representations intersect with their bodily experiences and how these representations and bodily experiences shape body image management and management of their conditions, care needs and experiences.

A mixed-qualitative research design was employed, guided by Social Representation Theory (SRT). Data collection involved in-depth individual interviews, dyadic interviews, focus group discussions, and ethnographic observations. The data was gathered from 91 participants, comprising 31 individuals with chronic illnesses, 15 caregivers, 8 healthcare providers, 33 (self-reported healthy) focus group participants, and 4 participants who were observed during ethnographic fieldwork. All participants were purposively selected from three communities in Accra, Ghana: Jamestown, Ussher Town, and Legon. Theory-driven thematic analysis was used to identify themes across individual, interpersonal, community, and structural levels.

Findings revealed that chronic illness shaped largely negative post-diagnosis body image. This undermined participants' sense of embodiment, leading to physical, emotional, and social challenges such as stigmatization, reduced self-esteem, and social withdrawal. Caregivers and healthcare providers also faced psychological distress due to the visible physical changes in care

recipients and the caregiver burden. Management of body image concerns emerged as a critical aspect of chronic illness care. Participants emphasized the need for culturally sensitive healthcare approaches that integrate biomedical, cultural, and spiritual knowledge systems. Effective management also required addressing societal stigma and enhancing public awareness to reduce misconceptions and promote supportive environments. The study highlighted the importance of multi-level, culturally sensitive interventions in chronic care, which consider the interplay of personal, social, and structural influences. Future research should address socioeconomic diversity and adopt broader observational strategies to deepen understanding of these complex phenomena.



CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Non-communicable diseases (NCDs) are a global public health crisis, affecting individuals across regions, sexes, and age groups, regardless of socioeconomic status. As the leading global cause of death, NCDs not only threaten health systems but also impose significant economic burdens, undermining development and productivity worldwide (World Health Organisation, 2023). However, their impact is disproportionately severe in low- and middle-income countries (LMICs), where limited healthcare resources exacerbate the challenges of prevention, treatment, and management (Dube et al., 2017; Owusu et al., 2024)

In LMICs, NCDs account for over three-quarters of the global disease burden, driven by rapid urbanization, globalization, and changes in lifestyle. Unhealthy behaviours such as poor dietary habits, physical inactivity, and substance abuse are major contributors, resulting in biological risk factors like hypertension, obesity and stroke (Awuah et al., 2019; Zhang et al., 2020). Environmental factors, including pollution and inadequate access to healthcare services, further compound the prevalence and progression of NCDs in these settings (Maimaitiming et al., 2023; Vineis et al., 2014; Walls et al., 2016).

Africa is experiencing a significant rise in NCD prevalence, with the proportion of deaths attributed to these diseases increasing from 24% in 2000 to 37% in 2023 (World Health Organisation, 2023). In Sub-Saharan Africa, the burden of NCDs has escalated sharply, with a 67% increase reported between 1990 and 2017 (Anand, 2024; Coates et al., 2020; Global Health, 2019). This alarming trend highlights the complex interplay between unhealthy lifestyle

behaviours, environmental exposures, and fragile healthcare infrastructure, which together drive the continent's growing NCD epidemic (Anand, 2024; Gouda et al., 2019; Issah et al., 2024).

The situation in Ghana reflects these regional challenges of grappling with a dual burden of NCDs and communicable diseases that strains its already fragile health system (Awuah et al., 2014; Nyaaba et al., 2017, 2020). Chronic illnesses account for approximately 43% of deaths in the country, underscoring their significant contribution to national mortality rates (de-Graft Aikins et al., 2010; Nyaaba et al., 2017, 2020). Despite this growing burden, chronic disease prevention, treatment, and management remain underfunded and under-prioritized in Ghana (Issah et al., 2024; Laar et al., 2019; Seidu et al., 2024).

Chronic illnesses impact several aspects of life, including physical, psychological, social, and emotional aspects (Holmes & Deb, 2003). They can cause impairment of physical function, limitations in daily activities, loss of independence, pain and stress, and a negative impact on self-image (Charmaz & Rosenfeld, 2016; Holmes & Deb, 2003). The term invisible illness refers to conditions that do not produce visible symptoms or signs on the outside. Many people with invisible diseases experience symptoms such as fatigue, dizziness, weakness, pain, and mental health disorders. Some examples of invisible chronic diseases include depression, heart disease, hypertension, diabetes, and some mental illnesses (Attinger & Brown, 2012; Sahu et al., 2016). The effects of some of these conditions are not immediately apparent, and their symptoms are internal, resulting in the sufferer feeling isolated. Besides, individual sufferers experience an emotional burden of managing these conditions — the nature of which makes it difficult for others to appreciate their struggles. Additionally, individuals with invisible chronic illnesses may encounter diagnostic delays due to the absence of clear diagnostic indicators (Hwu, 2020; Joachim & Acorn, 2000).

In some cases, chronic illnesses that are initially classified as invisible may become visible following treatment, as certain medical interventions or procedures reveal the physical manifestations of the conditions, thereby helping to prevent further complications and preserve the lives of those affected (Barber & Williams, 2021; Hoppe, 2010). Diabetes after an amputation and breast cancer after a mastectomy are the most common conditions. Experiences of chronic illnesses, particularly where the effects are physically visible, are associated with significant body image concerns (Aziato & Clegg-Lampsey, 2015; Clarke & Griffin, 2008; Iddrisu et al., 2020). The concerns are two-fold. First, chronic conditions lead to significant changes in physical appearance, depending on the kind of condition. Chronic diseases can cause physical changes, such as weight gain or loss, which can make an individual feel less attractive. They can also cause fatigue and depression, which can lead to an individual feeling disconnected from their body and less confident in their appearance (Brunet et al., 2022). For example, some chronic physical conditions and their management and treatment are associated with hair loss, scarring, swelling, and severe weight loss (Davis et al., 2020). Second, chronic conditions create functioning impairment such as difficulties in movement, sexual dysfunction, and infertility among others (Davis et al., 2020; Sanuade, 2018). These significant changes in appearance and functional impairments affect how individuals with chronic illnesses think about and experience their bodies (Arday et al., 2019; Aryeetey, 2016; de-Graft Aikins, 2006; Laar et al., 2019). For example, symptoms and treatment of chronic illnesses such as cancers, stroke, diabetes, hypertension, sickle cell disease, asthma, and depression may contribute to feelings of body dissatisfaction due to the way they impact functionality and ability to perform daily tasks as well as the physical appearance of the bodies (Davis et al., 2020; Sanuade et al., 2021; Sündermann et al., 2020). Body image concerns are, therefore, fundamental psychosocial processes that impact

chronic illness experience (Sündermann et al., 2020), as well as management and self-care practices (Markey et al., 2020).

Body image refers to an individual's perception of their physical self, shaped by societal standards of an ideal body size and shape (Cassin & Friedman, 2017; Piran, 2016, 2018). It encompasses not only one's overall sense of physical appearance, but also perceptions of body functionality (Davis et al., 2020; Piran, 2018). Research indicates that body image begins to form during adolescence and young adulthood but remains fluid throughout (Mainwaring et al., 2021). Furthermore, body image significantly influences intrapersonal relationships and social interactions (Mainwaring et al., 2021; Piran, 2016).

Individuals often compare their actual body to an idealized image, which can lead to body dissatisfaction when there is a perceived mismatch between the two (Brunet et al., 2022; Cassin & Friedman, 2017). This perceived mismatch frequently results in negative body image, which is linked to social anxiety, depressive symptoms, and low self-esteem (Brunet et al., 2022; Cash, 2004; Cassin & Friedman, 2017; Tylka & Wood-Barcalow, 2015). These negative feelings may prompt individuals to seek ways to address the perceived gap, sometimes leading to unhealthy behaviours such as disordered eating, excessive exercise or overtraining, risky aesthetic practices, and use of harmful substances like diet pills (Mogre et al., 2013; Ra & Cho, 2017). However, not all mismatches between the actual and ideal body image result in body dissatisfaction. This outcome depends on individual characteristics and cultural contexts (Kling et al., 2019; Vartanian, 2012). When body dissatisfaction occurs, it can have a detrimental impact on mental health and overall quality of life (Arday et al., 2019; Iddrisu et al., 2020; Salifu et al., 2021). Body (dis)satisfaction refers to the positive or negative thoughts and feelings that arise from evaluating aspects of the body, such as size, shape, weight, and muscle tone (Grogan,

2006, 2021a). Negative body image is particularly concerning in individuals with chronic illnesses, as it can interfere with essential self-care practices necessary for managing their conditions (Ribeiro et al., 2021; Verbist & Condon, 2021).

Empirical studies in critical social and health psychology consistently demonstrate that body image changes are common among individuals living with chronic physical conditions (Bowie et al., 2022). These changes have drawn significant research attention to the concept of embodiment in understanding and managing chronic conditions. Embodiment refers to the lived experience of inhabiting a body (Gallagher, 2001a; Kirmayer & Gómez-Carrillo, 2019; Piran, 2018). It is a multifaceted concept that integrates the physical, psychological, emotional, and social aspects of living within a body (Bowie et al., 2022; Gallagher, 2001b; Piran, 2018). Unlike body image, which is concerned with how individuals perceive their body in relation to societal or cultural standards, embodiment is about the intra-subjective experience—how individuals feel, live, and navigate their bodies in everyday life (Kirmayer & Gómez-Carrillo, 2019; Piran, 2018). This distinction highlights a fundamental difference between body image and embodiment: while body image is focused on perception and external comparisons, embodiment emphasizes the subjective and dynamic interplay between intra-subjectivity and external influences.

Embodiment challenges the conventional Cartesian dualism, which views the body and mind as separate entities (Wilkerson, 2013). Instead, it highlights that our bodies are integral to how we experience the world (Kirmayer & Gómez-Carrillo, 2019). Emotions, thoughts, and interactions are shaped by bodily sensations such as pain, pleasure, or fatigue (Wilkerson, 2013). For example, living with chronic pain not only affects physical functioning but also affects emotional and cognitive experiences, influencing how individuals perceive and interact with their environment (Kirmayer & Gómez-Carrillo, 2019). A key feature of embodiment is its

dialectical nature, which describes the continuous and dynamic interaction between conflicting forces or influences. Dialectical embodiment, in this context, refers to the interplay between internal and external forces that shape how the body is experienced (Piran, 2018; Tsaplina, 2020). Internal forces include subjective experiences, emotions, and thoughts, while external forces encompass societal norms and cultural expectations (Kirmayer & Gómez-Carrillo, 2019; Piran, 2018). For instance, individuals with chronic illnesses may experience an internal desire to rest due to experiences of fatigue yet they face external pressures to appear productive or healthy. Similarly, the tension between agency—how individuals actively live and use their bodies—and structure—societal and cultural elements that shape bodily experiences—illustrates the active role of the body in navigating these interactions (Kirmayer & Gómez-Carrillo, 2019; Tsaplina, 2020).

In the context of chronic illness, embodiment provides critical insights into how individuals experience their condition. It captures the subjective, lived reality of inhabiting a body affected by illness while also grappling with external social expectations, such as the pressure to conform to an appearance of health (Piran, 2018; Tsaplina, 2020). Embodiment delves into the internal, lived experience of the body, emphasizing how individuals feel and experience their bodies in the context of their emotions, interactions, and environments. By contrast, body image pertains to how individuals see or evaluate their bodies, often in relation to societal ideals. It is shaped by cultural, psychological, and social factors and focuses on external perceptions and comparisons. Together, these concepts provide complementary lenses for understanding the psychological and social dimensions of living with chronic physical conditions.

Sociocultural and gendered nuances significantly shape body image concerns and embodiment in the context of chronic physical illness experiences (Gattario et al., 2020). Sociocultural influences pertain to how social and cultural contexts shape individuals' perceptions and management of their bodies, which in turn impact their experiences of chronic illness (Gattario et al., 2020). For example, the phenomenon of diabulimia—the manipulation of insulin by individuals with diabetes to achieve socially desirable body types—illustrates how cultural ideals intersect with the medical demands of managing chronic conditions (Coleman & Caswell, 2020). Gendered nuances also play a critical role. While both men and women report body dissatisfaction, men tend to exhibit higher levels of body appreciation than women (Addo et al., 2021; Coleman & Caswell, 2020; Gattario et al., 2020). Men are often more concerned with achieving muscularity, whereas women focus on body weight and shape (Tiggemann et al., 2008). These differences highlight the importance of understanding how gender influences perceptions of the body as well as the lived experience of individuals with chronic illnesses.

Moreover, the nature of many chronic conditions shapes gendered experiences of living with these illnesses, as well as their treatment, management, and self-care practices (Chang et al., 2019; de Graft Aikins et al., 2012; Kugbey et al., 2020). For instance, conditions such as hypertension, diabetes, and certain cancers (e.g., breast cancer and prostate cancer) manifest differently in body image perceptions based on gender (Bowie et al., 2022; Brunet et al., 2022). Understanding these gendered pathways is essential for developing tailored interventions that address the unique challenges faced by men and women in managing chronic illnesses.

1.2 Problem Statement

Research has consistently demonstrated a strong link between how individuals perceive and manage their bodies in the context of chronic illness and how these experiences influence both their overall well-being and the management of their conditions. Chronic illnesses are widely recognized as disruptive events, altering not only the physical body but also the life trajectories of those affected (Brunet et al., 2022; Bury, 1982; Pinguart, 2013; Pinguart & Sörensen, 2011). These conditions can cause temporary or permanent disruptions to specific bodily systems, profoundly influencing individuals' self-perception, including their body image (Clarke & Griffin, 2008; Faircloth et al., 2004; Loizeau & Annequin, 2021). Individuals with chronic illnesses often experience body dissatisfaction, feelings of depersonalization or disconnection from their physical selves, and social withdrawal. These challenges can adversely affect emotional well-being and adherence to treatment and management regimen. Despite this, there is insufficient attention given to how chronic illness and its management influence body image and embodiment, which are critical to understanding how individuals navigate life with altered bodies and changing self-identities (Kirmayer & Gómez-Carrillo, 2019; Tateyama et al., 2019).

In Ghana and other African contexts, there is limited research exploring the intersection of chronic illness, body image, and embodiment. Existing studies primarily focus on the physical and emotional impacts of single diseases, such as cancer, diabetes, or hypertension, without adequately considering the psychological dynamics of body image and self-perception (Akuoko et al., 2022; Aziato & Clegg-Lampsey, 2015; de-Graft Aikins, 2003; Iddrisu et al., 2020; Okop et al., 2019). Furthermore, these studies rarely examine the experiences of individuals with comorbidities, despite evidence suggesting that patients with multiple chronic conditions face

unique and complex challenges. The effects of these comorbidities on body image and self-perception remain underexplored (Dube et al., 2017; Okop et al., 2016).

Additionally, there is a notable lack of cultural and gendered analyses in studies of chronic illness and body image. Research suggests that certain body parts hold differing levels of significance for men and women living with chronic conditions. For instance, the breast and male sexual organs tend to be critical to self-perception in conditions such as hypertension, breast cancer, and prostate cancer (Brunet et al., 2022; Mainwaring et al., 2021). Empirical evidence indicates that men may avoid hypertension medication due to concerns about its potential side effects, such as sexual dysfunction, highlighting how cultural and gendered factors shape chronic illness management (Akinyede et al., 2022; Kretchy et al., 2020). However, there is insufficient research on how men and women living with chronic illnesses express body dissatisfaction or aestheticize their bodies.

Additionally, studies often overlook how ethnicity, culture, and age intersect with body image and embodiment in chronic illness experiences. These factors are crucial in understanding how diverse individuals navigate changing bodies and the social expectations placed on them. This study aims to address these gaps by examining the experiences of men and women of different ethnicities and age groups in Accra, Ghana, providing a nuanced analysis of cultural, gendered, and age-related influences on body image and embodiment.

Finally, there are methodological limitations in existing research. Most studies rely on single methods or levels of analysis, limiting the depth of insights into the lived experiences of individuals with chronic illnesses. This study employs a multimethod approach, combining individual interviews, dyadic interviews, focus group discussions, and ethnographic observations. With a focus on analyzing data at intrapersonal, interpersonal, and societal levels,

the study aims to offer a comprehensive understanding of the embodied experiences of individuals living with chronic illnesses in Ghana.

1.3 Aim and Objectives

The main aim of this study is to explore social representations of body image among individuals living with a range of chronic illnesses in Accra, and to investigate how these representations intersect with their bodily experiences, as well as how both shape their body image management practices and the management of their conditions.

Specifically, the study seeks to:

1. Explore social representations of body image in the context of chronic illness.
2. Explore lived experiences of changing bodies among individuals living with chronic illnesses and their caregivers.
3. Investigate how social representations of body image and lived experiences shape body image management and chronic illness management.
4. Investigate care needs, experiences and strategies for enhancing care support for chronically ill individuals facing body image and embodiment challenges.

1.4 Research Questions

Based on the objectives of the study, the following research questions are explored:

1. How do social representations of body image influence individuals' perceptions and experiences of body image in the context of chronic illness?
2. How does chronic illness impact individuals' embodied experiences of their changing bodies?

3. How do social representations of body image and the lived experiences of individuals with chronic illness influence the management of body image and embodiment among individuals with chronic illness?
4. What are the implications of body image and embodiment challenges for improving care and support among individuals with chronic illness?

1.5 Significance of the Study

Chronic illnesses are well-known for their physical, psychological, and social impacts, often leading to significant disruptions in body image and self-management. These disruptions highlight the need for comprehensive, holistic intervention programs that address the psychosocial factors shaping the experiences of individuals with chronic conditions. Body image and embodiment in the context of chronic illness, particularly in low- and middle-income countries like Ghana, remains underexplored. This study seeks to establish the empirical link between body image, embodiment, and chronic illness experiences within the Ghanaian context. Its significance is underscored by the current global health crisis, which has strained the delivery of effective and sustainable health interventions for people with chronic conditions.

The study has both theoretical and practical relevance. Theoretically, it applies Social Representation Theory (SRT) as a framework to offer a deeper understanding of how social constructions influence the lived experiences of individuals with chronic illnesses and, in turn, shape their self-perception and body image. SRT views body image not only as a psychological construct but also as a socially constructed phenomenon, influenced by societal norms, stereotypes, and collective representations. This study explores how individuals internalize these societal judgments, leading to body dissatisfaction and emotional distress. By examining these

processes, the study lays the foundation for interventions that challenge stigmatization and stereotypes related to chronic illness and body image, and ultimately broadens understanding of how body image is shaped by external social factors. Furthermore, by applying SRT, this study introduces a new framework for understanding how gendered, cultural, and societal narratives shape the body image and embodiment of individuals living with chronic illness.

This research also fills a critical gap in the body image and embodiment literature by providing a social psychological perspective that goes beyond individual experiences. It demonstrates how collective beliefs about health and illness influence how chronic illness sufferers perceive their bodies, with subsequent implications for care and management. Furthermore, the study contributes to the empirical knowledge base on the care and management of chronic conditions in a lower middle-income country context, such as Ghana, where resources for chronic disease care are limited. It sheds light on how individuals living with chronic conditions aestheticize their bodies, engage in body enhancement practices, and how these practices intersect with the management of their conditions.

The findings also enhance the theoretical understanding of the gendered and sociocultural nuances of embodiment and chronic illness experiences in Ghana and contribute to the development of a model of positive body image in chronic illness. In terms of practical relevance, the study has important implications for healthcare providers, mental health professionals, caregivers, and support groups. It uncovers the role of SRT in body image disturbances to inform interventions designed to address both the psychological and social challenges faced by individuals with chronic illnesses. SRT helps identify the dynamic interaction between individual experiences of illness and broader societal narratives about health, normality, and body attractiveness. Public health campaigns aimed at reducing stigma and

promoting a more inclusive understanding of body image in the context of chronic illness can also benefit from these insights. Practically, also, the study offers valuable insights into the care and management of chronic conditions using critical social and health psychological frameworks. The knowledge generated is especially useful in developing culture- and gender-sensitive intervention programs, ultimately helping individuals navigate the complexities of chronic illness care. This research is thus significant for individuals with chronic health conditions, caregivers, healthcare providers, and the broader health system, offering strategies for more effective and supportive care.

1.6 Organization of Chapters

The thesis is structured into eight chapters (Chapters 1-8).

Chapter One – Introduction: Chapter One presents the background of the study, identifying gaps in existing knowledge about body image in chronic illness. It highlights the significance of understanding how individuals with chronic conditions perceive their bodies and manage these perceptions, and sets out the research questions, objectives, and scope of the study.

Chapter Two – Literature Review: Chapter Two discusses both theoretical and empirical literature on body image, embodiment, and chronic illness. It establishes the theoretical framework, integrating levels of social organization and social representation theory (SRT) to explain how body image is shaped by individual experiences and societal influences. The chapter also examines studies on body image disturbances in chronic illness, identifying key contributing factors and their impact on self-perception and well-being.

Chapter Three – Methodology: Chapter Three outlines the research design, approach, and philosophical foundations of the study. It describes the research setting, participant selection, and

data collection methods, including interviews and observations. The chapter also details the data analysis procedures and the measures taken to ensure rigor and validity in the research process.

Chapter Four – Social Representations of Body Image: Chapter Four explores how body image is shaped by cultural and societal contexts. It examines how collective beliefs, norms, and media portrayals influence societal understanding of body image and, in turn, affect individuals' self-perception. This chapter sets the stage for understanding body image in the context of chronic illness in the following chapters.

Chapter Five – Social Representations of Body Image in Chronic Illness: Chapter Five focuses on how chronic illness influences social representations of body image. It investigates the impact of societal beliefs and stereotypes about illness and physical appearance on individuals with chronic conditions, examining how these representations lead to disruptions in body image, emotional distress, and altered self-perception.

Chapter Six – Body Image Management and Chronic Illness Management: Chapter Six examines the strategies individuals with chronic illnesses use to manage their body image and how they integrate these strategies into their overall health management. The chapter discusses coping mechanisms, self-care practices, and how these intersect with the management of chronic conditions.

Chapter Seven – Care Needs, Experiences, and Improvement: Chapter Seven addresses the care needs and experiences of individuals living with chronic illness, particularly in relation to body image. It highlights challenges in receiving appropriate care for both chronic conditions and body image disturbances, and identifies opportunities for improving healthcare services to better support the psychosocial aspects of chronic illness management.

Chapter Eight – Synthesis and General Discussion: Chapter Eight synthesizes the key findings from the previous chapters, integrating them into a comprehensive understanding of how social representations of body image influence experiences of chronic illness. The chapter discusses the implications of the findings for theory, practice, and policy, and offers recommendations for improving healthcare practices and public health interventions. It also addresses the study's limitations and suggests directions for future research.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The impact of chronic illness on individuals' lives is complex and multifaceted, affecting their physical, psychological, and social well-being. Body image and embodiment, as important components of individuals' self-concept and functioning, are significantly affected by chronic illness. Body image refers to individuals' subjective evaluation of their appearance, while embodiment refers to individuals' subjective experience of their bodies. Chronic illness can disrupt individuals' body image and embodiment in various ways, including changes in physical appearance, bodily sensations, and functional abilities.

A social psychological theoretical framework such as social representation theory (SRT) provides a useful lens for understanding the ways in which chronic illness shapes individuals' body image and embodiment. This literature review chapter aims to critically examine the existing research on body image and embodiment among individuals living with chronic illness. By synthesizing the current literature, this chapter aims to identify gaps in knowledge and contribute to the development of a conceptual framework for understanding the complex relationships between chronic illness, body image, and embodiment.

2.2 Theoretical Framework

This section presents the theoretical framework that guides the analysis of the literature on body image and embodiment among individuals living with chronic illnesses. The theoretical framework incorporates social representation theory (SRT) (Moscovici, 1960) and levels of explanation in social psychology (de Graft Aikins et al., 2012; Doise, 1980, 1982; Doise &

Valentim, 2015; Rateau et al., 2012) to provide a comprehensive understanding of the complex ways in which chronic illnesses affect individuals' body image and embodiment. The study of body image and embodiment within the context of chronic illness is crucial and needs to be critically analyzed through an appropriate theoretical framework. SRT offers a distinct advantage which allows for capturing the nuanced ways in which social and cultural factors shape individual perceptions and experiences. It allows for the exploration of shared beliefs within groups to influence individuals understanding of complex concepts such as body image disruptions associated with chronic illness. Other social psychology theories may provide valuable insights to this study. However, SRT's foundational assumptions focus on communal meaning-making of events and paying attention to individual, interpersonal and social levels of analysis. It also has a unique adaptability to culturally specific contexts, and has been applied to African contexts, which makes it more an exceptionally appropriate choice for this research focus.

Social Representation Theory

Social Representation Theory (SRT) is a social psychological framework developed by Serge Moscovici, aimed at understanding how practical social knowledge is developed, shared, and transformed (Isambert & Moscovici, 1961; Moscovici, 1960). This theory explains how individuals and groups create and communicate shared understandings of the world around them. Drawing from psychology, sociology, and linguistics, SRT focuses on how people make sense of their reality, including the challenges they face and the solutions they propose. According to Moscovici (1984a), social representations are collective ways of thinking that allow individuals to convey and share a common understanding of their experiences and the world with others.

SRT is built on key concepts that are particularly useful for understanding collective beliefs, especially in contexts where personal and social identity are shaped by broader cultural ideals (Wagner & Hayes, 2005). The theory emphasizes the collective nature of human understanding, focusing on how groups make sense of complex or unfamiliar phenomena by creating shared beliefs, symbols, and practices (Moscovici, 1984b). These shared representations serve as frameworks through which individuals and communities interpret their world, bridging the gap between scientific knowledge and everyday understanding (Jovchelovitch, 2007). At its core, SRT posits that people use common-sense knowledge to navigate the world around them (Moscovici, 1984a; Wagner & Hayes, 2005). This common-sense knowledge is not merely a collection of individual beliefs, but a shared understanding that develops through social interaction (de Graft Aikins et al., 2012; Jovchelovitch, 2007).

In further building the SRT, Moscovici (1982) introduced two fundamental processes—anchoring and objectification—that shape the formation of social representations. Anchoring involves connecting new or unfamiliar concepts to pre-existing categories, integrating them into an established framework of knowledge (Moscovici, 1984a, 1984b; Wagner, 2020). For example, unfamiliar diseases are often anchored in common cultural understandings of health or illness, enabling people to interpret them through a familiar lens (de Graft Aikins et al., 2012). Objectification, in another vein, transforms abstract ideas into concrete images or symbols, making them more accessible and understandable (Moscovici, 1984a). For instance, the ideal body image may be objectified through representations of physical fitness or specific body types, reinforcing societal ideals.

Moscovici (1960) also introduced the concept of cognitive polyphasia, which refers to the coexistence of multiple, sometimes contradictory belief systems within individuals or groups.

This allows for flexible and diverse responses to complex social situations. Cognitive polyphasia enables individuals to draw on different sources of meaning depending on the social context, and hold conflicting beliefs, often without psychological discomfort (de Graft Aikins et al., 2012).

This concept is particularly relevant for individuals with chronic conditions, who may simultaneously draw on medical, cultural, and personal understandings of their bodies.

In the current study, three methodological concepts from SRT are applied: content, source, and function. These dimensions allow for a nuanced exploration of how chronic illness impacts body image and embodiment within cultural and social contexts. The content of social representation refers to the ideals, symbols, and meanings that define a specific phenomenon within a given social group. It reflects the collective knowledge and beliefs that communities use to understand complex experiences, such as the bodily changes induced by chronic illness (Morrison et al., 2016). For instance, chronic illness may be associated with weakness, influencing how individuals perceive their bodies when living with conditions like diabetes or sickle cell disease. Additionally, body image may be objectified through cultural symbols, an example being associating fatness with good health and wealth.

The sources of social representations explore where these ideas originate and how they are generated, maintained, and communicated. Representations of chronic illness and body image are shaped by multiple overlapping sources, including family, personal experiences, and healthcare providers. The function of social representations concerns their role within social and individual contexts. Social representations are not static; they are dynamic tools that communities use to make complex phenomena more comprehensible by framing them within a familiar cultural context.

In the study of social representations, the concepts of consensus, contradiction, and absence play a critical role in understanding how shared knowledge evolves within societies. These elements connect the static dimensions of content, sources, and function with the fluid, contested realities in which representations are developed, maintained, and challenged within communities. They offer insight into how social representations are negotiated, highlighting the complexities of collective understanding, particularly in the context of chronic illness, body image, and embodiment. Another key focus of SRT is its emphasis on the multi-level nature of social representations, which are developed at different levels of social organization. These levels refer to the various contexts in which representations are generated, shared, and maintained, from the individual to the broader societal level. Moscovici (1984a, 1988) and Wagner (2020) distinguish between different layers of social representations, such as those expressed in daily, informal interactions (interpersonal communication) and those found in larger public discourse (media, education, policy). This multi-level focus of SRT aligns closely with Doise (1982) levels of explanation in social psychology, which considers the interplay between individual, interpersonal, and collective levels in shaping social knowledge.

Doise (1982), in his work in critical social psychology, presents a framework that offers a robust understanding of how social representations function across different levels of social organization. Doise identifies four levels of analysis that correspond to distinct domains in which psychological and social phenomena are situated: intra-personal, interpersonal, social and structural levels. Intra-personal level concerns the cognitive processes within individuals, such as how they internally process, categorize, and make sense of their experiences, including their body image and health-related behaviours (Link & Phelan, 2001). At the interpersonal level, social representations are shaped through interactions between individuals, such as discussions

between friends, family members, or healthcare providers (Doise, 1980, 1982; Murray, 2000). This level is important in understanding how body image and illness perceptions are negotiated through direct social exchanges. The positional level relates to the roles, positions, and social structures that individuals occupy within society, influencing how they relate to others and to cultural norms regarding body image, illness, and health (Doise, 1980; Doise & Valentim, 2015; Link & Phelan, 2001). For example, certain social positions (e.g., healthcare professionals, patients) are likely to have distinct representations of chronic illness and body image. The ideological level refers to the broader cultural and societal discourses, ideologies, and representations that shape how individuals and social groups interpret illness and body image (Doise, 1980; Doise & Valentim, 2015). These are the dominant public representations found in media, policy, and public health messaging.

SRT has broad implications for fields like social psychology, sociology, and communication studies. It assumes that individuals' knowledge and beliefs are shaped by their social context and the culture in which they live (Moscovici, 1988). Thus, people's understanding of the world is not solely based on personal experience, but is also influenced by the collective experiences and values of their society (Rosa & Mannarini, 2020). Social representations are not static but evolve as individuals continuously negotiate and update their understanding of the world, influenced by changing social, cultural, and historical contexts.

SRT is a valuable framework for understanding the experiences of individuals living with chronic illnesses, which are shaped by social, cultural, and psychological factors (de-Graft Aikins, 2006). The theory provides a lens through which one can examine how these factors influence individuals' experiences with chronic illness and how social representations of illness can affect illness trajectory, care, and treatment outcomes. According to SRT, shared

understandings of reality are constructed through social interactions and cultural processes (Moscovici, 1988). These representations influence how individuals respond to chronic illness, including their attitudes toward treatment, health behaviours, and relationships with healthcare providers (de-Graft Aikins, 2003, 2006). SRT has been applied to various health-related topics, including body image. Body image is a complex construct shaped by an individual's attitudes, beliefs, and feelings about their physical appearance. SRT provides a useful framework for understanding the social and cultural factors that shape body image. Body image is not only an individual experience but is influenced by the cultural and social context in which an individual lives (Cluley et al., 2024). Representations of the body within a particular culture—including media images, social norms, and interactions—impact how individuals perceive their bodies and attitudes that are adopted toward their appearance (Ne Joffe, 2003).

According to SRT, individuals are active participants in constructing shared representations of the body, rather than passive recipients of cultural messages. This means that cultural and social representations of the body shape individuals' experiences. Research has shown that exposure to the "thin ideal" in media can lead to body dissatisfaction and disordered eating behaviours (Grabe et al., 2008), while exposure to diverse, inclusive representations of the body can foster body acceptance and positive body image (Tylka & Wood-Barcalow, 2015). SRT has also been applied to understanding the experiences of individuals with chronic illnesses, including their perceptions of body image and embodiment. Chronic illness can affect an individual's body image, altering physical appearance and causing functional limitations that impact self-perception and relationships (Cluley et al., 2024). SRT provides a framework for understanding how cultural, social, and psychological factors shape these experiences. Studies have shown that social representations of illness and disability significantly influence body

image and embodiment (Morrison et al., 2016). For example, stigmatization and discrimination can negatively affect individuals with chronic illnesses, leading to poor body image and diminished self-worth (de-Graft Aikins, 2006; Morrison et al., 2016). Disability is often viewed as a deviation from the norm, which can shape an individual's sense of embodiment (Titchkosky, 2001).

Finally, SRT helps explain how cultural beliefs and practices influence body image and embodiment among individuals with chronic illnesses. Recent studies demonstrate the usefulness of SRT in understanding body image and embodiment globally. For instance, in a study of individuals with chronic kidney disease in India, researchers found that social representations of illness impacted body image and self-perception, with stigma and social exclusion being key factors (Singh et al., 2019). Similarly, research on individuals with multiple sclerosis in Australia found that social representations of illness and disability influenced body image and embodiment, drawing attention to the psychological impact of invisible symptoms (Morrison et al., 2016).

2.3 Conceptual Framework

This section presents the conceptual framework that guides the analysis of the literature on body image and embodiment among individuals living with chronic illness. The conceptual framework synthesizes the key themes and findings from the literature review, drawing on the theoretical perspectives SRT and levels of explanation. SRT's three central methodological components—content, source, and function—were applied to this multi-level framework to the study of chronic illness and body image. These components enable a nuanced analysis of how social representations are structured at different levels of social organization.

Content of Social Representations

The content refers to the ideals, symbols, and meanings that define specific phenomena within a particular social group. At the intra-personal level, individuals internalize these representations, forming personal understandings of body image and chronic illness, such as associations between illness and weakness or the perceived “ideal” body shape. At the interpersonal level, the content of representations is negotiated in everyday interactions—family members may discuss the ideal way to manage diabetes, for example, or healthcare providers may communicate messages about what constitutes a healthy body. At the social level, the content of representations is shaped by shared cultural values, media portrayals, and institutional discourses that define collective understanding of health, illness and the body. At the structural level, content could be shaped by media and public health messages that portray specific representations of illness, body image, and embodiment, reinforcing cultural norms and expectations.

Sources of Social Representations

Sources of social representations refer to the origins of social representations and the processes through which they are generated and communicated. At the intra-personal level, sources of social representation arise from individual experiences, personal reflections, and emotional responses to health and the body. These include one’s lived experiences of illness, bodily changes, and self-perceptions, which shape how the individual interprets and internalizes meanings about body image and chronic illness. At the interpersonal level, sources include interactions between individuals, such as familial knowledge passed down about health, body image, and illness. Healthcare providers also serve as key sources in shaping representations of chronic illness and body image, particularly through medical advice or health interventions. At

the social level, sources of social representations may emerge from individuals' social roles and the norms associated with these roles. For example, the representation of body image may differ for healthcare professionals, who may prioritize health over appearance, compared to individuals living with chronic illness, who may have different priorities based on personal experience. At the structural level, sources of social representations are largely influenced by dominant cultural narratives found in media, education, and political discourse.

Function of Social Representations

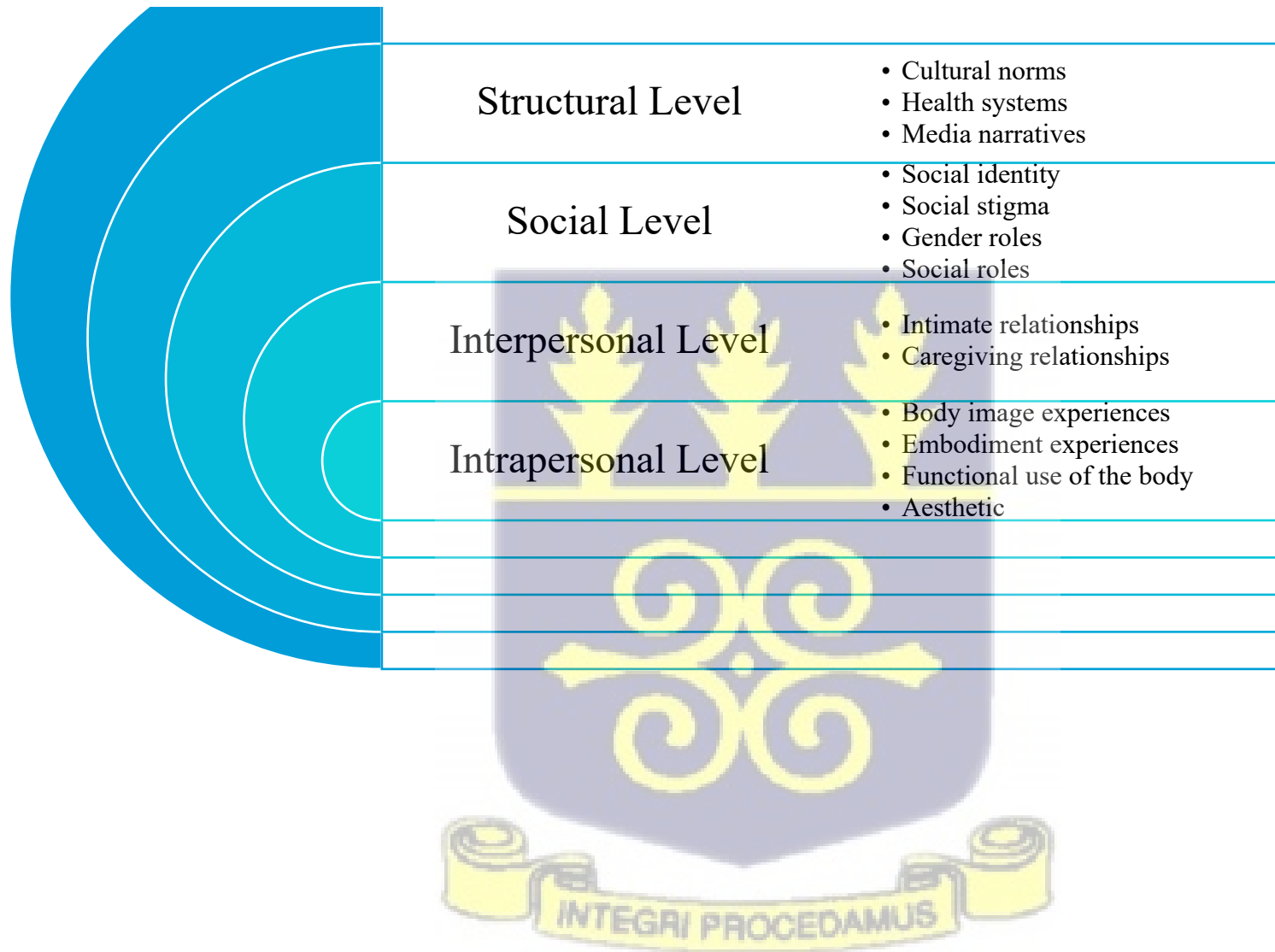
The function of social representations refers to the role or purpose that social representations serve in a given social context. At the intra-individual level, these representations provide individuals with a framework for understanding their own bodies and illnesses, guiding their personal behaviours and decisions about health. At the interpersonal level, representations of chronic illness and body image may serve to facilitate or hinder communication between individuals, shaping their ability to offer support or advice. At the social level, the functions of social representations lie in promoting shared understanding and social cohesion. They enable groups and communities to communicate about health, illness, and body image using common cultural meanings. Through collective narratives, public discourse, and institutional communication, social representations help maintain social order by defining what is considered normal or acceptable, while also guiding collective responses to chronic illness and bodily changes. At the structural level, representations play a critical role in shaping public policy, public health strategies, and societal attitudes toward chronic illness and body image. For example, the function of social representations in media may shape how society views disability, health, and body image, which, in turn, impacts the treatment and care individuals receive.

This framework allows for a comprehensive understanding of how social representations of chronic illness and body image are constructed, maintained, and transformed across different levels of social organization. At each level—whether intra-individual, interpersonal, positional, or ideological—social representations of chronic illness and body image function in unique ways to shape individuals' experiences, behaviours, and interactions. This multi-level approach enables a deeper understanding of the complex social, cultural, and psychological factors that influence the embodiment of chronic illness and body image, offering valuable insights for interventions that aim to improve health outcomes and quality of life for individuals living with chronic conditions.

As shown in Figure 1, the conceptual framework outlines the key constructs and relationships.



Figure 1:Multilevel representations of body image, embodiment, and chronic illnesses



2.4 Empirical Review

Chronic illness can have profound effects on individuals' experiences of their bodies and their body image. This literature review examines current evidence on how individuals living with chronic illnesses experience their bodies and their body image, drawing on both older and more recent research studies. This section provides a synthesis of empirical studies conducted on chronic illness experience and how that impacts body image and embodiment among individuals living with chronic illnesses. The chronic illness conditions in focus include overweight and obesity, diabetes, cancers, sickle cell disease, hypertension, and stroke. Informed by the objectives and conceptual framework of the current study, the discussion is organized into four thematic areas: individual-level experiences, interpersonal-level experiences, group influences and societal influences on chronic illness experiences.

2.4.1 Individual Level Experiences of Chronic Illness, Body Image and Embodiment

The individual-level discussion examines how chronic illnesses influence the life trajectories of those affected, particularly through physical and psychological disruptions. Chronic illnesses often lead to significant changes in the body's aesthetics (such as weight fluctuations, changes in appearance, and visible scars) and functional capacities (activities of daily living). These physical disruptions are accompanied by psychological challenges, including altered self-perception, with many individuals perceiving themselves as unattractive or less desirable due to the changes in their bodies. Chronic illness can lead to profound physical changes that significantly impact individuals' body image and embodiment. Studies have highlighted various physical disruptions, such as weight change, scarring, hair loss, and fatigue, all of which contribute to a negative body image. For instance, research by Charmaz and

Rosenfeld (2016), Foster et al. (2003), and Lee et al. (2012) have shown that these changes can result in body dissatisfaction, shame, embarrassment, and social isolation. Some individuals, however, manage to adapt to their new physical realities by focusing on inner strength, cultivating a more positive body image over time (Charmaz & Rosenfeld, 2016; Foster et al., 2003).

In a study conducted by Iddrisu et al. (2020) among young women with breast cancer in Ghana, the women reported severe disruptions in both their body image and bodily functions. Chemotherapy led to noticeable physical changes, including hair loss, skin darkening, changes in nail and tongue color, boils, and significant weight fluctuations. Some women gained weight, while others lost weight. Functionally, they faced challenges with mobility (inability to walk), basic bodily functions (such as eating, drinking, vomiting), and daily activities like praying. These disruptions resulted in a heightened sense of bodily discomfort and a negative impact on their body image and emotional well-being. A study by Kocan and Gursoy (2016) also explored the impact of mastectomy on women's body image in Turkey, reporting that the extent of the surgery and the type of reconstruction procedure influenced how women viewed their bodies post-surgery. Women who underwent more extensive surgeries or had no reconstruction generally expressed more dissatisfaction with their body image. Similarly, Begovic-Juhant et al. (2012) found that women who reported negative body image after breast cancer surgery also exhibited higher levels of depression and a lower quality of life.

In addition to physical changes, chronic illness can lead to significant psychological and emotional challenges that further affect body image. Research indicates that individuals with chronic conditions often experience anxiety, depression, and stress, which may stem from feelings of loss of control over their bodies or from the stigmatization associated with illness

(Barnett et al., 2010; Holmes & Deb, 2003). These negative emotions can reinforce poor body image, creating a vicious cycle that negatively impacts both mental health and physical well-being. However, some individuals with chronic illness manage to develop a more positive body image by engaging in self-care, seeking social support, and finding meaning or purpose in their lives (Barnett et al., 2010; Holmes & Deb, 2003).

Clarke and Griffin (2008) explored how multiple chronic conditions affected body image in later life among older adults in Canada, finding that many participants expressed frustration and shame about their changing bodies. These emotions often led to social withdrawal and a diminished quality of life. Similarly, Iddrisu et al. (2020) reported that women with breast cancer in Ghana also experienced significant emotional distress, including shock, sadness, crying, and sleep disturbances. Participants in the study mentioned fear of death and psychological instability, which compounded the impact of their physical health challenges. Chronic illness also affects how individuals experience their bodies in more metaphorical or embodied-experience ways. Poku et al. (2020) investigated how adolescents with sickle cell disease (SCD) in Ghana constructed their experiences of fatigue. The participants described their bodies as machines that needed maintenance and repair, using this metaphor to explain their symptoms of fatigue and to justify the need for rest. This embodied metaphor underscores the way individuals with chronic illness may perceive and narrate their bodily experiences as part of their ongoing struggle with illness.

Ribeiro et al. (2021) examined body image among women with type 1 diabetes in Brazil, specifically exploring the risk of diabulimia, a behaviour where individuals intentionally reduce insulin doses for weight loss. The study found that a significant proportion of women with type 1 diabetes exhibited negative body image and engaged in disordered eating behaviours like

diabulimia. Metta et al. (2015) explored diabetes care and representations of the illness in Southeastern Tanzania, highlighting how participants managed their symptoms through strategies such as dietary changes and herbal remedies. The study also revealed that the illness influenced participants' perceptions of their bodies, as they sought to reconcile visible and physical changes associated with diabetes with culturally grounded ideals of health. However, the study also highlighted the difficulties participants faced in managing their condition due to high medication costs and limited resources.

In Zambia, Tateyama et al. (2019) explored how body image and dietary habits of cardiovascular disease (CVD) patients were influenced by cultural views of body size. In some rural communities, larger body sizes were associated with wealth and health, while others expressed concerns about their weight and sought to manage it through dieting and traditional remedies. This reflects how body image perceptions in chronic illness are shaped not only by physical changes but also by cultural and societal influences on what constitutes an ideal body. The studies show that chronic illness disrupts both the physical and psychological aspects of an individual's life, leading to significant changes in body image and embodiment. These disruptions manifest in various ways, including physical changes, functional limitations, and psychological distress. The studies reviewed suggest that individuals with chronic illness often experience negative body image and emotional distress, but they may also develop positive body image through adaptation and self-care. Understanding these individual-level experiences is essential for designing interventions that address both the physical and psychological dimensions of living with chronic illness, emphasizing the importance of body image and emotional well-being in the management of chronic conditions.

2.4.2 Interpersonal Level Experiences of Chronic Illness, Body Image and Embodiment

The interpersonal level of analysis focuses on the impact of chronic illness on intersubjective experiences, particularly in intimate and caregiving relationships. The impact of chronic illness on body image and embodiment affects emotional intimacy, sexual functioning, and overall relationship satisfaction. Research indicates that chronic illnesses can significantly disrupt intimate relationships by altering sexual intimacy and emotional closeness (Kocan & Gursoy, 2016; Martire & Helgeson, 2017; Martire & Schulz, 2007; Van Houtum et al., 2015). The physical limitations imposed by chronic illness can complicate sexual activity, causing discomfort or a reduction in sexual desire, which can lead to sexual dissatisfaction and even avoidance of intimacy (Martire & Helgeson, 2017). For example, Begovic-Juhant et al. (2012) found that chronic illnesses affect not only sexual functioning but also emotional intimacy, contributing to decreased relationship satisfaction.

Further, body image and embodiment are critical aspects of how chronic illness impacts intimate relationships. Kocan and Gursoy (2016) reported that mastectomy significantly altered women's body image, making them feel less feminine and less attractive, which negatively affected their sexual relationships. These shifts in body image are often accompanied by feelings of self-consciousness, especially in intimate contexts. Iddrisu et al. (2020) further found that cancer treatments like chemotherapy introduced visible side effects such as hair loss, skin changes, and nail discoloration, which led to partner dissatisfaction and strained sexual relationships. In these cases, the burden of altered body image is not solely borne by the individual with chronic illness but is shared with their partner, who may express dissatisfaction or discomfort, complicating emotional intimacy and sexual satisfaction. Knobf (2007) showed that breast cancer significantly impacted women's body image and sexual functioning, leading to

decreased intimacy and partner communication. Similarly, Basson and Gilks (2018) and Singh et al. (2019) found that chronic kidney disease and type 2 diabetes, respectively, disrupted both the emotional and physical aspects of intimate relationships, often resulting in decreased sexual desire, intimacy, and support.

The burden of body image and embodiment is not always negative. Gray et al. (2011) found that couples coping with chronic illness reported lower levels of relationship satisfaction and increased emotional distress compared to healthy couples. Nevertheless, some couples reported an increase in emotional intimacy as they navigated these challenges together, highlighting that the strain of chronic illness could sometimes bring partners closer. Chronic illness not only affects intimate relationships but also caregiving dynamics, where one partner often assumes the caregiver role. This role shift can lead to stress and strain, particularly for the caregiving partner, who may experience increased burden, resentment, or dissatisfaction (Litzelman, 2019; Litzelman et al., 2018). While caregiving can strain the relationship, it is not always negative. Some couples find that the shared experience of dealing with illness strengthens their bond. For instance, Martire et al. (2018) and Martire and Helgeson (2017) found that caregivers who reported higher levels of marital satisfaction also reported better physical health. On the other hand, caregiving has been linked to depressive symptoms and lower marital satisfaction, especially when one partner feels overwhelmed by caregiving responsibilities (Kim et al., 2019; Pinquart & Sörensen, 2011). Studies also highlight the shared nature of caregiving in the context of chronic illness. For example, Martire and Helgeson (2017) and Martire and Schulz (2007) found that caregivers of individuals with chronic illness reported greater physical health challenges, more depressive symptoms, and higher caregiving burdens compared to caregivers of individuals with acute

illnesses. While caregiving is often viewed as a burden, there are instances where couples experience emotional closeness through this shared responsibility. The impact of caregiving on relationship dynamics underscores the complex, dynamic nature of how chronic illness affects both individuals and their partners.

2.4.3 Group Influences on Chronic Illness Experience, Body Image and Embodiment

Chronic illness affects individuals not only at the personal level but also at the group level, influencing families, communities, and cultural groups. Recognizing the diversity and intersectionality of experiences is crucial, as the impact of chronic illness on body image and embodiment can vary based on factors such as illness type, gender, age, race, and other social identities (Grogan, 2021b; Oliver & Flint, 2014). For instance, in some cultures, being overweight may be viewed as a sign of wealth or status, while in others, it may be stigmatized. In a study by Ofei-Dodoo et al. (2018) on body image perception among Ghanaian immigrants in the United States, participants reported feeling pressured by their cultural community to maintain a certain body size, which conflicted with their efforts to manage chronic illness through weight loss.

The intersectionality of chronic illness and body image also varies by gender. Women with chronic illnesses often face unique challenges, as they are frequently expected to conform to societal beauty standards. For example, Broom et al. (2020) found that women with multiple sclerosis (MS) reported feeling socially isolated and stigmatized due to physical limitations and body image changes. Similarly, men with chronic illnesses may experience challenges related to body image and masculinity. Zare et al. (2020) studied Iranian men with diabetes and found that

participants felt their masculinity was threatened by the physical changes associated with the illness.

In addition to gender, intersectionality can include a factor such as social identity. Women with chronic illnesses may experience challenges related to both their gender and the social expectations surrounding physical appearance (Cash, 2004). Additionally, individuals from marginalized communities—such as racial or ethnic minorities or the LGBTQ+ community—may face additional stigmatization and discrimination, further impacting their body image (Linden et al., 2022).

In Africa, research has examined how group-level experiences shape body image and embodiment in individuals with chronic illness. Awotidebe et al. (2019) studied Nigerian women with breast cancer and found that they faced significant challenges with body image, including feelings of shame and unattractiveness due to physical changes such as hair loss, weight gain, and scars from surgery. These changes often affected their intimate relationships, with some women reporting a decrease in partner attraction. Similarly, Okoro et al. (2014) explored the impact of type 1 diabetes on Nigerian body image. The findings emphasize that factors such as social networking and friends' inadequate understanding of the disease lead to judgment based on appearance, resulting in social isolation, lower quality of life and also negative self-perception.

In Ghana, people who are overweight are often stigmatized and referred to as Obolo or Oboshie, terms in the Ga language meaning "fat" or "overweight person." This stigmatization contributes to dissatisfaction with body image, prompting some individuals to seek weight loss (Frempong, 2017; Quaidoo et al., 2018). Additionally, health consciousness drives many individuals to shed excess weight to avoid chronic conditions associated with obesity, such as

diabetes, cardiovascular diseases, and hypertension (Coleman & Caswell, 2020; Ettarh et al., 2014; Hunter-Adams, 2019; Quaidoo et al., 2018). Therefore, behaviour change strategies are essential to helping individuals keep from becoming overweight to avoid adverse health consequences while improving psychological well-being.

At the social level, chronic illness can influence self-presentation in social contexts. Iddrisu et al. (2020) reported that participants undergoing cancer treatment struggled with attending social events due to physical, functional, and aesthetic disruptions. Those who underwent mastectomy, for instance, faced difficulties wearing bras due to pain and had to adjust their choice of clothing. Social support plays a crucial role in shaping body image and embodiment among individuals living with chronic illness. Research has shown that emotional, informational, and practical support can improve psychological well-being and quality of life for individuals with chronic illness (Linden et al., 2022). Social support helps counteract negative emotions and stigmatization, thereby improving body image.

Adam and Koranteng (2020) explored the availability and impact of social support for breast cancer patients in Ghana. The findings revealed that while social support was available, access to it was limited. Family members were the primary source of support, followed by friends, healthcare providers, and support groups. However, some patients reported inadequate support from their families. The study found that patients who received higher levels of social support experienced better physical and emotional well-being, better treatment adherence, and improved quality of life. In contrast, those who lacked support experienced higher levels of anxiety, depression, and stress, negatively affecting their treatment outcomes.

Synthesizing these studies shows that at the group level, experiences of chronic illness, body image, and embodiment are complex and shaped by cultural and societal factors.

Healthcare providers must understand these diverse experiences and offer culturally sensitive, gender-responsive care to individuals and communities affected by chronic illness. These studies highlight how body image and embodiment are influenced by cultural norms, societal expectations, and individual experiences of illness and treatment.

2.4.4 Societal Influences on Chronic Illness Experience, Body Image and Embodiment

The societal discussion centers on how structural factors shape body image and embodiment, particularly among individuals living with chronic illnesses. Structural elements like poverty, social inequality, and limited access to healthcare significantly impact how chronic illness is experienced, alongside body image and embodiment. For instance, Janzon et al. (2015) found that the shift from rural to urban living conditions in Uganda led to increased obesity rates among women due to changes in diet and physical activity, which were tied to social and economic factors.

Moreover, societal norms and expectations around body size and shape, influenced by cultural, historical, and political contexts, play a crucial role in shaping body image. In some African cultures, a larger body size is seen as a symbol of beauty and health, while in Western cultures, thinness is idealized (Okop et al., 2016). These cultural beliefs directly influence how individuals perceive their own bodies and experience embodiment. Marinda et al. (2017) highlighted how traditional gender roles in Zimbabwe complicate the management of chronic conditions like HIV/AIDS, with women often prioritizing family care over their health. This can result in feelings of guilt and shame regarding their illness, further impacting body image and embodiment.

A study such as Ribeiro et al. (2021) examined the relationship between body image and chronic illness, specifically focusing on women with type 1 diabetes in Brazil. The study found that societal pressure to conform to the beauty ideal of thinness, combined with low self-esteem and body dissatisfaction, contributed to diabulimia. Participants reported feeling stigmatized by healthcare providers, which hindered their ability to seek help. Similarly, Liburd et al. (1999) explored body image perceptions among African American women with diabetes, noting how cultural and societal norms shaped their understanding of body size. The study revealed a tension between cultural ideals of larger body sizes as symbols of beauty and a desire to conform to mainstream standards of thinness. Further, Clarke and Griffin (2008) further explored how social and cultural factors, including ageism and ableism, shape body image among individuals with chronic conditions in later life. The study showed that these factors contributed to stigmatization and marginalization, as participants felt excluded due to their health status and age. In the case of black South Africans, Okop et al. (2016) and (2019) found that participants had mixed perceptions of obesity, with some associating larger body sizes with health and prosperity, while others viewed it negatively due to the health risks it posed. These diverse views reflected the complex relationship between body image, cultural norms, and health risks.

In Ghana, structural factors such as poverty and inadequate healthcare systems also impact the experience of chronic illness and body image. Studies have reported that limited access to healthcare services and resources like medication affect the management of chronic illnesses, leading to negative impact on body image and embodiment. Individuals with chronic conditions are reported to express feelings of shame and frustration due to their inability to manage their conditions effectively (de-Graft Aikins, 2006; Ofei-Dodoo et al., 2018). For instance, Ofei-Dodoo et al. (2018) highlighted how cultural beliefs about food, body size, and

physical activity shaped experiences of obesity and body image among Ghanaian women. These beliefs often conflicted with medical advice, further complicating the management of chronic conditions.

Gender also plays a significant role in shaping body image among individuals with chronic illness. de-Graft Aikins (2006) found that women with diabetes in Ghana faced gender-based stigma, which influenced both their ability to manage their condition and their body image. The societal pressure to conform to femininity, which includes being thin and attractive, led many women to feel judged and devalued for not meeting these ideals. Poku et al. (2020) examined how adolescents with sickle cell disease (SCD) in Ghana constructed their experiences of fatigue. The study found that social stigma and a lack of understanding of the condition contributed to a negative self-image and challenges in accessing healthcare. Cultural preferences also influence body image perceptions in Ghana. Balis et al. (2019) and Ofori-Asenso et al. (2016) found that most Ghanaian women preferred a body size that was neither too skinny nor too large, associating a moderately plump body with good health and fertility. However, perceptions of the ideal body size varied by factors such as age, education, and ethnicity. Older women, for instance, were more likely to prefer a larger body size, while younger women and those with higher education levels preferred a thinner body. This diversity of preferences underscores the importance of considering cultural values, as well as life course, when addressing body image and health.

Structural factors—such as limited access to healthcare resources and infrastructure—contribute to difficulties in managing chronic illnesses, impacting body image and embodiment. Bosire et al. (2020) and Mendenhall et al. (2017) found that rural South Africans faced significant challenges in managing chronic illnesses such as hypertension due to limited access

to healthcare resources. This inaccessibility often resulted in delayed treatment and inadequate symptom management, which heightened frustration and stress among participants. The stress of navigating their conditions without sufficient support, combined with visible changes such as weight fluctuations or physical symptoms of untreated illness, negatively impacted their body image, as individuals struggled with a sense of diminished control over their health.

Additionally, healthcare systems can inadvertently affect body image through the language used by providers. Studies suggest that referring to individuals with chronic conditions as "sick" or "disabled" can undermine their sense of self-worth and contribute to negative body image (Swan, 2016).

Cultural perceptions of body size also play a significant role in shaping the experiences of individuals with chronic illnesses in African contexts. While obesity is often viewed positively as a sign of wealth, health, and prosperity (Hunter-Adams, 2019; Puoane et al., 2010), the increasing influence of Western ideals of thinness has led to body dissatisfaction among some individuals. These changing cultural influences shape how individuals perceive and manage their bodies, further complicating the intersection between chronic illness, body image, and embodiment (Quaidoo et al., 2018).

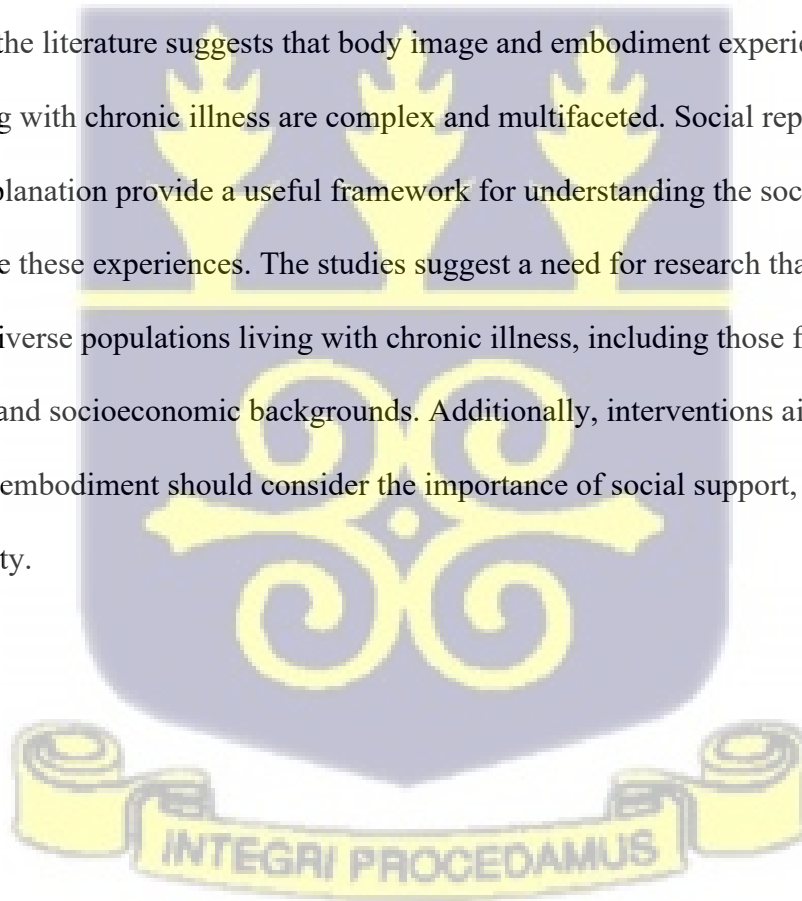
2.5 Summary of Literature Review

The literature on body image and embodiment among individuals living with chronic illness highlights the complexity of this phenomenon. Social representations provide a useful conceptual framework for understanding how people make sense of their bodies and their illness experiences. Studies suggest that individuals with chronic illness often experience disruptions in their body image, including changes in appearance, function, and perception of their bodies.

These changes can have significant effects on their mental health, social relationships, and overall quality of life.

The literature also highlights the importance of the social and cultural contexts in shaping body image and embodiment experiences among individuals living with chronic illness. The stigma associated with chronic illness can contribute to negative body image and feelings of shame, guilt, and inadequacy. In contrast, social support, positive relationships, and access to resources can facilitate positive body image and embodiment experiences. Therefore, interventions aimed at improving body image and embodiment among individuals with chronic illness should consider the social and cultural factors that shape these experiences.

Overall, the literature suggests that body image and embodiment experiences among individuals living with chronic illness are complex and multifaceted. Social representation theory and levels of explanation provide a useful framework for understanding the social and cultural factors that shape these experiences. The studies suggest a need for research that explores the experiences of diverse populations living with chronic illness, including those from different cultural, ethnic, and socioeconomic backgrounds. Additionally, interventions aimed at improving body image and embodiment should consider the importance of social support, resources, and cultural sensitivity.



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methodological approach employed in this study, which investigates the experiences of body image and embodiment among individuals living with chronic illnesses in Ghana. To understand these experiences, the study applies a multi-level approach to assess how individual, interpersonal and societal factors shape participants' experiences by utilizing a range of qualitative methods. The chapter highlights the research settings, research paradigm (critical social sciences perspective), and the procedures that were taken to ensure ethical integrity and rigor of the study. It includes a description of the data gathering methodologies, participant recruitment strategies, and the analytical procedures employed to analyze the collected data.

3.2 Research Setting

The study was carried out in Accra, the regional capital of the Greater Accra region. Greater Accra has been the capital city since 1877 and has evolved through different developmental stages. Greater Accra is a multifaceted region with lots of people travelling from all over the country and from outside the country. It is the smallest of the 16 regions in terms of area, occupying a total of 3,245 square kilometers or 1.4 percent of the land area of Ghana. Accra is now the most densely populated region in the country. The region is made up of 2 Metropolitan Assemblies, 23 Municipal and 4 district Assemblies. Akans constitute 39.8% of the population, Ga-Dangmes account for 29.7%, and Ewes make up 18%.

Accra has been described as a multi-cultural global city, whose global status was sealed by a significant increase in population, and rapid structural and socio-cultural shifts, such as the arrival of multinational companies, hotels, telecommunication, entertainment industry and fast-food revolution (Agyei-Mensah & de-Graft Aikins, 2010). The rapid structural and cultural shift in Accra has been argued by Agyei-Mensah and de-Graft Aikins (2010) to have had a significant impact on the health of inhabitants, particularly in the increased prevalence of non-communicable diseases (NCDs) such as diabetes, hypertension, cancers, and stroke (Quaidoo et al., 2018).

This study was conducted in three communities in Accra: Legon, an affluent community, and Jamestown and Ussher Town, two poor communities. The Jamestown and Ussher Town communities are located along the coastal area of Accra and are close to the Central Business District of Accra, Ghana. Jamestown and Ussher Town are indigenous communities inhabited primarily by the Ga-Dangme ethnic group. On account of their geographical proximity, Jamestown and Ussher Town are often referred to as a twin community or township. They make up the traditional Ga-Mashie. According to historical records, the ancestors of the present residents of Jamestown, formerly known as Ngleshie, migrated from Nigeria around the 15th century and settled in Ga-Mashie, the current location. The term Ga-Mashie means indigenous Gas. They are known as the main indigenous people of Accra Central. These two communities have a high population density, low socioeconomic status, and an environment marked by poor sanitary conditions and inadequate housing (Awuah et al., 2014). These towns have some well-constructed features, including concrete drains and tarred roads. Their main economic activities are fishing and petty trading. The men are primarily involved in fishing while the women are involved in fish mongering.

In Ga-Mashie, other ethnic groups are represented in the communities, including the Akans who speak Twi, the Ewes who speak Ewe, the Mole-Dagbani who speak Dagbani and Hausa, and the Guans who speak Guan. Ga-Mashie is characterized by a low level of education. The communities have public and private schools, clinics and herbal centres that serve the people. About three-quarters of the population have completed Junior High School (or middle school) (Awuah et al., 2014). They speak the Ga language and celebrate the Homowo festival. The system of inheritance is patrilineal. The main staple food of the people is Ga kenkey and fish with pepper. These communities face the challenge of low level of access to healthcare services with a double burden of communicable diseases and non-communicable diseases (de-Graft Aikins et al., 2014; UN-HABITAT, 2009). There is one government hospital, Ussher Hospital and a clinic, Jamestown Maternity Clinic.

Legon is a suburb of Accra, Ghana, widely known for being the location of the University of Ghana, the country's largest and oldest institution of higher education. The community encompasses a much wider area than only the University's campus. It is located within the Ayawaso West Wuogon constituency within the Accra Metropolitan District of the Greater Accra Region. The main landmark is the University of Ghana which dominates the area.

It is a prominent residential area in the northern part of Accra, Ghana. It is a community classified as upper-middle-class, with modern housing developments, shopping malls, restaurants and recreational spaces including the now closed Legon Botanical Gardens, which formerly served as a major green and leisure site. It is home to a diversified population including students, academics, business professionals, and local inhabitants from various social, economic and cultural backgrounds. As an affluent area, Legon has better access to healthcare facilities. Numerous private hospitals and health centers are situated in or near Legon and major public

facilities such as the University of Ghana Medical Center (UGMC) providing services ranging from general healthcare to specialty medical services. Legon has an active community life, particularly inside the University campus and its surroundings. The Legon community has several religious and social groups.

3.3 Research Paradigm

In this study, a critical social psychological analysis is conducted to examine how body image concerns shape experiences and management of chronic illness in urban Accra, Ghana. I therefore draw on the Critical Social Science Perspective (CSSP) as the philosophical background. Critical Social Science Perspective is a research philosophy that focuses on the power dynamics and structural inequalities that underlie social phenomena. According to Charmaz (2020), a critical social science perspective recognizes that knowledge is socially constructed and that the researcher's role is to challenge power relations and inequalities within society. This perspective aims to reveal and challenge the dominant ideologies and power structures that shape social reality. It assumes that social problems are not natural but are constructed through social processes and that social structures and institutions are not neutral, but rather are created and maintained to serve the interests of those in power.

Critical Social Science Perspective often employs a reflexive approach, where the researcher acknowledges their positionality and biases, and critically examines their assumptions and values in relation to the research subject (Burr, 2015). The goal of this approach is to empower marginalized voices, challenge dominant narratives, and promote social justice and equality. This perspective is often used in fields such as critical psychology, sociology, anthropology, and political science, and has been applied to a wide range of topics, including race, gender, class,

and power relations. Other studies have also employed a critical social science perspective in examining the social and cultural influences on health behaviours and experiences, particularly in marginalized communities example (Adams et al., 2009; Agyei et al., 2024). Given the aim of the current study—to examine the impact of chronic illness on body image and embodiment—a critical social science perspective is particularly relevant in shedding light on the power dynamics at play in shaping cultural norms and societal expectations around body size and shape (Holland & Tiggemann, 2016). Critical Social Science Perspective is well-suited for this study as it allows for a critical examination of the social structures and power dynamics that shape the experiences of chronic illness, body image, and embodiment in Ghana. This perspective recognizes that social phenomena are complex, and that they are shaped by social, cultural, economic, and political factors. It seeks to analyze and critique these factors in order to understand how they shape individuals' experiences and to identify opportunities for change (Burr, 2015).

In the present study, adopting a critical social science perspective allows for a critical analysis of how multilevel factors such as gender, and cultural beliefs influence the experiences of chronic illness, body image, and embodiment. It also enables the researcher to understand the power dynamics and social hierarchies that shape these experiences and to identify opportunities for interventions that can help to address these issues. By taking a critical perspective, the study aimed to go beyond describing the experiences of individuals, to understanding how broader intrapersonal, interpersonal, group social and cultural factors shape these experiences. The Critical Social Science Perspective guides a methodological and analytical approach that challenges dominant cultural narratives and assumptions that may perpetuate stigma and discrimination around chronic illness, body image, and embodiment (Burr, 2015).

3.4 Research Design

The current study employs an exploratory qualitative approach as the main research methodology. This design is well suited to investigate a phenomenon that is not well understood or has not been sufficiently studied in a specific context (Charmaz, 2006, 2017). It is to explore issues, gather insights and gain familiarity with a phenomenon. Given the exploratory nature of the study, qualitative methods were chosen, as they are particularly effective for capturing participants' narratives, and how they navigate societal beliefs about how chronic illness impacts body image and self-perception. It also allows for in-depth exploration of the nuanced lived experiences of individuals within their social and cultural contexts (Amoah & Phillips, 2018).

In-depth interviews (ID) were conducted with individuals with chronic conditions (ICC) focusing on their personal experiences. Also, in-depth interviews were conducted among caregivers to provide their insights into how chronic illness and body image disruptions affected their relationships. Dyadic interviews were conducted with pairs of individuals who both had chronic illnesses. This method enabled an exploration of shared experiences and how two people with similar or different health conditions discuss their experiences regarding their bodies. Also, dyadic interviews were conducted among caregivers of chronic patients. By interviewing the two caregivers together, the study was able to capture how they navigate their challenges of supporting chronic patients and the social beliefs they encounter about caregiving and illnesses.

Further, focus group discussions (FGDs) with lay healthy individuals allowed for the exploration of broader societal representations of chronic illness, body image and health. The FGDs provided an opportunity to explore how societal narratives and collective beliefs are

constructed and shared among individuals who are not directly affected by chronic illness. The last approach was ethnographic observation, which was conducted among individuals with chronic conditions. The method involves close observation of participants within their natural environments (Fetters & Rubinstein, 2019; Gains, 2011). By using this research method, the researcher was able to observe or interact with the study participants and gain a better understanding of their lived experiences within their specific cultural settings (Atkinson & Pugsley, 2005; Hammersley, 2006, 2018). Ethnographic observations were conducted in participants' homes, to observe their everyday interactions with their bodies and disease management. The use of interviews, dyadic discussions, FGDs and ethnographic observations is particularly effective in exploring sensitive topics like body image and chronic illness, where individuals' experiences are deeply personal yet influenced by broader social and cultural factors (Patton, 2006). This combination allows for a more complete and accurate representation of the participants' realities, as it incorporates both their subjective narratives and the objective observations of their behaviours and interactions.

3.5 Study Participants and Segmentation Plan

Qualitative data was gathered from different groups of people, sexes, ages, life stages, and ethnicities. Ninety-one (91) participants took part in this study. A total of 31 individuals with chronic conditions were recruited and interviewed to obtain an understanding of their personal experiences with body image and chronic illness-related changes. Out of this total, 23 of the participants engaged in individual interviews and the remaining 8 participated in the dyadic interviews. In addition to these, 15 caregivers were interviewed to gain insights into their perspectives on caregiving and body image challenges. Among them, 7 participated in individual

interviews, while 8 of the caregivers participated in the dyadic interviews. Furthermore, 8 healthcare providers were interviewed to obtain their professional perspectives on the management of body image concerns in patients with chronic illnesses. To explore societal attitudes and beliefs surrounding NCDs and their influence on body image, 33 participants were recruited for 4 FGDs, each comprising a minimum of 8 (self-reported) healthy lay community members. Lastly, ethnographic observations and interviews were undertaken with 4 individuals living with chronic diseases to capture their lived experiences and to explore the intricate ways in which they manage their body image and the chronic illness in their daily lives. The segmentation plan is summarized in Table 1.

Table 1

Segmentation Plan for Participant Recruitment

Method	Participants	Frequency
Individual interviews	Individuals with chronic conditions	23
	Caregivers	7
Dyadic interviews	Healthcare providers	8
	Individuals with chronic conditions	8
Focus group discussion	Caregivers	8
	Lay healthy individuals	33
Ethnographic observation	Individuals with chronic conditions	4
	Total	91



Sociodemographic Characteristics of Participants with Chronic Conditions

An analysis of the sociodemographic characteristics of the study participants with chronic conditions is as follows. A total of 31 participants were involved in the study, they were persons who either had a single chronic disease, a co-morbidity, or a multi-morbidity chronic disease. In total, there were 15 participants from Jamestown, 10 from Legon, and 6 from Ussher Town. The majority of participants were Akans, followed by Gas, Ewes, and one Dagbani. Twenty-one participants were females, 10 were males. They ranged in age from 18 to over 60. Most of the participants from Legon had received tertiary education, while most of the participants from Jamestown had Junior High or middle form four school education. Additionally, a total of 14 participants out of the 26 participants had acquired Junior High Education, while two participants had no formal education at all. Almost all of the participants were Christian, with one participant identifying as a traditionalist. Twelve of the participants were engaged in petty trading, and 8 reported being unemployed. Regarding relationships, 13 participants were married, 7 were divorced, 9 were single, and one was cohabiting. Table 2 presents the demographic characteristics of the participants with chronic conditions.

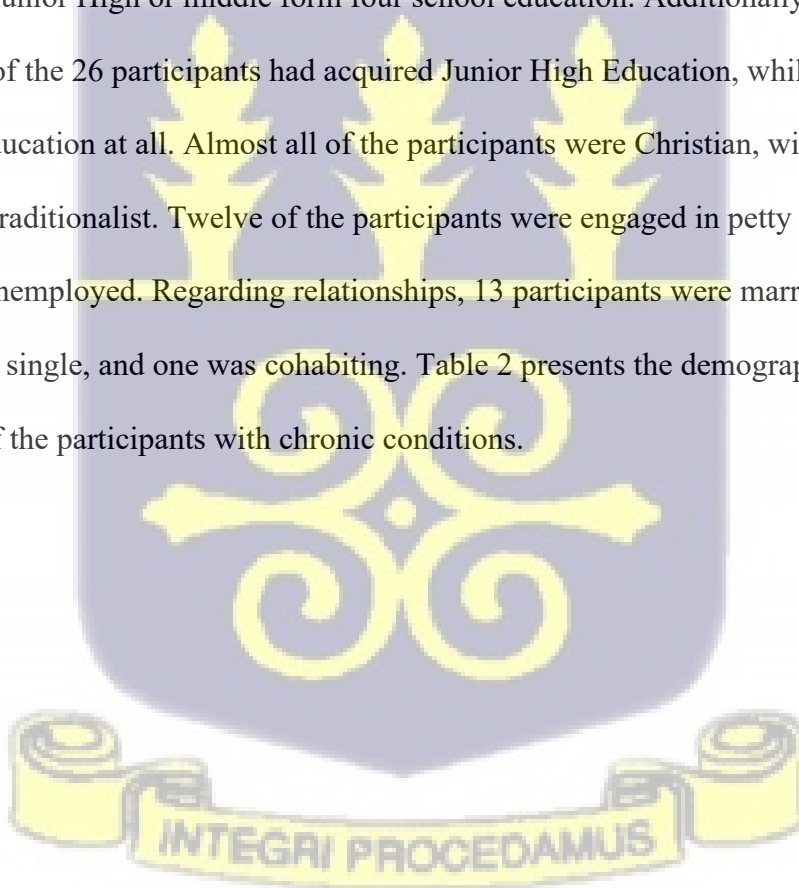


Table 2
Sociodemographic Profile of Participants with Chronic Conditions (N = 31)

Demographics	Legon	Jamestown	Ussher-town	N	%
Gender					
Female	5	11	5	21	67.7
Male	5	4	1	10	32.3
Age Group					
18-30	2	1	3	6	19.4
31-50	4	3	2	9	29.0
51-60+	4	11	1	16	51.6
Education					
No Education	1	1	0	2	6.6
Primary	1	4	2	7	22.6
Junior High/Middle school	2	9	3	14	45.4
Secondary school	0	1	1	2	6.5
Tertiary	6	0	0	6	19.4
Occupation					
Unemployed	0	5	1	6	19.4
Students	1	0	0	1	3.2
Petty traders	2	6	4	12	38.7
Artisan	2	4	1	7	22.6
Retirees	2	0	0	2	6.5
Civil servants	2	1	0	3	9.7
Marital Status					
Married	5	6	2	13	41.9
Single	2	2	2	6	19.4
Co-habitation	1	0	0	1	3.2
Widowed	1	3	0	4	12.9
Divorce	1	4	2	7	22.6
Ethnicity					
Ga-Adangme	3	6	3	12	38.7
Akan	3	8	3	14	45.2
Ewe	3	1	0	4	12.9
Dagomba/Mamprusi	1	0	0	1	3.2
Religion					
Christianity	8	16	6	30	96.8
Traditionalist	1	0	0	1	3.2

Sociodemographic characteristics of caregivers of chronic patients

The following table shows the characteristics of the caregivers of chronic patients. A total of 15 participants were interviewed (see Table 3). There were 6 participants from Legon, 6 from Jamestown, and 3 from Ussher Town. Females accounted for 73% of the participants, while males accounted for 27%. The majority of the caregivers were between the ages of 18 and 30. A little over half of the participants were petty traders (53%), about (40%) of the participants had secondary education and 13% had tertiary education. All participants were Christians. 5 were married, 2 were divorced, 3 were cohabiting, and 1 was widowed. There were four different ethnic groups represented in the study. There were approximately six Ga people, five Akan people, and two each from the remaining groups.



Table 3:***Sociodemographic Profile of Caregivers of Chronic Patients (N=15)***

Demographics	Legon	Jamestown	Ussher-town	N	%
Gender					
Female	3	5	3	11	73
Male	3	1	0	4	27
Age Group					
18-30	4	3	0	7	47
31-50	2	1	2	5	33
51-60+	1	1	1	3	20
Education					
Primary	1	2	0	3	20
Junior high/Middle school	2	0	2	4	27
Secondary school/SHS	1	4	1	6	40
Tertiary	2	0	0	2	13
Occupation					
Unemployed	2	0	0	2	13
Students	1	1	0	2	13
Petty traders	2	4	2	8	53
Professional (Accountant)	1	0	0	1	7.0
Auxiliary worker	0	1	1	2	13
Marital Status					
Married	3	2	1	6	40
Single	2	1	0	3	20
Co-habitation	1	2	0	3	20
Divorce	0	1	1	2	13
Widowed	1	0	0	1	7.0
Ethnicity					
Ga-Adangme	0	3	3	6	40
Akan	3	2	0	5	33
Ewe	1	1	0	2	13
Dagbani/Mamprusi	2	0	0	2	13
Religion					
Christianity	6	6	3	15	100

Sociodemographic Characteristics of Healthcare Providers (N=8)

A total of eight healthcare professionals were recruited and interviewed for the study. Table 4 presents the demographic and professional characteristics of the participants. The majority of the participants were females (5), while (3) were males. Most participants fell within the 31-50 years of age group, one participant was between 18-30 years, and another was between 51-60 years. Educational attainment was generally high, six participants had tertiary education and two held diplomas. The participants represented diverse health-related professions. The nurses were 2 in number, 1 clinical psychologist, 1 medical officer, 1 dietician, 1 physiotherapist and 2 clinical pharmacists. Half of the participants were married and the other half were single. Akan participants constituted the largest group of 5, followed by Ga-Adangme (who were 2 in number) and the 1 participant who was Guan (1). All participants identified as Christians.



Table 4
Sociodemographic Characteristics of Healthcare Providers (N=8)

Demographics	N	%
Gender		
Female	5	62.5
Male	3	37.5
Age Group		
18-30	1	12.5
31-50	6	75.0
51-60	1	12.5
Education		
Diploma	2	25.0
Tertiary	6	75.0
Specialty		
Nurse	2	25.0
Clinical Psychologist	1	12.5
General practitioner	1	12.5
Dietician	1	12.5
Physiotherapist	1	12.5
Pharmacist (Clinical)	2	25.0
Marital Status		
Married	4	50.0
Single	4	50.0
Ethnicity		
Ga-Adangme	2	25.0
Akan	5	62.5
Guan (Nzema)	1	12.5
Religion		
Christianity	8	100

Sociodemographic Characteristics of Focus Group Discussion Participants

The detailed table provides an overview of the diverse backgrounds of the FGD participants. There were 33 participants in total, 18 from Legon and 15 from Ga-Mashie (Jamestown and Ussher Town). Four groups were convened: 2 female groups and 2 male groups. Males constituted a slightly higher proportion (51.5%) than females, with the highest age range being 31-50. Over 54.5% of the participants had Junior High School education. Thirty-one of the participants constituting 93% were Christians while 6.1% were Muslim. There were 15 Ga-Adangmes and 9 Akans, the two ethnic groups with the highest representation. The appendix contains detailed information about the participants. The characteristics of the focus group discussion (FGD) participants are shown in Table 5.



Table 5:*Sociodemographic characteristics of Focus Group Discussion participants (N=33)*

Demographics	Legon	Ga-Mashie	N	%
Gender				
Female	9	7	16	48.5
Male	9	8	17	51.5
Age Group				
18-30	3	8	11	33.3
31-50	12	3	15	45.5
51-60+	3	4	7	21.2
Education				
No education	2	0	2	6.1
Primary	0	3	3	9.1
Junior high/Middle school	9	9	18	54.5
Secondary school/vocational	2	3	5	15.2
Tertiary	5	0	5	15.2
Occupation				
Unemployed	0	2	2	6.1
Students	1	0	1	3.0
Petty traders	5	8	13	39.4
Artisan	7	5	12	36.4
Professionals	4	0	4	12.1
Retirees	1	0	1	3.0
Marital Status				
Married	12	3	15	45.5
Single	4	6	10	30.3
Co-habitation/ separated	2	3	5	15.2
Widowed	0	1	1	3.0
Divorce	0	2	2	6.1
Ethnicity				
Ga-Adangme	3	12	15	45.5
Akan	8	1	9	27.3
Ewe	3	1	4	12.1
Guan/Dagbani	4	1	5	15.2
Religion				
Christianity	17	14	31	93.9
Islamic	1	1	2	6.1

Sociodemographic Characteristics of the Ethnographic Participants

Four participants were involved in the ethnographic observations, comprising two females and 2 males. There were two people between the ages of 51 and 60, one between the ages of 41 and 50, and 1 other person in the above 60 age group. Among them, one had no educational background, one had a primary education, one had a middle school education, and one had a tertiary education. Two of the participants were married, one was divorced, and one was a widow. Three of them indicated that they were Christians and one claimed to be neither Christian nor traditionalist. A no-religion status was assigned to him. Regarding employment status, 3 were not working while 1 was a petty trader. A summary of the demographic characteristics of the ethnographic participants is provided in Table 6.

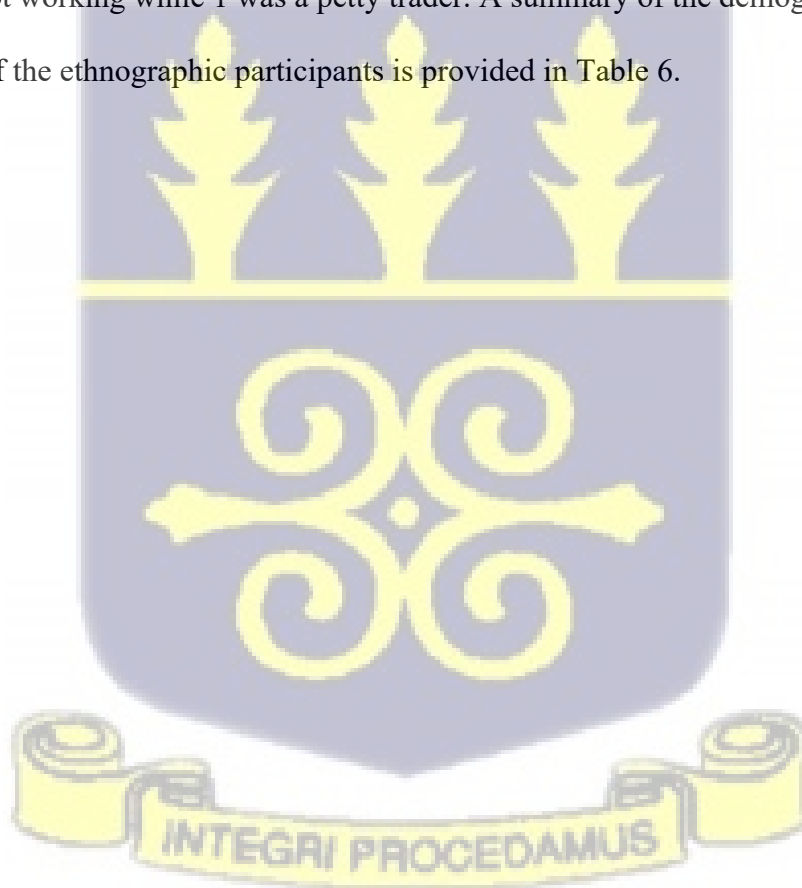
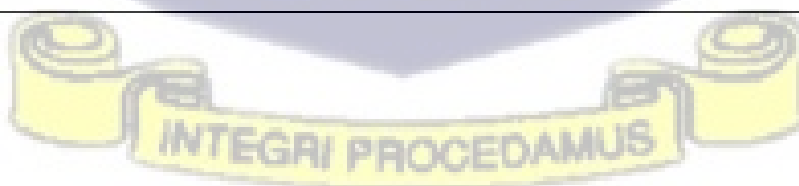


Table 6

Sociodemographic Characteristics of Ethnographic Participants (N=4)

Observation participants	N	%
Gender		
Female	2	50.0
Male	2	50.0
Age Group		
41-50	1	25.0
51-60	2	50.0
61+	1	25.0
Education		
No education	1	25.0
Primary	1	25.0
Junior high/Middle school	1	25.0
Tertiary	1	25.0
Occupation		
Petty traders	1	25.0
Not working	3	75.0
Marital Status		
Married	2	50.0
Widowed	1	25.0
Divorce	1	25.0
Ethnicity		
Ga-Adangme	2	50.0
Akan	1	25.0
Ewe	1	25.0
Religion		
Christianity	3	75.0
No religion	1	25.0



Participant Identifiers

To distinguish between participants while maintaining anonymity, pseudonyms and assigned numbers were used. Table 7 presents the identifiers for the three main participant groups: individuals with chronic conditions (ICCs), caregivers (CGs), and healthcare providers (HCPs). ICCs and CGs are identified by their pseudonyms, along with their age, type(s) of chronic condition and the community. HCPs are identified by their assigned number (e.g., Participant 1, 2, 3), followed by their age, professional area, and community of practice. Table 8 presents identifiers for participants involved in the ethnographic observations. The same principles of anonymity were applied. These participants are identified by pseudonyms, their ages, types(s) of chronic condition, and the community.

Table 7

Participant Identifiers

Group	Marker
Individuals with chronic conditions, (ICC) were identified by pseudonyms, their age, type(s) of chronic condition, and community.	ICC, Naa, 39 years, hypertension & diabetes, Ussher Town
Caregivers, (CG) were identified by pseudonyms, their age, type(s) of chronic conditions of the care recipient, and the community.	CG, Celine, 30 years, hypertension & diabetes, Legon
Healthcare providers (HCP) were identified by an assigned number, followed by their age, professional area, and community of practice	HCP-5-Psychologist-35years, Legon

Table 8

Participants' Identifiers for Ethnographic Observation

Group	Marker
Individuals with chronic conditions followed by pseudonym, age, type(s) of chronic conditions and their communities	Owen, 66 years, hypertension & stroke, Jamestown
	Aurora, 44 years, breast cancer, Legon
	Jack, 65 years, diabetes, hypertension, stroke, prostate cancer, Jamestown
	Mia, 78 years, diabetes, hypertension, Jamestown



Table 9***Reported Chronic Illness(es) by ICCs and Caregivers***

Type of chronic illness	ICCs	Caregivers
Hypertension	16	9
Diabetes	9	-
Sickle cell disease	5	1
Stroke	5	4
Asthma	3	1
Arthritis	3	-
Cancers	3	2
Obesity	1	-
Hypertension, Diabetes	4	8
Hypertension, Stroke	4	-
Hypertension, Arthritis	2	-
Hypertension, Obesity	1	-
Hypertension, Diabetes, Stroke	2	1
Hypertension, Diabetes, Arthritis	2	-
Hypertension, Diabetes, Stroke and Prostate Cancer	1	1

Many of the participants had co-morbidity and multiple chronic health problems, a total of 8 different chronic health problems were reported (see Table 9). Hypertension was the most prevalent condition reported, affecting 16 participants. Nine participants reported diabetes, followed by sickle cell disease and stroke (5) and the remaining were asthma (3), arthritis (3), cancer (2), and obesity (1).

Caregivers reported that their care recipients were diagnosed with co-morbidities and multiple chronic conditions. A total of 5 different chronic illnesses were reported. The most prevalent being hypertension (9). Hypertension and diabetes were the second most prevalent (8). Stroke (4), cancer (2), and sickle cell disease (1) were also reported, with one participant caring for recipients with four ~~multiple~~ conditions.

A participant reported being diagnosed with multiple conditions such as hypertension, diabetes, stroke and prostate cancer. Two participants were diagnosed with hypertension and diabetes, and hypertension and stroke. Only one participant had a single condition, breast cancer.

3.6 Recruitment of Research Participants

The selection of the participants for this study was based on the participant segmentation as shown in Table 1. The recruitment of participants from the three communities, Jamestown, Ussher Town and Legon, involved a systematic approach that considered the explicit needs and challenges of each group. The participants recruited for the study included individuals with chronic illness (medically diagnosed), caregivers, healthcare providers and lay community members. Due to the diversity of these groups, purposive and snowball sampling methods were used to guarantee that the recruitment procedure was both targeted and inclusive, capturing the full range of experiences and perspectives necessary for the study. The use of snowball was considered to help some participants link the researcher to other participants. The initial participants were asked to recommend more individuals within their networks for the study. Some individuals declined participation owing to the fact that individuals with chronic illnesses face stigmatization which can result in their reluctance to discuss their health issues openly and participate in studies such as this one (Mohamed Boushab et al., 2017; Skinner & Mfecane,

2004). Researchers have confirmed that non-disclosure and keeping illnesses secret helps individuals negotiate their lives without adverse effects on their relations, agency, identity, and safety (Bruce et al., 2020).

Healthcare providers play a crucial role in providing professional insights on managing chronic illness. Recruiting this group required careful reflection of their time commitments, due to their demanding schedules and limited availability. Time constraints were a peculiar challenge to HCPs and caregivers because of their demanding schedules. Scheduling interviews was difficult, and the options for HCPs involved arranging interviews outside of their regular working time. Previous research has documented this difficulty (Redjem et al., 2011).

Focus group discussions (FGDs) were instrumental in gathering data from the community members. The interactive nature of the FGDs enabled participants to expand on each other's ideas to encourage exploration of shared beliefs, misconceptions and social representations of chronic illness. The FGDs were conducted with eight participants each to allow each individual the opportunity to express their diverse perspectives (Cortini et al., 2019).

The recruiting of participants was effective due to the researcher's ability to establish rapport with the consenting participants from the beginning. A positive connection was cultivated by the researcher's intentional exhibition of respect, trustworthiness, confidentiality and credibility which were important while working with the participants. Notwithstanding the challenges of rescheduling meetings and unavailability and some withdrawing at the last minute, an ideal number of participants willing to participate in the study was successfully obtained. The researcher's fluency in the indigenous languages of Twi and Ga facilitated rapport building and played a key role in obtaining participants and ensuring they felt understood and comfortable throughout the process.

3.7. Procedure and Data Collection

Semi-structured interview guides were used to facilitate in-depth and dyadic interviews with participants ensuring that key topics were covered while allowing for flexibility in responses. A purposive sampling procedure was employed to select the participants for the study. The inclusion criteria required participants to have been diagnosed with (a) chronic condition(s). participants were eligible only if they had been living with the condition(s) for a minimum of six months. This time frame ensured that participants had sufficient experience with these health conditions which was essential in addressing the research objectives of the impact of chronic conditions on body image and embodiment.

Unfortunately, some individuals could not participate in the study for various reasons, including poor health, conflicting work schedules, fear of stigmatization and lack of approval from family members. Although their input could have significantly enriched the study, their unavailability prevented them from taking part. However, the rights of all the participants were observed and respected. (Heath et al., 2007; Jokinen et al., 2002; Orb et al., 2001).

3.8 Data Collection Tools

There were four main data collection instruments used in this study. The semi-structured interview guides, focus group guide, Pulver's body image silhouettes and observational notes taken on the field. An in-depth semi-structured interview guide with open-ended questions guided the interviews. There was a list of predetermined questions in the semi-structured interview guides, as well as other unplanned follow-up questions that assisted the researcher in probing further (Adams, 2015). This allows the researcher to navigate different aspects of the

research question and topics that need to be covered in a conversation (McIntosh & Morse, 2015). A typical interview involves the interviewer posing some questions to explore the interviewee's experiences in much deeper depth. The interviewee then discusses their experiences with the topic(s) under discussion. It is also common for the interviewer to follow up with questions based on information volunteered or to ascertain certain facts and to cross-check evidence for specific confirmation of particular information. For example, in this study, the interviewer wanted to explore how chronic illness shapes the perceptions of body image and embodiment. Therefore, participants were asked to describe their body before and after they were diagnosed with the chronic condition. Follow-up questions were asked regarding weight, shape, skin color, functionality and associated body image concerns.

The interview guide questions were tailored to each group of participants. While the overall structure was consistent, some specific questions were adjusted depending on the participant group. For example, individuals with chronic conditions were asked questions slightly different from those of CGs, HCPs and FGDs. This approach ensured that the interview content remained relevant and specific to each group's experience and perspectives while still aligning with the broader research objective. The key interview areas developed for each participant group are presented in the sections that follow: Key Interview Areas for ICCs, CGs, HCPs and FGDs. See appendices A for the full versions of the interview guides.

The second data collection tool used was Pulver's body image silhouettes by Pulvers et al. (2013) (2004). It is a body image tool that was adapted and used by the Research on Obesity and Diabetes among African Migrants (RODAM) study on obesity and type 2 diabetes among Ghanaians in Ghana and three European countries (Agyemang et al., 2009, 2016). Pulver's

silhouettes have not only been applied in Western contexts but have also been used in African settings to examine body size perceptions and body image. In these contexts, the silhouettes have served as a useful tool for exploring body cultural ideals of body size, perceptions of health and the broader social meanings attached to body image (Johnson et al., 2019). These silhouettes, presented in Figures 2 and 3, illustrate a range of culturally validated body sizes and have been widely used in both Western and African contexts.

In the present study, participants were shown the silhouettes and asked to indicate the body size they perceived as the closest to their own and the size they considered ideal. They were to provide reasons for their selections of particular silhouettes or body sizes. Also, there are nine images in total, for both males and females. While Pulver's silhouettes are a widely used and validated tool for assessing body size perceptions, they are not without limitations. Their applicability across cultural contexts may be constrained by differences in body ideals, shape preferences and interpretations of size. Furthermore, the silhouette focusses primarily on body size overlooking other dimensions of body image such as tone, proportion and attractiveness. They also rely on subjective interpretation. However, despite these limitations of the silhouettes scale when compared to multi-dimensional body image scales, the simplicity, brevity, and minimal literacy requirements make silhouette scales beneficial for community-based assessment. Such scales are made more useful when indicators are provided for the interpretation of the scores. Silhouette provides BMI standards for interpreting body image data. The silhouettes are aligned with BMI categories ranging from 16.0 to 40.0 kg/m² with an increment of approximately 3 kg/m² per silhouette. Table 10, presents the BMI classifications associated with the silhouettes, illustrating how body images A through I correspond to incremental categories of underweight, normal weight, overweight and obesity (Pulvers et al., 2004). It is

arranged in a standardized sequence labeled alphabetically from *A* to *I*. In this scale, silhouettes *A* and *B* represent underweight categories, silhouettes *C* and *D* represent normal body weight, *E* and *F* represent overweight while *G*, *H* and *I* represent the obese categories.

Table 10
BMI Categories Represented by Pulver's Silhouettes

Body image/size	Category	Approximate BMI Range kg/m ²
Body Image A and B	Underweight	16.0-18.9
Body Image C and D	Normal size	19.0-24.9
Body Image E and F	Overweight	25.0-30.9
Body Image G, H, and I	Obese	31.0-40.0



Figure 2: Silhouettes for women's body sizes

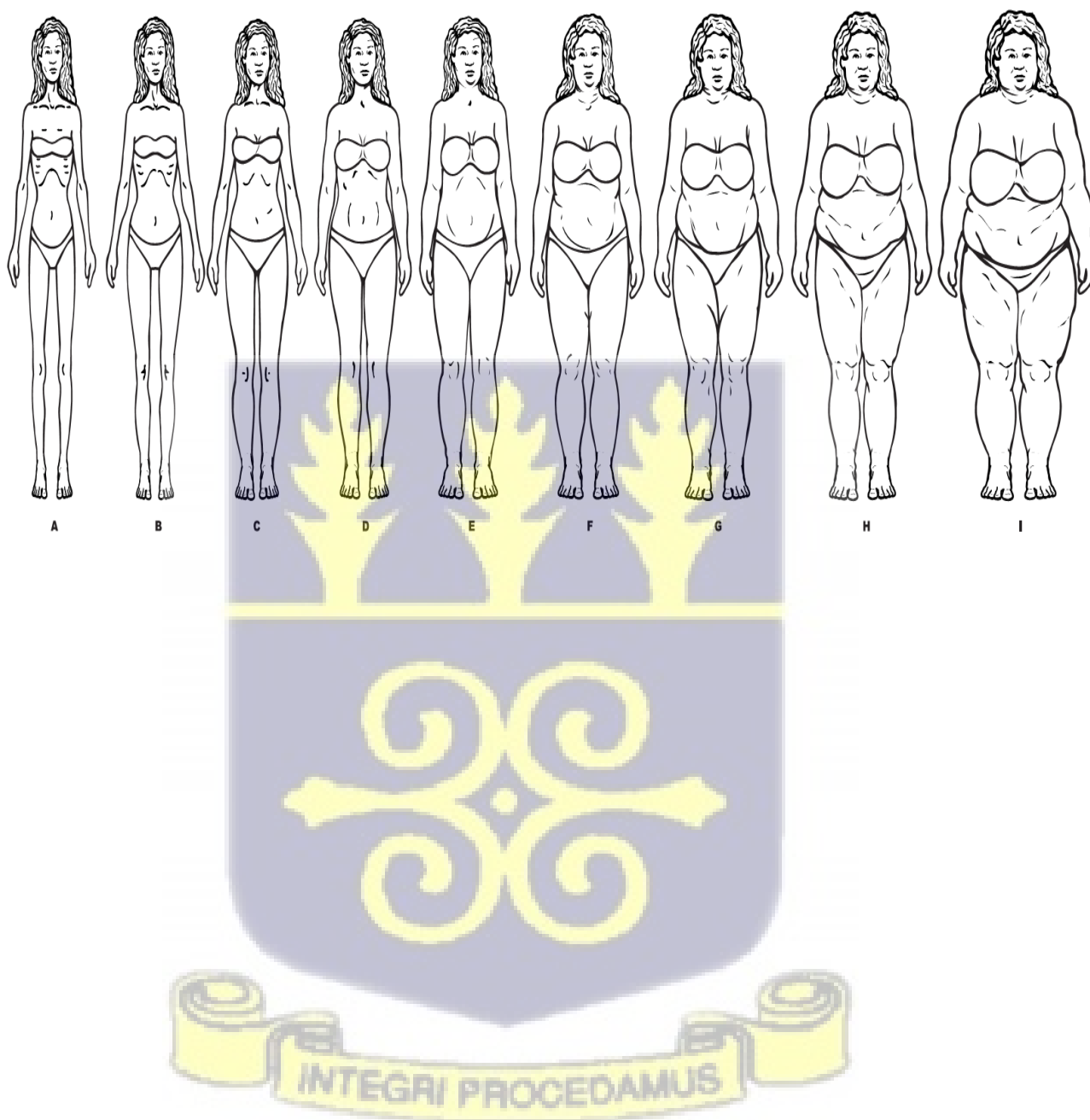
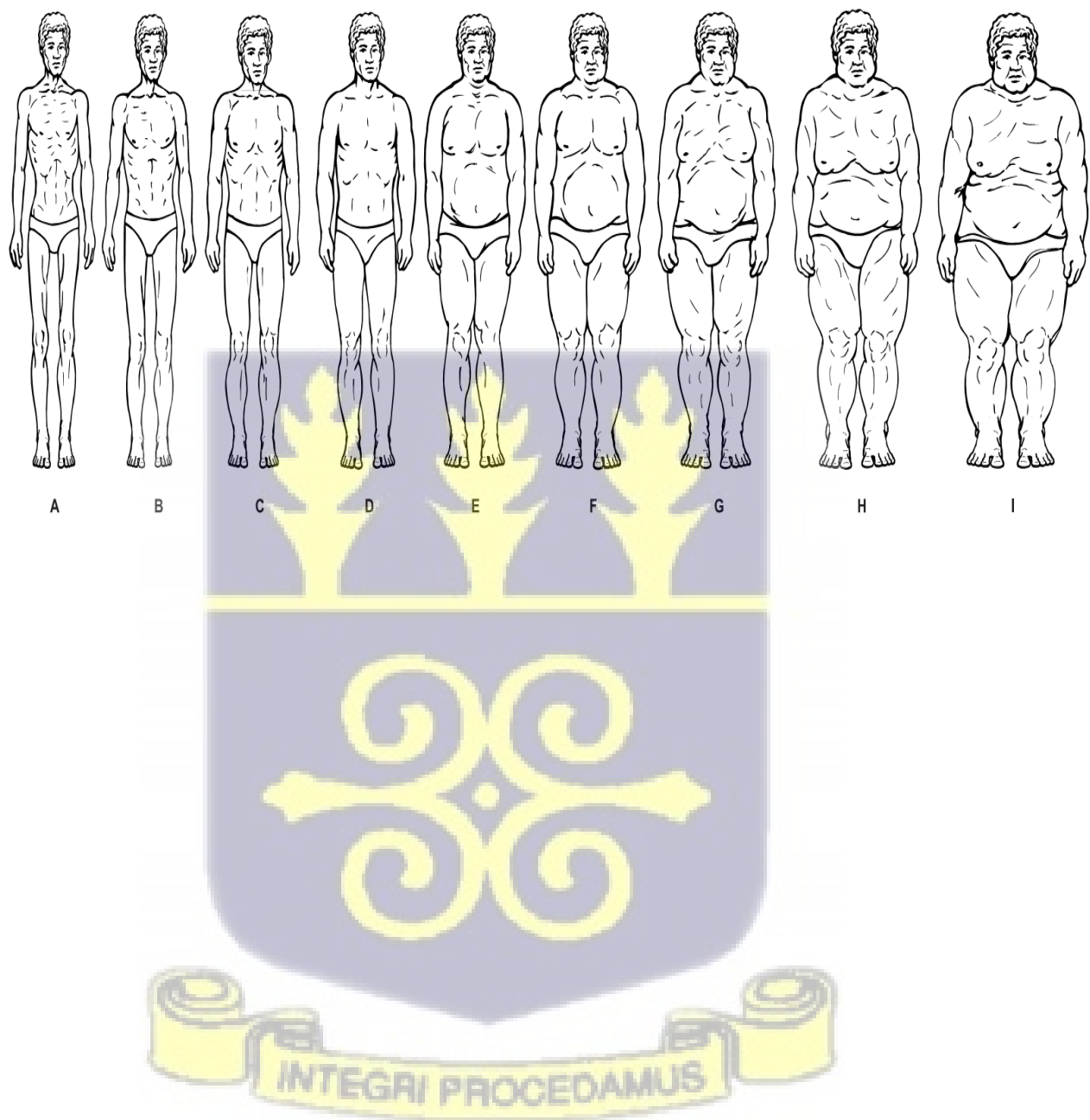


Figure 3: Silhouettes for men's body sizes



The last data collection tool was the notes taken during the observational study made by the researcher. Field notes were taken to document observations, ensure accurate tracking of key details, and serve as a reference during interviews. These notes, guided by the field checklist, helped record salient points made by participants effectively. All the interviews were audio-taped with permission from participants. Four participants declined audio recordings, and one stated a preference for a short conversation. Notes were taken on the brief discussions which were included in the data for analyses.

Key Sample Interview Area and Discussion Questions for each Group.

Key Interview Area for Individuals with chronic conditions [ICCs].

1. I am going to show some cards with pictures/images of body sizes. Look at the cards and select the one that best describes your ideal body size.
2. What are your feelings about your current size/weight?
3. How has your body changed following your diagnosis of [state the condition]?
4. Where did you obtain information about the [state the condition] and its effects or changes to the body? What was that information?

Key Interview Area for Caregivers [CGs]

1. I am going to show some cards with pictures/images of body sizes. Look at the cards and select the one that best describes your ideal body size.
2. How would you describe the body image of your care recipient before he/she was diagnosed with [state the condition(s) of the care recipient]?
3. How has the change in the body image of your care recipient(s) affected your personal relationship with him/her?
4. How did you react to hearing about your care recipient(s) condition when you first heard about it?

Key interview Area for Healthcare Professionals [HCPs].

1. I am going to show some cards with pictures/images of body sizes. Look at the cards and select the one that best describes your ideal body size.
2. In your experience as a [state the health profession], how does chronic illness affect the body image of patients?
3. Do people with chronic diseases report having body image issues as a result of these diseases?
4. What psychological complaints do they experience and communicate because of their physical condition?

Key Interview Area for Focus Group Discussants [FGDs]

1. I am going to show some cards with pictures/images of body sizes. Look at the cards and select the one that best describes your ideal body size.
2. Do chronic diseases affect the body image of those suffering from them? How?
3. Please tell me how and where you learned chronic diseases can affect body image.
4. Within your community, how do people relate with those suffering from chronic conditions and experiencing issues regarding body image?

3.9 Ethical Considerations

This study aimed to investigate body image, embodiment, and chronic illness experiences among Ghanaians as part of a larger research project called the Accra Chronic Care Study. The Accra Chronic Care Study aims to examine chronic illness experiences and chronic care practices in multicultural contexts in Accra. Ethical approval for this study covered the study of body image, embodiment, and chronic illness. ECH 189 /20-21 is the ethics certificate protocol number issued by the Ethics Committee for Humanities (ECH) of the University of Ghana.

Consent procedures

Obtaining informed consent from participants is an important ethical procedure in research. Study participants were informed of the purpose and scope of the study, as well as the procedures and duration of the interviews. In addition to these, they were informed of the benefits and risks associated with the study. Prior to the interview, the participants were informed that the interview would be audio recorded, and notes would be taken. Participants recruited for the ethnographic observations were duly informed they would be observed and engaged periodically over the course of about one year. Participants voluntarily agreed to participate in the research and provided their informed consent. In addition to the oral agreement, they were asked to sign or thumbprint a consent document to confirm that they fully understood and agreed to participate in the study.

Confidentiality and Privacy

A pseudonym was given to each participant in the study to anonymize all transcripts. This was done to ensure that all participants in the study remained anonymous. The transcripts were encrypted and stored on the researcher's devices. To ensure security and anonymity, audio recordings of interviews were deleted after they had been transcribed. Apart from the researcher, no one could link any of the transcripts to any specific participant.

Eligibility Criteria

Adults with chronic conditions who were at least 18 years of age participated in the study. To be eligible for the study, participants had to have lived with a chronic condition (or chronic conditions) that had been diagnosed for at least six months. This time frame was also used for caregivers. All participants had to be residents of one of the three research sites:

Jamestown, Ussher Town, or Legon. Healthy community members without chronic conditions were recruited for the FGDs to represent the broader voices of the community as emphasized by SRT.

Pilot Study

A pilot study was conducted in March 2022 to pre-test the interview guide, particularly questions concerning body image and embodiment. The pilot was carried out in Accra New Town and West Legon (also known as Westlands), communities similar to Ga-Mashie and Legon respectively. Safety protocols were followed for both the researcher and the participants. The pilot study provided valuable insights that informed the refinement of the final interview and the FGD guides. For example, during the pilot interviews with the individuals with chronic conditions, the researcher realized that there were no questions asked about the reaction(s) of significant others after being informed by medical professionals that chronic conditions had caused visible changes in body image of ICCs or limitations in functioning. This gap was addressed in the final guide by including targeted questions on these issues, which generated richer accounts of interpersonal and social responses to illness. In addition, a new question *‘What beliefs do people in your community and ethnic groups hold about chronic illness and body image?’* was included, and applied across all groups (ICCs, CGs, HCPs, and FGDs) to capture broader socio-cultural perspectives. The pilot also revealed the need to reorganize the flow of some questions in the final guide; certain questions were regrouped under themes such as body image and embodiment. Furthermore, a few questions were rewritten for clarity, while others were removed entirely, and new questions added to strengthen thematic coverage. The revised semi-structured interview guide is presented in Appendix 3. These adjustments ensured greater

clarity, improved thematic focus and enhanced the depth and relevance of the data collection in the main study.

Data management and transcriptions

All participants provided both written (signed) and oral consent before participating in the study. Consent was given for the audio recording of all interviews and FGDs. The research assistants recruited for the study received training to ensure consistency and adherence to ethical and methodological standards. To enhance the accuracy and reliability of the data, the transcripts of both the individuals and FGDs against the original recordings were cross-checked. This was facilitated by the researcher's fluency in Ga and Twi, the two main languages spoken in the study communities. The individual interviews lasted approximately one hour, while the FGDs lasted about one and half hours.

All audio recordings and transcripts were stored on a password protected computer and backed up on an encrypted external drive. To ensure confidentiality, transcripts were anonymized using pseudonyms, and no personal identifiers were retained. Interviews and FGDs conducted in Ga and Twi were transcribed verbatim and translated into English for analysis. The translations were all cross-checked to ensure linguistic accuracy. In addition, a sample of the transcripts produced by research assistants were reviewed and verified against the recordings to ensure reliability and consistency.

3.10 Data analysis

The data analysis process employed a systematic and iterative approach to examine various forms of qualitative data, including individual interviews, dyadic interviews, focus group discussions (FGDs), and ethnographic observations. These datasets were integrated and analyzed

using a combination of thematic analysis and the principles of Social Representation Theory (SRT).

Individual Interviews

The individual interviews provided in-depth insights into personal experiences with chronic illness and body image. Audio recordings were transcribed in Twi, Ga, and English, ensuring fidelity to the original narratives, and the indigeneous languages were translated into English. Deductive codes were developed based on existing literature on chronic illness and body image (Bury, 1982; Clarke & Griffin, 2008; de-Graft Aikins, 2006; Piran, 2016, 2018; Williams, 2000). These studies provided a conceptual guidance on the psychosocial and embodied dimensions of the illness, informing the identification of the themes such as body dissatisfaction, changes in physical appearance, illness-related stigma, hair loss, emotional response to embodied changes etc. Inductive codes emerged directly from participants' narratives, reflecting novel insights into how embodiment is experienced and understood. The analysis also highlighted areas of consensus (shared cultural ideals of body image), conflict (disagreements on the role of biomedical versus traditional remedies), and absence (limited discussion on psychological support needs).

Dyadic Interviews

These interviews, involving pairs of participants such as individuals with chronic illness and their caregivers, were analyzed to explore the dynamics of how illness impacts relationships and shared perceptions of body image. The analysis of the dyadic interviews followed a similar approach to the individual interviews, with careful attention to the interactions between

participants. Coding emphasized mutual perceptions, caregiving roles, and the interplay of individual and relational identities. Anchoring was evident in how caregivers contextualized bodily changes through cultural norms, while objectification surfaced in shared metaphors describing illness and recovery. Cognitive polyphasia emerged as participants navigated differing perspectives within the dyadic relationship.

Focus Group Discussions (FGDs)

This provided a platform for participants to engage in collective dialogue about body image and chronic illness. These discussions offered valuable insights into social norms, community-level beliefs, and collective representations of ideal body images and the impact of chronic illness. The analysis of FGDs involved transcribing and translating the discussions, followed by coding for recurring themes that emerged from group dynamics and interactions. The collective nature of FGDs revealed the influence of social and cultural context on participants' understanding of body image. For instance, in these group discussions, participants reflected on how societal expectations of beauty and body norms shape their experiences with chronic illness and how these norms are challenged or reinforced by illness-related bodily changes. The coding process captured the convergence and divergence of opinions within the group, highlighting both shared and contrasting views on embodiment and illness. The group dynamics helped to explore convergences and divergences in beliefs, with coding capturing both shared representations (consensus) and contested views (conflict). Anchoring was also explored as participants referenced societal ideals of beauty and health, while objectification appeared in discussions about visible markers of illness, such as scars or weight changes.

Ethnographic Data

This included field notes, observations, and contextual information gathered during the research process, providing a rich cultural backdrop for understanding how body image and chronic illness are perceived in specific social settings. This data was crucial for situating individual and group-level findings within everyday life contexts. The ethnographic data were analyzed to contextualize the experiences of participants and to identify how social representations of illness and body image are shaped by community practices, rituals, and interactions.

Once the individual datasets were analyzed separately, they were synthesized to develop basic, organizing, and global themes that captured the overarching patterns across the data (Attride-Stirling, 2001). The initial stage involved the identification of deductive codes, which were directly informed by existing literature and theoretical frameworks. These codes highlighted established themes related to chronic illness and body image, such as body dissatisfaction, appearance changes, loss of control, and social stigma. These codes were then grouped into basic themes, which represented specific patterns or categories identified in the data. For example, codes such as “pleasing and attractive,” “curvaceous body,” and “fit dressing” were grouped under the basic theme of “aesthetic appeal,” while codes such as “loss of control” and “sexual dysfunction” were categorized under “disruptions to functionality.”

The next step involved organizing these basic themes into broader organizing themes. Organizing themes represented clusters of related basic themes that reflected key aspects of body image and embodiment in the context of chronic illness. For instance, the basic themes of “aesthetic appeal,” “functionality,” and “healthiness” were grouped under the organizing theme “representations of ideal body image.” This stage of the analysis allowed for a deeper

understanding of how different dimensions of body image, such as appearance, function, and health, interact and contribute to participants' overall perceptions of their bodies.

Finally, the organizing themes were synthesized into global themes, which reflected the overarching patterns across the data. Global themes represented significant insights about the collective beliefs, cultural narratives, and shared understandings of body image and embodiment in the context of chronic illness. These global themes were visualized in a thematic network, which mapped the relationships between basic, organizing, and global themes, providing a clear pathway for understanding the complex interplay of individual, relational, and societal factors in shaping body image and embodiment. The final coding framework was developed iteratively, with careful attention to consensus, contradiction, and absence in the data, ensuring that all relevant aspects of participants' experiences were captured and integrated into the analysis.

Application of Social Representation Theory (SRT) to Thematic Analysis

Social Representation Theory (SRT) was applied in the thematic analysis to understand how participants collectively interpret and make sense of chronic illness, bodily changes, and body image. The coding framework developed during the analysis is presented in Appendix 3. Key concepts from SRT—*consensus*, *conflict*, *absence*, *anchoring*, *objectification*, and *cognitive polyphasia*—guided the analysis. Using the consensus – conflict – absence (C-C-A) approach by de-Graft Aikins (2003), (2006), the key concepts helped identify shared beliefs (*consensus*), divergent views (*conflict*), and areas where certain topics were notably missing or unaddressed (*absence*) in the participants' narratives.

Anchoring was used to explore how participants anchored their understanding of body image and chronic illness to familiar cultural references—for example, how changes in the body

were often linked to traditional ideals of beauty, health, and functionality. *Objectification* was employed to examine how bodily changes were represented using metaphors or visual symbols, such as equating weight gain with prosperity or viewing scars as marks of resilience. *Cognitive polyphasia* was used to explore the coexistence of multiple, often contradictory, knowledge systems—specifically, traditional and biomedical understandings of illness and body image. Participants navigated these diverse sources of knowledge to make sense of their experiences. This application of SRT allowed for a holistic understanding of the individual, relational, and societal influences on participants’ perceptions of body image and embodiment.

Furthermore, to understand how participants made sense of body image in the context of chronic illness, it was important to identify and define the various sources of knowledge that influenced their perceptions. These sources were categorized into distinct knowledge systems, each contributing to participants' understanding of body image and illness. Cognitive polyphasia was used as an analytical tool to focus on the stocks of knowledge which participants drew from. This approach was based on a framework adapted from de-Graft Aikins et al. (2019), who applied it to explore lay knowledge of type 2 diabetes in both rural and urban Ghana, as well as among Ghanaian migrants in Europe. The framework categorizes sources of knowledge into four primary stocks: *cultural*, *common-sense*, *scientific*, and *religious* knowledge (de-Graft Aikins et al., 2019). *Cultural knowledge* is rooted in traditional beliefs and societal norms, shaping how individuals perceive illness and body image based on collective heritage and long-standing cultural values. *Scientific knowledge* encompasses medical and biomedical understandings of health, illness, and body changes, often communicated by healthcare professionals. *Common-sense knowledge* arises from everyday experiences, social observations, and informal networks, while *religious knowledge* draws on spiritual and faith-based perspectives on health and the

body. Applying this framework helped to unearth the coexistence of diverse, often contradictory, knowledge systems as individuals attempt to reconcile different perspectives.

3.11 Reflexivity, Trustworthiness and Rigor

In conducting this research, I collected data from a diverse group of participants, including individuals from the general population in the Legon and Ga-Mashie communities. In this role, I occupied a dual position as both a researcher and someone closely affiliated with the group. To ensure objectivity and maintain the rigor of the research process, I took deliberate steps to manage this dual role across all participant groups. While research assistants interviewed the few participants from the Jamestown Health Club self-help group, I was solely responsible for conducting the ethnographic observations with participants. The Jamestown Health Club (JTHC) is a community self-help group (est. October 2017) that offers monthly education, psychosocial support, and basic monitoring for people living with hypertension, diabetes, and stroke. This distinction helped mitigate any potential bias on account of my personal involvement with the group. The research assistants were trained to uphold professional and ethical standards, ensuring consistency in the interviews conducted.

I remained constantly aware of the potential influence my familiarity with participants might have on the research process. To address this, I applied various reflexivity strategies to minimize bias and ensure that my role did not unduly shape the data collection, analysis, or interpretation. As mentioned earlier, I serve as the field coordinator for the self-help group, and my research was integrated into the broader *Chronicity and Care in African Contexts Project - Accra Chronic Care Study*. This project aims to examine experiences of chronic illness and chronic care practices within multicultural contexts in Accra, and my research became part of

this larger initiative, allowing me to gather data for both studies simultaneously. Participants for the ethnographic data were recruited from the self-help group component of this Accra Chronic Care Study.

Throughout the fieldwork, I encountered varying emotions and revelations regarding the contextual behaviours and meanings people assign to health matters when faced with limited options for change. Having worked with the self-help group for the past seven years, I had the opportunity to understudy PhD students previously involved with the group. These interactions were instrumental in teaching me how to establish rapport with participants, a skill that proved invaluable during data collection. Furthermore, I developed a deeper understanding of cultural nuances, moving beyond my initial experience of cultural shock to appreciating and comprehending these nuances from the participants' perspective.

My association with the self-help group facilitated the data collection process, making it easier to gather sensitive information about chronic illness within these communities. Without this existing relationship, collecting such data would have been more challenging. There were moments during the fieldwork that were emotionally challenging, particularly in my interactions with some of the individual participants, including one who declined to participate. These encounters were marked by expressions of pain, disappointment, and emotional distress. Some participants were visibly affected and wept uncontrollably during our interactions. I found this experience unforgettable. Although I tried to remain composed and offer support, I found it difficult to hold back my own tears. In these moments, I realized that empathy was necessary, as the participants were experiencing significant emotional distress, which at times included psychological exhaustion. As noted by Vingerhoets and Bylsma (2016), crying can serve as a release of emotional tension, and I recognized that such expressions were an essential part of the

research experience. As a result of this emotional exchange, two participants sought psychological assistance from me. In response, I referred them to a colleague with clinical experience for counselling support. Additionally, I assisted another participant in seeking psychological help at a nearby hospital, drawing upon my professional background as a psychologist to make appropriate referrals. While my primary role was to conduct research, my position as a social psychologist motivated me to offer support where needed, particularly when participants were facing difficult circumstances. Though I was there to gather data, I found it easy to slip into a more supportive role when required. I soon realized that long-term involvement with participants often demands personal sacrifices, and I was committed to assisting those who requested help during the research process.

Cultural dynamics played a significant role in shaping my research relationships with participants across the three communities, as each had unique traditions, norms, and communication styles. Navigating these dynamics required ongoing sensitivity, respect, and reflexivity. I adhered strictly to ethical guidelines, maintaining professionalism and prioritizing a researcher-oriented perspective throughout the study. During the coding and analysis stages, I was mindful of potential biases that could shape my interpretation of the data. Some of these biases stemmed from my position as an academic, which could have led me to privilege biomedical explanations of illness and embodiment over cultural and social narratives. Another potential bias was related to my own perceptions of body image, shaped by personal and societal norms, which might have influenced my understanding of participants' experiences.

Acknowledging these biases, I engaged in a process of bracketing and reflexivity. This involved constantly reflecting on how my positionality influenced the co-construction of meaning with participants. For example, I actively sought to challenge my assumptions by

revisiting raw data, incorporating alternative interpretations from my research team, and embracing participants' voices. I was also open to critique and revising my analyses to ensure they authentically reflected the diverse perspectives shared by participants. Through these processes, I aimed to ensure a collaborative approach that enriched the data and analysis. I therefore recognize that the insights generated were not solely the product of my interpretation but emerged from a dynamic interaction between myself, the participants, and the cultural contexts of the study. This openness and iterative reflection ensured a richer, more nuanced understanding of the cultural and social dimensions of body image and embodiment in chronic illness.



CHAPTER FOUR

FINDINGS ON SOCIAL REPRESENTATIONS OF BODY IMAGE

4.1 Introduction

The first objective explored the social representations of the ideal body image among the participants. This chapter explores the social representations of the ideal body image among participants, focusing on the content, sources, and cultural functions of these representations. Drawing on qualitative data from across individuals with chronic conditions (ICC), their caregivers (CG), healthcare providers (HCP) and focus group discussants (FGD), the analyses examine how individuals and groups construct, interpret, and navigate body image ideals in the Ghanaian context.

The chapter begins by presenting the content of these representations, highlighting shared understandings of the ideal body image while incorporating nuances related to gender, age, and ethnicity. It further delves into social interpretations of body size, including perceptions of fatness and thinness, to provide insight into the cultural meanings attributed to different body shapes and sizes. Participants' selections from body silhouette cards—ranging from underweight to obese—are also integrated to contextualize preferences and societal ideals.

The subsequent sections examine the sources of these body image ideals, shedding light on the stocks of knowledge that shape societal norms—including cultural narratives, media, and healthcare discourses. While the functional roles of these representations in shaping body behaviours and managing chronic illness are acknowledged, a detailed exploration is deferred to Chapter Seven. This chapter concludes with a discussion that synthesizes the findings, reflecting

on their implications for understanding body image in the context of chronic illness and healthcare in Ghana.

4.2 Content of Representations of the Ideal Body

4.2.1 Representations of Ideal Body

Participants were also asked to select their ideal body size from silhouette cards ranging from underweight (A-B), normal weight (C-D), overweight (E-F), and obese (G-H-I) categories. Notably, 15 individuals with chronic conditions, 5 caregivers, 6 healthcare providers, and 19 participants across the focus groups selected the “normal weight” category, reinforcing preferences for moderate body representations rather than extremes. 10 individuals with chronic conditions, 3 caregivers, and 5 participants from the focus groups all expressed similar preferences. Across these groups, most chose silhouettes in the overweight range (E-F), while none selected silhouettes in the obese range. This pattern highlights a shared cultural preference for balanced body representations and an aversion to extremes. The shared emphasis on the ideal body size was reflected in participants own words, as the quotes below demonstrate:

I want ‘C’ or ‘D’, I will say I prefer that body type because there are people with sickle cell that have weight. When I go to the sickle cell clinic and see fat people, I am surprised because mostly I assume most people with sickle cell are very slim. I don’t know if it is the blood or what because one may have weight, another is slim while the other is average in weight, I don’t even know. I am slim and prefer the C or D. [ICC-Stephen, 37yrs, Sickle cell disease, Legon]

“My ideal body size is depicted on card C, but then, my body size corresponds to the image on card ‘I’” [ICC, Padiki, 67yrs, Hypertension, Diabetes, Arthritis].

“I prefer a slim body size and therefore will choose body type ‘A’” [CG, Nana, 42yrs, Stroke, Jamestown]

“This one has enough shape and curves. The ‘C’.” [HCP-5, 37yrs, Clinical Psychologist, Legon]

“I do not like a fat person. I like ‘E’” [FGD-10-F-GM-Akweley].

In terms of how the participants’ selections depict body image, six themes emerged in the representations of the ideal body: aesthetic appearance, functionality, appropriate size, healthiness, muscularity and attractiveness to others, and occupational suitability. Table 11 presents the spread of themes among the three groups of participants.



Table 11

Spread of Themes and Codes on Representations of Ideal Body Image

Themes and Codes	ICC	CG	HCP	LI
Aesthetic appearance	✓	✓	✓	✓
Fine body	✓	✓	✓	✓
Curvaceous	✓	✓	✓	✓
Fit dressing	✓	X	✓	✓
Pleasing and attractive	✓	X	✓	✓
Nice body	✓	✓	✓	✓
Functionality of the body	✓	✓	✓	✓
Daily activity (walk, sit, stand)	✓	✓	X	✓
Size	✓	✓	✓	✓
Average/normal body size	✓	✓	✓	✓
Previous body size	✓	✓	✓	✓
Healthy body	✓	✓	✓	✓
Unsusceptible to diseases	✓	✓	✓	✓
Active	X	X	X	[✓]
Muscular	✓	X	X	✓
Muscularity and attractiveness	✓	X	✓	✓
Muscular body	✓	X	✓	✓
Attractive to opposite sex	X	X	X	[✓]
Occupational suitability	✓	X	X	✓
Professional appearance	✓	X	X	✓

Note: ICC = Individuals with chronic condition(s); CG = Caregivers; HCP = Healthcare providers,

LI = Lay Individuals.

✓ = theme is mentioned, [✓] = theme mentioned with conflicting views, X = theme not mentioned.

Description of Themes

Aesthetic appearance

Participants across all four groups emphasized aesthetics as central to the ideal body. They described the ideal as one that is pleasing and attractive. This ideal, as expressed by participants, aligned with a desire for a fine body image that appears curvaceous and fit. 16 participants across the groups indicated a preference for body shapes that present as aesthetically pleasing and attractively dressed. A participant from a focus group described the ideal body as one that “makes you feel good in any attire and appears pleasing to others,” underscoring the broader social value placed on physical appearance.

“With aesthetics, this shape too when you dress with it is nice so you realize here, we like slit and ‘kaba’, sometimes we like off shoulders, we like fitting dresses; it will draw your curvatures fine and perfect. Aesthetically, it is good, so it is the C for me” [HCP-5, 37yrs, Clinical Psychologist, Legon]

“‘D’ has developed a nice body. She has nice thighs. If my thighs were like this, nothing would worry me. If my thighs were like this, I could easily sit down. I can stand up and sit down easily. I can do everything. But with my current body, it is not good for me at all. The way I am is not good at all!” [ICC, Eloise, 47yrs, Hypertension, Jamestown]

Functionality of the body

Functionality and mobility emerged as a second major theme, with participants citing the ability to engage in daily physical tasks—walking, sitting, and standing—as integral to the ideal body. This theme was noted across the ICC (4 mentions) and CG (3 mentions) groups, as well as

in focus group discussions. Participants suggested that body functionality is tied to both health and practicality. One participant shared, “I want to be able to move freely without feeling weighed down. A healthy body should allow for that” [ICC, Naa, 39yrs, Diabetes, Ussher Town]. Other narratives expressed by participants are provided below.

“I prefer size D. This is because, when you become too fat, you are unable to walk briskly and don’t become clever, or smart; you get tired easily. With this body size, it makes you very smart in all your dealings” [ICC, Marie, 44yrs, Asthma, Ussher Town]

“C I like C because with other body types when you run, you feel heavy because of the body, but with type C body, it becomes easy when running because you feel light. You are flexible and can easily maneuver your way around narrow spaces” [FGD-21-M-GM-Odeshay]

“You can go anywhere if you have a body size like that. With a body size like C, you can pass through any small pathway, you can climb the mountains, if need be, without falling back but if you are overweight, you can't go everywhere like that” [CG, Korkor, 30yrs, Diabetes-Jamestown]

Size

Preferences for size were widely referenced, with most participants associating normal or average body sizes with ideal body images. Participants across the four groups consistently indicated a preference for sizes they deemed neither too small nor overweight, to reflect a widespread preference for moderation in body size.

“‘C’ So from what I see, the person is not too fat, not too lean either. I mean, in terms of weight, it doesn’t look like the person is either overweight or underweight. She’d be in an ideal BMI range”. [ICC, Brenda, 35yrs, Breast Cancer, Legon]

“This is because size D doesn’t describe a fat person; it’s the normal size that I like and that’s how I used to be”. [ICC, Beryl, 63yrs, Breast Cancer, Legon]

“I’m looking at the proportions, the height, and the body size; it’s not too big, in other words, it’s not obese or slim. The average body size, I like the height as well (D)” [CG, Kweku, 40yrs, Breast Cancer, Legon].

Notably, participants with chronic conditions often referenced past body sizes, reflecting a nostalgic association with previous images of themselves when healthier. The following excerpt illustrates these perspectives:

“Yes, this is how I wish I looked...if I’m like this, I would like it. I would really like it because previously, I was like this, so I would like to be like this. (“D”) [ICC, Chloe, 59yrs, Hypertension, Jamestown]

Healthiness

Health was a key component in the ideal body for many participants, especially among healthcare providers, who strongly associated moderate body sizes with better health outcomes. All HCPs and several ICC participants mentioned that the ideal body should be unsuceptible to diseases and allow for an active lifestyle. HCPs expressed concerns about the health implications of larger body sizes, with one HCP stating, “For me, the ideal body is the one that is neither too big nor too small, as that is healthier” [HCP-5, 37yrs, Clinical Psychologist, Legon]. Other views expressed by participants are provided below:

“Because I know if you have a body size like that (A or B), you won’t get any sickness” [ICC, Ray, 59yrs, Diabetes, Hypertension, Legon]

“I do not want to be too fat because fatness comes with some sicknesses. When you are middle-sized, you can do whatever you want, you won’t feel too tired when you go for walks. You will look smart” [FGD-14-F-GM].

Being active was an important marker of a healthy body, especially among participants in the focus group discussions. Activeness was perceived as evidence that the body functions properly and is normal. For example , one participant stated,

“This one has a medium-shaped body, so with this body, you can do everything actively. You become active in doing everything” [FGD-6-F-L-Ama].

Muscularity and attractiveness

Among male participants with chronic conditions, healthcare providers, and some of the focus group discussants, muscularity was frequently referenced as a key aspect of the ideal male body. They associated muscularity with physical strength and enhanced attractiveness. Similarly, attractiveness to the opposite sex emerged as an implicit ideal in the discussion of body image preferences. Some of the participants highlighted the appeal of a muscular and fit male body, noting that such a physique draws attention and is widely perceived as attractive. The following quotes highlight these views:

“I’m C because he looks fit and in the sense that he’s been exercising, and all his muscles are showing. Such a person looks attractive and draws attention” [ICC, Jeremy, 37yrs, Sickle cell disease-Legon]

“The body is muscular. I can lift weights, yea muscular body and pleasing to the eye” [ICC, Stephen, 25yrs, Sickle cell disease, Legon]

“I think I can see a lot of muscles, Um, less bones. So for muscular body, and it's fit too [HCP-4, 34yrs, Medical Officer, Ga-Mashie].

The narratives highlight both male and female perspectives on the value of muscularity in shaping ideals of physical appeal. This suggests that gendered preferences exist within ideal body representations, where certain physical attributes align with broader societal expectations around gender and appeal.

Occupational suitability

Finally, occupational suitability was highlighted, particularly by ICC participants, who noted that certain body types align with professional roles. This association was noted by a participant who expressed a desire to join the military, associating body sizes C and D with physical readiness and capability for this role: “I told you I wanted to be a soldier, so with that C would be good for me. C or D, the rest are too big” [ICC, Stephen, 37yrs, Sickle cell disease, Legon]. Another focus group participant linked preferred body size to his occupation. “Size B: the height, shape and structure. I am a footballer, and this structure is good for me. Some body types do not fit well with football in terms of stamina” [FGD-12-M-GM-Jah]. Finally, one participant remarked, “You have to look a certain way to be taken seriously in some professions,” [FGD-33-M-Legon-Fred] highlighting the societal links between body representation and occupational identity.

4.2.2 Gender and Age-based Nuances in Representations of the Ideal Body

Gendered and age nuances in representations of the ideal body were explored across participant groups (ICC, GC, HCP, and LI). The findings showed that in terms of gender, participants from all the groups discussed attractiveness and social expectations. The participants, for instance, valued a curvaceous and average body size for women to signal beauty and attractiveness. The participants however expressed preferences for leaner, more muscular bodies for men, to signal strength and physical capability. Further nuances emerged when gender intersects with age, with various body ideals for young women, old women, young men and old men.

Perceived Body Ideals of Young Ghanaian Women

Body image and health perceptions for young women were largely linked to attractiveness and social desirability. Attributes like sexy, smart, and aesthetic appeal were central. The following quotes illustrate how participants expressed these views:

“I mean, most of them are talking about girls who have the curves and have a flat tummy and are fair” [ICC, Celia, 22yrs, Sickle cell disease, Legon].

“For the young female, I will go for the ‘C’. Yeah, because as I said for the young ones if the person is obese it’s frowned upon. Of course, because an image like this also portrays sexiness or smartness and you’re able to carry yourself around more easily” [ICC, Brenda, 35yrs, Breast cancer, Legon]

These ideal body attributes for young women suggest a desire to be attractive to men. Some of the participants, particularly young women expressed a preference for body sizes that are integral to intimacy, mobility, health and vitality. Some women noted using enhancers to

meet these body ideals, though a generally balanced figure was favoured to maintain appeal without extremes. The following quotes illustrate these perspectives:

“I selected B because young ladies like to be slender in order to stroll comfortably. If they are not slender, they will feel uncomfortable and fatigued when participating in any activity, hence the desire of younger ladies to be slim” [ICC, Mansa, 27yrs, Diabetes, Ussher town]

“D would be good for young ladies, but I have some comments on that; some ladies prefer to have big bodies because some men prefer ladies with big bodies” [ICC, Jayden, 44yrs, Diabetes, James town].

Participants linked body size not only to appearance but also to functionality in everyday life.

This view was expressed in relation to the practical advantages of a fuller body size, as captured in the following quotes.

“They can use the body (F) to do a lot of things. They can go to the market and come back early, and manage their home. But when you are too slim and you can see that your bones are showing, it is not good” [CG, Mina, 44yrs, Sickle cell disease, Legon].

The male participants exhibited preferences for women who appear fit and healthy without excessive muscularity, reflecting a complex balance between personal health awareness and societal attractiveness standards. This was highlighted in the words of the participants.

Personally, I have not really seen a young woman who would want to be like B and A because they see them be too skinny and most people in that age bracket would prefer to be seen. As you see, Ghanaians have the perception that the more flesh you have the richer you are so on averagely, even if they don't have enough money and they can eat to look bit C, D, E and F, they are okay [ICC, Evans, 41yrs, Asthma, Legon]

“In today's world, being overweight makes it harder to attract the opposite sex, thus you should lose weight. When you are smaller, you are more active; nevertheless, when you are overweight, you cannot be active” [ICC, Padiki, 67yrs, Hypertension, Diabetes, Arthritis].

Perceived Body Ideals of Older Ghanaian Women

Health and social appearance dominated ideal body size for older women. Participants across the groups described body image preferences that prioritize a normal and healthy appearance, linking body size to age-related health concerns. As physical appearance shifts with age, these women emphasized mobility, lifestyle adaptability, and social independence over outward attractiveness. Remaining active and maintaining a normal weight was considered ideal to balance health needs and age-related physical changes as reflected in the quotes below.

“For older women, it is good for them to have a slim body like body type A or B” [CG, Nana, 42yrs, Stroke, Jamestown].

“I think body size D is still good for the old women. They are able to walk” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown].

“There are some elderly women who prefer to be like C. It's not good. If they become fat, they will not be able to do anything” [ICC, Caitlin, 56yrs, Hypertension, Arthritis, Jamestown].

Using the body image cards, the participants showed that underweight (A-B) was viewed as too frail, while obese sizes (G-H-I) were seen as a threat to functional independence and health, reflecting a shift from beauty-centered ideals to practical considerations as women age. Below are examples of such views as presented by some of the participants.

“Older Ghanaian women have the same size because when they grow older, they become fat. Since older people do not work but rest and are taken care of by their children, they tend to grow

bigger and this affects them a lot especially their health” [ICC, Beryl, 63yrs, Breast Cancer, Legon]

“Our great-grandmothers were smallish; if you see anyone fat during their time, it's genetics. However, most women nowadays want to be big and it comes with a lot of health challenges” [ICC, Padiki, 67yrs, Hypertension, Diabetes, Arthritis].

“E would be good for them. This is because too much fat disturbs their waist and knees most often, so E would be good for them. But they want to be big” [ICC, Jayden, 44yrs, Diabetes, Jamestown].

Perceived Body Ideals of Young Ghanaian Men

The participants across all the groups showed a strong preference for fitness, muscularity, and strength as markers of attractiveness and self-confidence in representing ideal bodies for young men. Terms like “muscular”, “six-pack”, and “strong” were commonly used to describe body ideals. The participants expressed preferences for leaner, more muscular builds that signal strength and physical capability. The participants’ own words provide insight into these perspectives as seen in the accounts below.

“They want to have 6 packs. It’s important to them to build muscles, get the 6 packs, so they go to the gym, and do different styles that would make their muscles more visible” [ICC, Brenda, 35yrs, Breast cancer, Legon]

“C is good because as a young man, you should have muscles and six packs” [ICC, Stephen, 37yrs, Sickle cell disease, Legon]

“They like muscular men with 6 packs, well-built, and tall. I do not think that Ghanaians like people who are fat or big or obese, nor do they like people who are underweight with no flesh. They always prefer C or D” [HCP-6, 37yrs, Nurse, Ga-Mashie]

More so, for young men, participants highlighted the value of maintaining strength, vitality and attractiveness through a moderate body size. They also mentioned that moderation in the body size was tied to long-term strength and healthy ageing among men. These views emphasized functionality, health and social appeal. Some participants observations are shared below.

“I think D for the young men so that they keep being strong even as they grow old. If you take someone bigger, they get weaker as they grow older. They wouldn’t reach age 40 and then they start looking very old, like they are around 80 years” [CG, Celine, 30yrs, Hypertension, Diabetes, Legon]

“He looks very healthy, not just pleasing to the eyes, but everything is in proportion (Size D)” [CG, Kweku, 40yrs, Breast Cancer, Legon].

Aesthetic concerns also emerged with body size linked to showing how young men present themselves. Participants noted below:

“If you are a young man with a body size of D, you look great in dresses. However, if you have a body size of E or F, you do not look good in dresses” [ICC, Padiki, 67yrs, Hypertension, Diabetes, Arthritis].

“Young men in school—tertiary or just out of school—I mean, at those ages, there’s no responsibility of caring for a child, so the concentration is about building himself (body muscles) up to attract the opposite sex” [ICC, Brenda, 35yrs, Breast cancer, Legon]

Occupation also featured in the body preferences for young men. The participants emphasized that fitness and physical readiness are often required for specific job roles. Young men, in particular, viewed physical fitness as positively impacting both job performance and social attractiveness. Occupation emerged as a factor that reinforced the importance of fitness, particularly in professions that require physical activity, making body image both a personal and professional consideration.

Perceived Body Ideals of Older Ghanaian Men

The participants expressed body image ideals centred around not being too slim while remaining active and independent. They emphasized the importance of a body that could sustain physical and social activities without dependency on others. Overweight and obesity were associated with health risks, prompting a preference for an average body size as an ideal that balances health with ageing for men. For older men, the focus is more on maintaining health and physical capacity than outward attractiveness, reflecting a shift toward functional body ideals with age.

“For elderly men, if you are very old, then you should have a body like this (‘D’)” [ICC, Caitlin, 56yrs, Hypertension, Arthritis, Jamestown]

“For our fathers, when they go on retirement, they don’t go anywhere so if they get a body like F, it’s okay” [ICC, Nkunim, 43yrs, Sickle cell disease, Legon]

“You reduce as you grow older, so the C is better. If you reduce to this stage, it is better because you will still have the strength to perform your normal duties. Even though it may not be like

how you used to be, you will have a little bit of your strength” [CG, Celine, 30yr, Hypertension, Diabetes, Legon]

4.2.3 Ethnic differences in perspectives on body sizes

This subsection explores how body size ideals and physical attributes are perceived across different ethnic groups in Ghana, including the Akan, Ga, Ewe, and Northern communities.

Perceived Body Ideals of the Akan: Balanced Body Size and Complexion

Participants described the Akan as having a balanced, average body size and height, with features that are generally perceived as proportionate. They highlighted that Akans tend to be dark-skinned, with shades described as black or chocolate. The participants noted that Akans often have a mix of body types, ranging from slim to moderately built, without extremes in body size. The quotes below capture these perceptions:

“Ashantis are very dark-skinned; no Ashanti person is light-skinned, unless maybe the person is bleaching” [ICC, Caitlin, 56yrs, Hypertension, Arthritis, Jamestown]

“I don’t mostly see fat people among the Akans; they are of medium body size. The fat ones are not many.” [ICC, Hazel, 75yrs, Hypertension, Jamestown]

“The Ashantis are not too big or too slim. They have average size.” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown]

“With the Akans, they are cute. Akans are cute people; they are not that fat” [Ferdinand, 64yrs, Diabetes, Jamestown]

“Ashantis, dark skin and then they are not big” [HCP-8, 31yrs, Physiotherapist, Korle-Bu]

Perceived Body Ideals of the Ga: Preference for Larger Body Sizes

Among the Ga, participants across all the groups (ICC, GC, HCP, and LI) consistently observed a preference for larger, heavier body types, often describing them as big or fat. They mentioned that Ga people generally have darker skin, though some reportedly bleach their skin, a practice expected to enhance their appearance in line with beauty ideals. The use of certain drug enhancers to achieve a fuller body shape was also noted among Ga participants, highlighting a culturally specific approach toward body enhancement within this group. The following quotes highlights these views:

“I think the community encourage fat bodies and women who are physically endowed” [HCP-1, 26yrs, Nurse, Ga-Mashie]

“You have some, some natural and then a lot of them are also bleaching, a lot. Go to chorkor, a lot, a lot” [HCP-8, 31yrs, Physiotherapist, Korle-Bu]

“They use bleaching pomades to change their complexions and make them fair” [ICC, Fiifi, 44yrs, Sickle cell disease]

“They (Gas) mostly take drugs with the motive of gaining weight and I know a lot of them”. [ICC, Aku, 60yrs, Diabetes, Hypertension, Jamestown]

“The Gas, most of them are fat, they take drugs to make them fat” [ICC, Chloe, 59yrs, Hypertension, Jamestown].

Perceived Body Ideals of the Ewe: Diversity in Size and Light Complexion

The Ewe community was perceived as having a mix of body types, with participants describing some individuals as big or moderately built, while others were described as slender.

The participants noted that Ewes were often noted to be fairer in complexion or light-skinned, with an average to above-average height. This variety in body size, combined with their lighter skin tones, distinguished the Ewe group's body representation in the eyes of participants. Here are some of the quotes from the participants to denote these:

“Ewes are mostly fat so they may like to look fat like I” [ICC, Marie, Asthma, Ussher Town, 44yrs]

“Some Ewes are very light-skinned, so you will know this person is an Ewe immediately you see them. They are very light-skinned; they don't bleach but...” [ICC, Caitlin, Hypertension/Arthritis, Jamestown, 56yrs]

“When you look at an Ewe, they are mostly fair and their women are also fat” [FGD-26-M-L-Benjilo]

Perceived Body Ideals of the Northerners: Height, Muscular Build, and Lean Body Composition

Participants associated Northerners with a slim and tall physique, often characterized by muscularity, which they attributed to the physically demanding lifestyle in the north. While some Northerners were described as fair-skinned, others were noted to have darker complexions, contributing to a perceived diversity of skin tones within the group. The participants highlighted that Northerners generally have a lower body fat percentage and an average body size that tends towards leanness, setting them apart as the tallest ethnic group in the country. The following accounts reflect these views:

“The Northerners do a lot of hard work, like the manual kind of work, the farm so you don’t always see them becoming that fat” [ICC, Brenda, 35yrs, Breast cancer, Legon].

“Yeah, energetic. They are tall, strong, related to their energetic” [ICC, Jeremy, 25yrs, Sickle cell disease]

“With the Northerners, most of them are slim and tall” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown]

4.2.4 Representations of Fatness and Thinness

Representations of fatness and thinness were also explored among the participants. The meanings and health consequences of fatness and thinness were attributed to four main factors: biological meaning (genetics/nature), physical meaning (slim/thin/low body mass, obesity, shapeless body size, active body size), sociocultural meaning (stigmatized/stereotyped body size, lack of respect, lifestyle), unhealthy/healthy body size (underlying health issues, healthy body size-not prone to diseases, unhealthy body size-prone to diseases). These representations are not only influenced by individual experiences but also vary across different groups, revealing distinct and sometimes contradictory attitudes towards body size. Below, is an exploration of how themes related to fatness and thinness are represented, and how they are distributed across groups, accompanied by sample quotes where necessary.

Meaning of Fatness

Fatness, as a concept, is associated with a variety of meanings, some positive and some negative. One of the most notable themes surrounding fatness is its connection to wealth and abundance. Larger body sizes are often viewed as a sign of prosperity and good living conditions. Fatness is considered an indicator of social status, with some individuals perceiving it

as a symbol of wealth. This view of fatness as an indicator of wealth was particularly prevalent among participants who identified as belonging to middle- and upper-class backgrounds. For these individuals, being well-fed was often associated with social mobility, financial success, and a higher socioeconomic status. Participants views are demonstrated below.

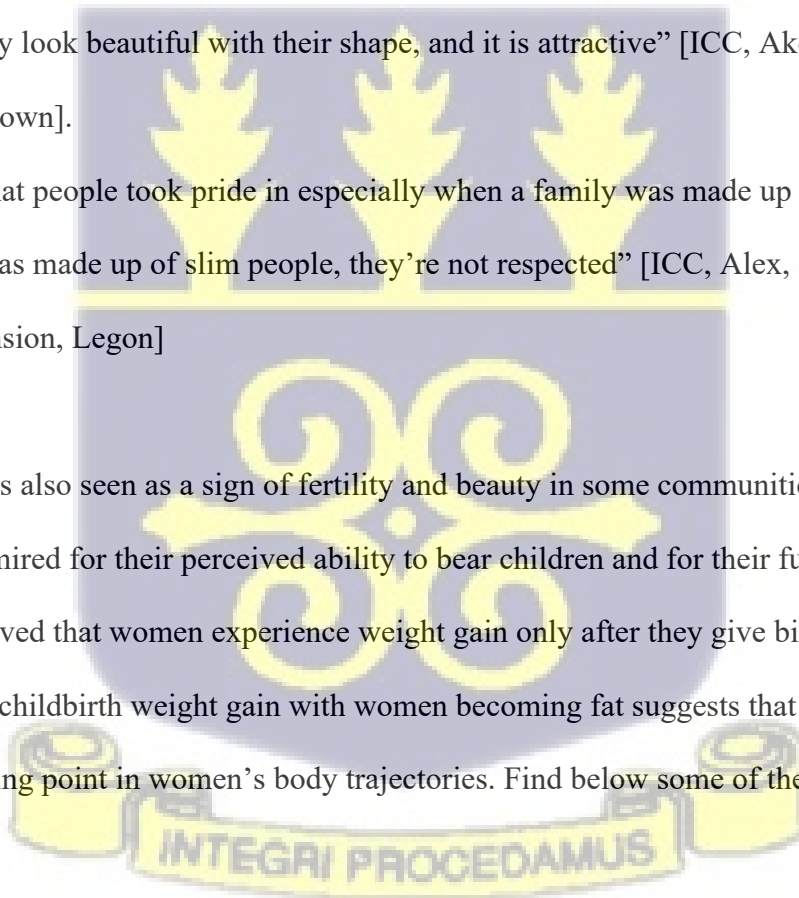
“They like big people, especially the rich ones who dress nicely” [ICC, Aku, 60yrs, Diabetes, Hypertension, Jamestown].

“Being fat is nice. Some people are fat, they take good care of themselves, they dress well, and how they move their bodies is more attractive” [ICC, Padiki, 67yrs, Hypertension, Diabetes, Arthritis, Jamestown].

“Fat people really look beautiful with their shape, and it is attractive” [ICC, Akosua, 60yrs, Diabetes, Jamestown].

“The reason is that people took pride in especially when a family was made up of fat people. But when a family was made up of slim people, they’re not respected” [ICC, Alex, 69yrs Diabetes, Stroke, Hypertension, Legon]

Fatness was also seen as a sign of fertility and beauty in some communities, where larger women were admired for their perceived ability to bear children and for their fuller figures. Others also believed that women experience weight gain only after they give birth. Participants associating post-childbirth weight gain with women becoming fat suggests that reproduction was viewed as a turning point in women’s body trajectories. Find below some of the quotes from participants.



Once you're growing fat it means you're healthy, life is smooth for you, all is well, and your money is coming, okay? You're at peace, you have a sound mind. Yeah, so if you're losing weight, even on a healthy weight journey they see you and the conclusion is that you're not well. Is something happening to you? Is your husband worrying you? [ICC, Brenda, Breast Cancer, Legon, 35yrs]

"Fatness to some people is a result of giving birth. Some people become obese when they give birth, they say fat people are able to give birth" [CG-Esaaba, 40yrs, CG, Stroke, Usser Town]

"Some people gain weight after childbirth, example, I was very small when I was born, slim, just like my grandchild. I started to gain weight after I gave birth, so fatness could be the course of childbirth" [Portia, 64yrs, CG, Diabetes, Prostate, Hypertension, Stroke, Jamestown]

However, fatness was also associated with negative health implications. Some participants, predominantly the healthcare professionals, viewed larger body sizes as a risk factor for diseases such as hypertension, diabetes, and cardiovascular conditions. The following accounts reflect these perceptions:

"People who are obese are often prone to hypertension as obesity is a risk factor" [HCP-1, 26yrs, Nurse, Ga-Mashie]

"The 'I' looks like someone with unhealthy weight, and that could lead to a chronic condition" [HCP-5, 37yrs, Clinical Psychologist, Legon]

"Fatness is unhealthy. You are taking too many calories found in fried foods or processed foods and you're not exercising" [HCP-6, 37yrs, Dietician, Ga-Mashie]

"The way you are fat, you know that you are at risk of cholesterol, hypertension, diabetes, stroke and all these cardiovascular problems" [HCP-6, 37yrs, Dietician, Ga-Mashie]

Fatness is also linked to immobility, with individuals often described as unable to perform physical tasks or engage in active lifestyles. As some participants described:

“For me fatness per se makes me feel or picture somebody who is immobile, who has difficulty carrying his/herself around and who probably is lazy because with weight you may not feel like doing things for yourself, so you have to send people here and there” [HCP-5, 37yrs, Clinical Psychologist, Legon]

The ‘I’. He is a fat person and does not exercise; he barely gets up or do anything. Such a person is affected from the inside out if they get sick. They become heavy as a result, unable to walk or do anything. There is always a need for someone to move you, you can’t even take a shower. They are prone to disease because they are unable to exercise and can’t do any effective work. Normally, these kinds of people, if they fall sick, they can’t even turn their bodies; one will have to turn and clean or bathe for them. They depend on people for everything. This kind of fatness becomes a burden when you fall sick; it’s disturbing [CG, Esaaba, 40yrs, Stroke, Ussher Town]

Moreover, fatness can lead to difficulty in finding romantic partners, with some individuals expressing that heavier individuals are often overlooked due to social and cultural preferences for slimmer bodies. One participant shared:

“And when they are obese, I believe nobody will want to be with them or marry them” [HCP-7, 35yrs, Nurse, Ga-Mashie]

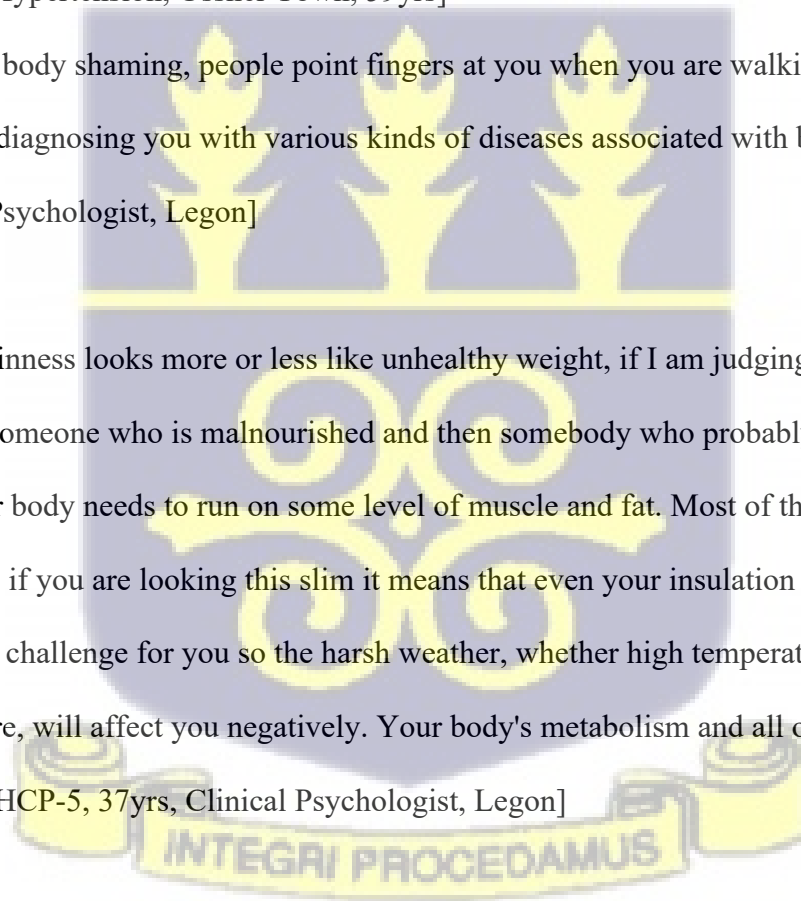
Meaning of Thinness

The participants' narratives showed a dominant perception that thinness reflects an individual's vulnerability to disease, leading to stereotypes of people with smaller body sizes as frail or weak. Therefore, thinness is also associated with illness or malnutrition. Many participants emphasized that a body that is too thin could signal a lack of proper nutrition or underlying health issues. For instance, some of the respondents narrated these perceptions below.

“Slim people who usually fall ill are mostly sickle cell people. Everyone can get sick, but slim people... I have lived with sickle cell people before in the same house and community, and immediately they show up you will know they are sickled or have sickle cell disease” [CG, Joy, Asthma/Stroke/Hypertension, Ussher Town, 59yrs]

“Sometimes too body shaming, people point fingers at you when you are walking and looking that thin and be diagnosing you with various kinds of diseases associated with being ill” [HCP-5, 37yrs, Clinical Psychologist, Legon]

For me, thinness looks more or less like unhealthy weight, if I am judging per what I see such that someone who is malnourished and then somebody who probably may equally be ill, and our body needs to run on some level of muscle and fat. Most of the fat lies under the skin so if you are looking this slim it means that even your insulation to temperature becomes a challenge for you so the harsh weather, whether high temperature or low temperature, will affect you negatively. Your body's metabolism and all of those may be affected. [HCP-5, 37yrs, Clinical Psychologist, Legon]



There are also negative perceptions of thinness, particularly in terms of social stigma. Thin individuals are sometimes perceived as unworthy of respect and lacking social value, as presented by some of the participants.

“The reason is that people took pride in especially when a family was made up of fat people. But when a family is made up of slim people, they’re not respected” [ICC, Alex, 69yrs, Diabetes, Stroke, Hypertension, Legon]

“A person like ‘A’ when you are slim, people think that you are ill and may have TB” [FGD-23-F-GM-Tsofa]

“When you see someone who looks like the A coming from afar, you will even question yourself whether the person just came from the dead. Sometimes, there are some people that you just see and ask if they are sick because of the way their bodies are. Their body depicts sickness and weakness.” [FGD-25-M-L-Akwesi]

Additionally, thinness can be associated with nutritional deficiencies, with some groups associating it with malnutrition or lack of access to adequate food. This perception was particularly evident in lower-income communities, where thinness was sometimes viewed as a sign of deprivation. A participant shared:

“Some of the health implications may be possibly the person is not having a balanced diet and does not have the necessary nutrients that are needed, so possibly stunted growth” [ICC-Celia-Sickle cell disease, Legon, 22yrs]

Participants, however, associated thinness with a positive outcome such as health, activity, and vitality, particularly in younger groups or health-conscious individuals. A small, lean body size

was seen as a sign of being active and healthy, often equated with physical fitness. Some participants explained:

“People who are slim are not prone to diseases because they are most of the time active, so their bodies don't really store fat” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown]

“A thin person is more energetic than a fat person and can run to wherever they want to go”
[ICC, Hazel, 75yrs, Hypertension, Jamestown]

4.3 Sources of Knowledge on Ideal Body

This section examines the various sources from which individuals acquire their understanding of ideal body image, highlighting how gender and other demographic factors shape these sources. Participants identified six key sources that informed their knowledge of body image, including its ideal form. These sources were culture/cultural institutions, educational institutions, lived experience, media, medical systems, and social networks. The spread of these themes across groups is summarized in Table 12, which shows how often each source was mentioned by individuals with chronic conditions (ICC), caregivers (CG), and healthcare providers (HCP) and lay individuals (LI).

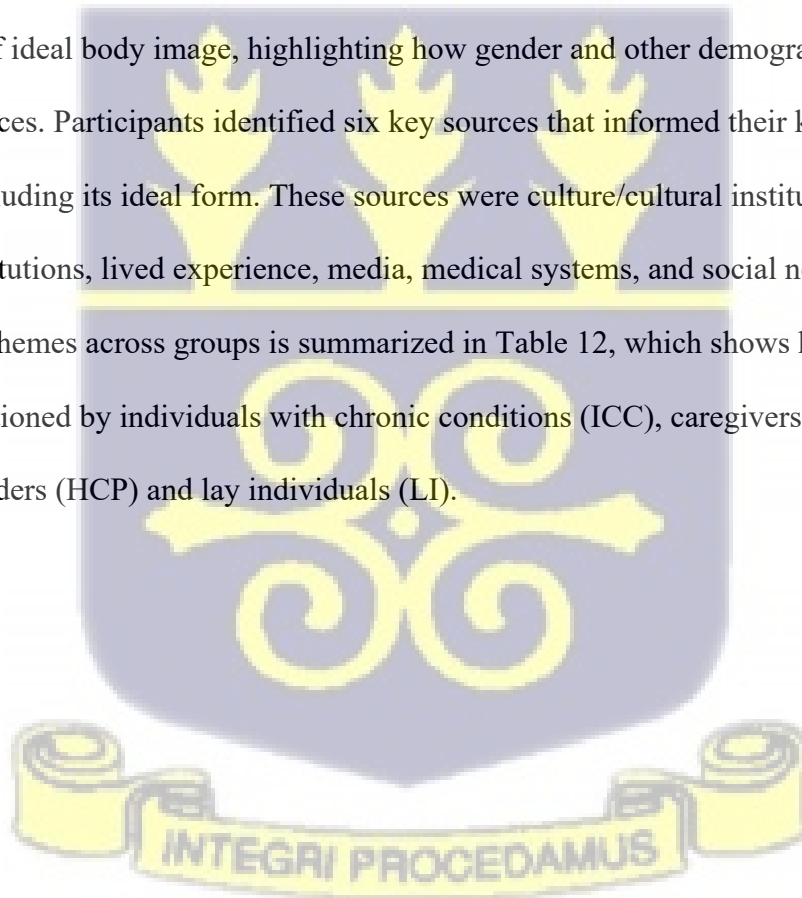


Table 12: Sources of Knowledge on Ideal Body Image

Source of knowledge	ICC	CG	HCP	LI
Culture/cultural institutions	✓	✓	✓	X
Educational institutions	X	X	✓	X
Lived experience	✓	✓	✓	✓
Media	✓	✓	X	✓
Medical systems (healthcare institutions)	✓	✓	[✓]	✓
Social networks	✓	✓	X	✓

ICC = Individuals with chronic condition(s); CG = Caregivers; HCP = Healthcare providers, LI = Lay Individuals.

✓ = theme is mentioned, [✓] = theme mentioned with conflicting views, X = theme not mentioned.

Description of Themes

Culture/cultural institutions

Cultural institutions, encompassing local traditions, common sense practices, and religious frameworks, collectively shaped participants' understanding of body image. Cultural beliefs and norms played a significant role, influencing perceptions of the ideal body and contributing to stigmatization or stereotyping of individuals with chronic conditions. Common sense was particularly influential, as participants often drew insights from visible symptoms such as paralysis, swelling, or other bodily changes observed in their communities. Religious institutions further enriched this knowledge base, especially for caregivers, by integrating health-related information into sermons, moral support, and community discussions led by faith leaders

or invited health professionals. One caregiver highlighted this influence, stating, “I get some of this information from church” [CG, Esaaba, 40yrs, Stroke, Ussher Town]. Together, these cultural and institutional sources provided a multifaceted framework for understanding body image, blending traditional, observational, and faith-based perspectives within the context of chronic illness. Below are sample quotes from participants.

“In our community, we also see people suffering from these conditions. Before we went to school people in the community with these conditions, they were born with it, but they had it” [HCP-1, 26yrs, Nurse, Ga-Mashie]

“Maybe by my observations, because some of the people I know who have asthma, some of them are very slim even though you see some of them they are average, some of them are very slim” [ICC, Evans, 41yrs, Asthma, Legon]

“The church they educated us on chronic disease awareness and the consequences by health expect” [FGD-33-M-Legon-Fred].

Educational Knowledge

Educational sources of knowledge, such as formal schooling or professional development workshops, were cited by healthcare professionals (HCPs) but were not mentioned by individuals with chronic conditions or caregivers. Healthcare professionals reported acquiring knowledge through both formal education and ongoing training about the impact of chronic diseases on body image. One HCP shared, “I have been taught in school, I have read research and journals” [HCP-7, 35yrs, Nurse, Ga-Mashie].

Another participant indicated, “It’s part of our education. Everyone who is a specialist did general practice before they specialize in their various fields” [HCP-4, 34yrs, Medical Officer, Ga-Mashie].

Lived experience

Self as a source of knowledge emerged as a critical source of information for participants, particularly those living with chronic conditions. This form of knowledge, rooted in lived, first-hand experiences, highlights how individuals interpret and internalize physical and emotional changes resulting from illness. The following quotes capture participants observations.

“In the neighbourhood and at home, there is someone with sickle cell. When I look at our bodies, they are alike. I realized mine changed at a point and it was different from theirs. One died and the other is alive. When I compare his (the one who died) to mine, I am bigger than him. He has type A body and I have type B.” [ICC, Stephen, 37yrs, Sickle cell disease, Legon]

“From my experience of how it has affected and changed my body ...” [ICC, Fiifi, 44yrs, Sickle cell disease]

Medical systems (health institutions)

All participant groups identified scientific/medical knowledge as a central source of information regarding the effects of chronic diseases on body image. Hospitals, healthcare professionals (HCPs), and medical expertise were frequently cited as reliable sources of information on how chronic conditions impact bodily appearance. For instance, participants with chronic conditions and caregivers frequently reported that healthcare professionals used scientific explanations to describe the bodily changes they experienced due to illness. Healthcare providers themselves acknowledged the role of both formal medical education and experiential

knowledge gained from patient interactions. They also noted that their knowledge was informed by peer discussions within medical settings. Participants' own words provided insight into these perspectives, as seen in the accounts below.

“The doctor explained that the swelling of her legs was because of the diabetes. They told me that managing the condition could help reduce it, but it still affects how people see her.” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown]

“During the consultations, the nurses showed us diagrams and explain how the weight gain was related to the medication. She said it was common, but I still feel uncomfortable with my body now.” [ICC, Hazel, 75yrs, Hypertension, Jamestown].

Media

The media was a dominant source of knowledge on body image for many participants. Two types of media were particularly influential: digital media (social media, online articles, and websites) and traditional media (television, radio, and printed materials). Many participants indicated that digital platforms provided a wealth of information regarding chronic diseases and their effects on body image. Traditional media sources were also frequently mentioned, though less so than digital media. This was expressed in the voices of participants, as illustrated in the excerpts below.

“Most often, I consult Google. It helped me in a lot of ways because what the physician would fail to let me know, I get that online, and if there's any confusion, that is when I come back to ask, to enquire from them for further explanation. Again, it made me to be always informed of what it is and what it will be. What I'm going through and what to expect so it really helped.” [ICC, Brenda, 35yrs, Breast cancer, Legon]

“There are a lot of journals and research. As a dietitian, I deal with evidence-based scientific facts from researchers, so we do a lot of reading.” [HCP-6, 37yrs, Dietician, Ga-Mashie]

“I hear them a lot on television and radio. We are taught of the symptoms of stroke and that it is how we figured that he has gotten a stroke.” [CG, Celine, 30yrs, Hypertension, Diabetes, Legon]

Social networks

This is knowledge derived from family, friends, and community members, which also played an important role in shaping participants’ views on body image. Family members, in particular, shared historical health information and personal stories that informed individuals’ understanding of how chronic conditions could affect body image. Many participants mentioned that knowledge of family health history and shared experiences with relatives helped them better understand their own conditions. Caregivers and individuals with chronic conditions also reported gaining social knowledge from their networks, which influenced their perceptions of the body’s ideal state.

“...my parents, and then my siblings, now, currently like my wife. I also got some of the information from other sources, so they are able to bring that information together.” [ICC, Evans, 41yrs, Asthma, Legon].

“My mother provided the information to me. She claims that I was extremely large when I was born, but the ailment has caused me to become smaller.” [ICC, Naa, 39yrs, Diabetes, Ussher Town].

“This illness is in our family. I saw it happened to my sister’s child, thus my niece.” [FGD-19, F-GM- Esaanaasa]

“My grandmother and uncle had asthma so I saw it. My uncle was alone in the room when he had an asthmatic attack; he couldn’t reach out to the inhaler, and he died.” [FGD-23-F-GM-Tsofa].

4.4 Discussion

The discussion focuses on the key findings related to objective one and is structured under two key themes: the content of representation of the ideal body and sources of knowledge on ideal body image. The discussion synthesizes these findings to highlight how this builds into understanding the systems of knowledge shaping representations of body image and embodiment, as well as the dynamics of social identity (gender, age, ethnicity).

4.4.1 Content of Representations of the Ideal Body

Participant narratives demonstrate that sociocultural influences shape the ideal body image among Ghanaians with chronic conditions. Participants, particularly young adults, expressed a preference for body types classified as normal weight, with a strong aversion to both underweight and overweight body types. This preference aligned with findings in existing literature where body image preferences often lean towards an average or normal body size (McCabe & Ricciardelli, 2003). However, the study also revealed unique cultural and gendered nuances. For instance, there was a pronounced difference in body image preferences across different age groups and between genders. While young women expressed a strong desire for curvaceous bodies, reflecting the influence of media and societal beauty standards that equate fuller figures with femininity and attractiveness, ideal body for older individuals showed a greater tendency to favour slimmer body types, associating them with health and wellness. The

desire for curvaceousness in younger women is particularly indicative of the societal pressures to conform to beauty standards that endorse voluptuousness, leading some to seek procedures or take substances to alter their body shape. This preference is consistent with the findings of Aryeetey (2016) and Wrigley-Asante et al. (2017), who noted that full bodies denote beauty ideals in Ghana and are often shaped by the interplay of media influences, traditional cultural practices, and social norms.

The participants show that body size ideals in Ghana are shaped by ethnicity, with distinct cultural meanings attached to the body image across groups. Among the Akan, participants emphasized moderation, describing balanced and proportionate body sizes as desirable. This aligns with research in Ghana showing that women often aspire to be “not too skinny, but not too fat,” preferring a moderate size associated with health and acceptability (Aryeetey, 2016; Pradeilles et al., 2022; Tuoyire et al., 2018; Waltsgott et al., 2024). By contrast, the Ga were described as valuing larger body sizes, with some adopting practices such as skin bleaching or body enhancement to achieve local ideals. These findings are consistent with studies in Accra where fuller body types were linked to social prestige and attractiveness (Aryeetey, 2016; de-Graft Aikins, 2003). However, it also contrasts with evidence from urbanising communities where slimmer body sizes are increasingly valorised under global health and beauty discourses (Tuoyire et al., 2018). The Ga case, therefore, highlights a tension between traditional associations of largeness with wealth and emerging preferences influenced by health concerns. Participants described the Ewe ethnic group as diverse in body sizes, but light skin tones emerged as a strong marker of beauty. This suggests that complexion functions as a symbolic attribute alongside body size. Northerners, on the other hand, were associated with tall, lean and muscular physiques, often explained in relation to physically demanding lifestyles

in the north. This supports findings from other African contexts where muscularity and leanness are associated with strength, resilience, and endurance (Pradeilles et al., 2022). Across groups, these ethnic differences reveal how shared cultural knowledge produces distinct representations of body image. Body size and complexions are not only aesthetic categories but also symbolic markers of identity that differentiate one ethnic group from another.

Fatness and thinness were discussed in relation to their perceived health implications. Thinness, while sometimes regarded as a sign of illness, was also seen as desirable by some groups, particularly among those who associate slimness with health and vitality. This duality echoes previous studies in South Africa (Ramukumba et al., 2013) and Ghana (Wrigley-Asante et al., 2017), which highlighted that thinness is often linked to negative health perceptions, especially when linked to conditions like HIV/AIDS. On the other hand, fatness is often associated with wealth and abundance, a finding consistent with the work of Duda et al. (2007) and Quaidoo et al. (2018) where larger body sizes are seen as indicators of prosperity and health in some contexts.

Additionally, participants highlighted the role of body size in terms of functionality and health, with a preference for body types that promote an active and functional lifestyle. This aligns with research by Clarke and Griffin (2008), who noted that individuals with chronic conditions often reframe their body image based on the body's capacity to function effectively. This shift towards valuing functionality over aesthetic appearance suggests a more holistic view of body image, where health and well-being take precedence over conforming to conventional beauty standards (Tylka & Wood-Barcalow, 2015). The current study also identified that societal views on body image were deeply intertwined with cultural norms. In Ghana, larger bodies are culturally viewed as symbols of affluence and good health, while smaller bodies, particularly

among women, are often stigmatized or associated with poor health or illness. This reflects broader African perceptions of body size as discussed by Puoane et al. (2010), which highlight the tensions between traditional body ideals and contemporary understandings of health.

4.4.2 Sources of Knowledge on the Ideal Body Image

Understanding the sources from which individuals derive their knowledge about ideal body image provides essential insights into the complexities of body image perceptions, especially in the context of chronic illness. The study found that individuals with chronic conditions, their caregivers, and healthcare providers relied on a variety of sources to shape their understanding of body image, which varied from scientific knowledge to personal and social influences. First, participants cited medical systems as a key source of information, particularly regarding the health implications of body size. Healthcare providers (HCPs) played a crucial role in shaping participants' perceptions, offering advice based on clinical guidelines that emphasise maintaining a normal weight range to reduce the risks associated with chronic diseases such as diabetes and hypertension. This reliance on medical expertise mirrors findings by Gallefoss and Bakke (2000) and Popoola et al. (2022), who noted that medical professionals are often trusted sources of information on health-related matters, particularly when managing chronic conditions.

However, beyond medical advice, personal and embodied experiences were also significant sources of knowledge. Many participants shared insights derived from their own lived experiences with chronic illness, especially regarding changes in body size and functionality post-diagnosis. This embodied knowledge often intersected with cultural norms and societal pressures, as individuals tried to reconcile their current body image with societal expectations. These personal experiences were sometimes in tension with medical advice, as participants

navigated between the idealized body images they were taught to aspire to and the realities imposed by their illnesses (de-Graft Aikins, 2006).

In addition to medical and personal sources, social and media influences played a prominent role in shaping body image perceptions. Participants frequently referenced media portrayals of ideal bodies, both through traditional forms such as television and print media and newer platforms like social media. The pervasive nature of media in shaping body ideals is well-documented (Tiggemann & Slater, 2014), and participants in this study also identified media as a powerful force influencing their desires for certain body types, particularly among younger adults.

The findings demonstrate that the social representations of the ideal body are intricately shaped by the processes of anchoring, objectification, and cognitive polyphasia, as outlined in the SRT. Anchoring is evident in how participants' ideas about the ideal body image are rooted in diverse domains, including cultural traditions, medical knowledge, media portrayals, and religious teachings. For example, participants drew on cultural norms to associate fatness with wealth and prosperity while simultaneously relying on medical discourses that positioned fatness as a risk factor for chronic illnesses. These representations are further informed by media influences that idealize certain body shapes and healthcare providers' explanations, which integrate scientific knowledge with practical observations. Through anchoring body image ideals to these pre-existing frameworks, participants create continuity between their lived experiences and broader societal narratives, enabling them to make sense of the visible bodily changes caused by chronic conditions (Bauer, 2006; de Graft Aikins et al., 2012; Moscovici, 1988; Wagner, 2020)

Objectification, on the other hand, synthesizes body image narratives around fatness and thinness, which emerge as the most visible and salient dimensions of the body. These dimensions

act as the core elements or symbols around which ideas around body image are simplified and made concrete within the participants' social contexts (de Graft Aikins et al., 2012; Moscovici, 1982). The focus on visible bodily attributes allows participants to simplify complex ideas about health, attractiveness, and functionality, making them accessible for their everyday discourse. Further, cognitive polyphasia underscores how the participants navigate and integrate multiple, sometimes contradictory, sources of knowledge—ranging from lived experiences and cultural norms to scientific and common-sense understandings (Jovchelovitch, 2007). This eclectic interplay of knowledge systems informs participants' perceptions and actions, particularly in managing body image and chronic illness. These processes highlight the dynamic and multifaceted nature of body image representations and their practical implications for body image management, chronic illness care and health communication (de Graft Aikins et al., 2012; Doise & Valentim, 2015; Jovchelovitch, 2007).

4.5 Conclusion

This chapter has provided insights into the factors shaping body image perceptions among individuals with chronic illness in Ghana. It highlights the role of aesthetic, health-related, and sociocultural influences, as well as the diverse sources of knowledge—medical, personal, social, and media—that individuals use to form their views on body image. The findings also show how body image perceptions are anchored in cultural, medical, and social frameworks, and how they can involve objectification, particularly in the focus on fatness and thinness. Participants draw from multiple, sometimes conflicting, knowledge sources (cognitive polyphasia), which shape both their body image and their approach to managing chronic illness. These insights underscore

the need to consider cultural context and the complexity of body image when developing healthcare interventions for chronic conditions



CHAPTER FIVE

FINDINGS ON SOCIAL REPRESENTATIONS OF BODY IMAGE IN CHRONIC ILLNESS

5.1 Introduction

This chapter presents findings for objective two, which explores social representations of body image as experienced by individuals living with chronic illness, with particular attention paid to how these individuals perceive and relate to their bodies both before and after their diagnosis. The chapter is presented in three sections. Section 1 presents findings on embodiment and chronic illnesses experiences, which explore how the experience of chronic illness reshapes body image and embodiment, often transforming previously held perceptions. It begins with an analysis of pre-diagnosis representations of body image, followed by a focus on post-diagnosis perspectives, examining whether individuals hold positive or negative views of their bodies and how these perspectives have evolved. Section 2 presents findings on the causes and attributions of changes in body image and embodiment, including how individuals make sense of these changes and the roles of social, psychological, and physical (illness-related) factors. Section 3 presents discussion which synthesizes and integrates the findings together to provide a deeper understanding of how chronic illness influences body image and social identity.

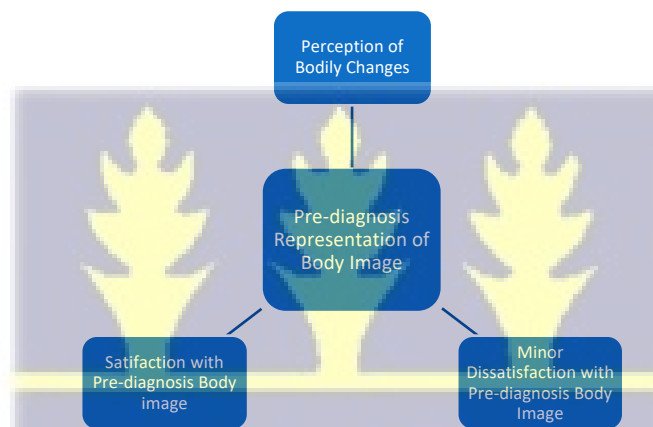
5.2 Embodiment and Chronic Illness Experience

5.2.1 Pre-diagnosis Representations of Body Image

This subsection explores how individuals with chronic conditions perceived and engaged with their physical appearance before their diagnosis. Key themes that emerged include perceptions of body changes, general satisfaction with body size, and the absence of significant

negative emotions such as embarrassment or shame regarding their pre-diagnosis bodies. These themes illustrate the varied ways participants constructed their body image, influenced by personal, cultural, and social factors. Each theme is examined in detail to provide a nuanced understanding of the factors shaping body image perceptions prior to the onset of chronic illness as illustrated in Figure 4.

Figure 4: Themes of Body Image Prior to Diagnosis



Perceptions of Bodily Changes

Before the diagnosis, the individuals with chronic conditions did not report noticeable alterations in their physical appearance, as visible signs of their conditions had not yet emerged. However, the first indications of trouble were embodied rather than related to body image, with participants reporting subtle disruptions to strength, mobility, and overall physical functioning. These early signs, such as unexplained fatigue or mild physical limitations, were often dismissed or attributed to external factors like stress or overexertion. Below are sample quotes from some participants.

“I used to have a normal body. I had muscles because I was a weightlifter, but I couldn’t lift anymore.” [ICC, Jayden, Diabetes, Jamestown, 44yrs]

“I couldn’t walk for long because I easily get tired when I walk for a minute or two and my heart starts beating fast.” [ICC, Aku, 60yrs, Diabetes, Hypertension, Jamestown]

“So, before the frequent attacks, I looked very active. I could do whatever I needed to do.” [ICC, Evans, Asthma, Legon, 41yrs]

“I was very energetic and active and could carry heavy loads before being diagnosed.” [ICC, Hazel, Hypertension, Jamestown, 75yrs].

The caregivers, based on their observations, noted that care recipients often displayed early signs of health decline that were not immediately recognized as part of a chronic condition. These included subtle skin discoloration, unexplained tiredness, or weight changes that the caregivers sometimes perceived as unusual but could not yet directly link to a formal diagnosis.

“He had no problems with his legs and arms. He walked home by himself. His friends in the community who are tailors (sew) come to him for help, in styling their dresses for them.” [CG, Esaaba, 40yrs, Stroke, Ussher Town].

“Oh, prior to getting the condition, he was strong; he went to work and back. He did steel works, ... He could do everything. He even used to do steelwork so he could do that and everything else, till he became...” [CG, Portia, 64yrs, Diabetes, Prostate, Stroke, Hypertension, Jamestown]

Satisfaction with pre-diagnosis body

Before the diagnosis, the individuals with chronic conditions expressed moderate satisfaction with their bodies. Their physical health was not yet seriously affected by the chronic condition, and they had no significant complaints about their appearance or functionality. For instance, Owen described his body type as muscular and in good health, attributing it to his profession. His position entailed instructing football players and doing frequent physical activity, demanding regular exercise. Owen, described a feeling of satisfaction with his physical look and bodily strength, saying, “My body was masculine, and I felt good having that kind of body” [Owen, 66yrs, hypertension, stroke, Jamestown]. He continued by saying that his neighbours gave positive comments about his body looks: “My neighbours used to say, I have a macho body...” (laugh).

Other participants also indicated:

“I had a normal body type. Ladies liked me because I was a gentleman. I was tall and had a good personality. I looked good and was not lazy.” [ICC, Jack, 66Yrs-Diabetes, Hypertension, Stroke & Prostate Cancer-Jamestown].

At the Makola market where I used to sell, customers come to me and tell me I have a very good shape, especially when they get to know I have given birth to 8 children. My fellow market women say I am fortunate I have a beautiful body that doesn’t show like some of them do. They claim my body doesn’t appreciate food and is always in shape. They were big with big stomachs, but I was not like that. [Mia, 78yrs, Diabetes, Hypertension, Jamestown].

“I also prefer how I was before as well because I was obese but could do everything, do you understand? I could wash, sweep, and cook without facing any problems even though I was obese, but now that I have lost weight, I am unable to do anything. So, I would prefer to be the way I was before, ...” [ICC, Caitlin, 56yrs, Hypertension/Arthritis, Jamestown]

Similarly, caregivers also reported that their care recipients had a generally positive outlook on their body image, with no major physical or emotional struggles. Both groups were largely satisfied with the weight, appearance, and general functioning of the body during this period.

“She had a nice body type. She used to dress very well, she was selling at Makola, so she had a lot of things to polish her face and her body, she was bleaching and was looking fine.” [CG, Komle, 20yrs, Stroke, Jamestown]

“He could also go out roaming and would come back late into the night when the door has been locked, forcing him to sleep outside. So that’s the kind of life I know he was living.” [CG, Esaaba, 40yrs, Stroke, Ussher Town].

Minor Dissatisfaction with Pre-diagnosis Body Image

Prior to the diagnosis, both individuals with chronic conditions and caregivers reported minor dissatisfaction with body image, as physical appearance had not been severely affected. However, some individuals with chronic conditions reflected that minor weight gain or fatigue, while not debilitating, caused slight concerns. Some caregivers also indicated observing their care recipients' pre-diagnosis state, noting that individuals with chronic conditions appeared

generally content with their body image, without significant concerns about skin, weight, or physical appearance.

“I didn’t like the way I used to be, I was too fat, and I got really tired walking short distances, sweating a lot. But now, I don’t even sweat going home. I use 4 yards to sew my slits.” [ICC, Caitlin, 56yrs, Arthritis, Jamestown]

5.2.2 Post-diagnosis representations of body image

The post-diagnosis experiences revealed a range of emotional and physical impact, as captured in several basic themes (see Figure 5). These experiences often intersect, though they differ in intensity between the groups, reflecting both the severity of the diagnosis and its treatment. Below are the descriptions of themes for the key findings across both groups, highlighting bodily changes, satisfaction with the current body, dissatisfaction with body image, and feelings of embarrassment and shame.

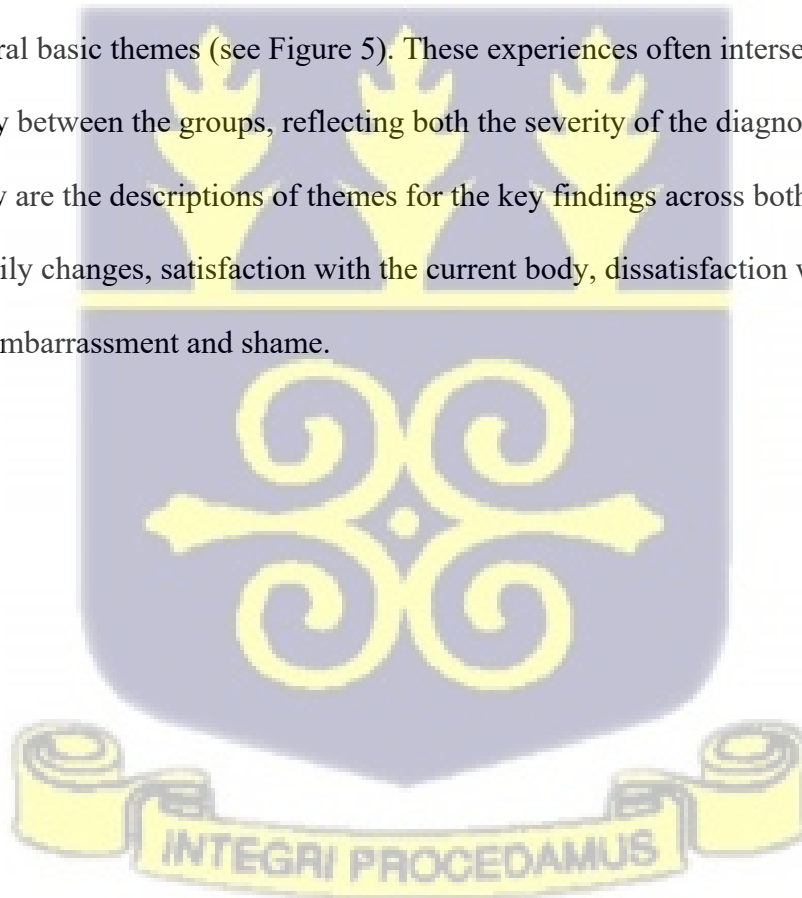
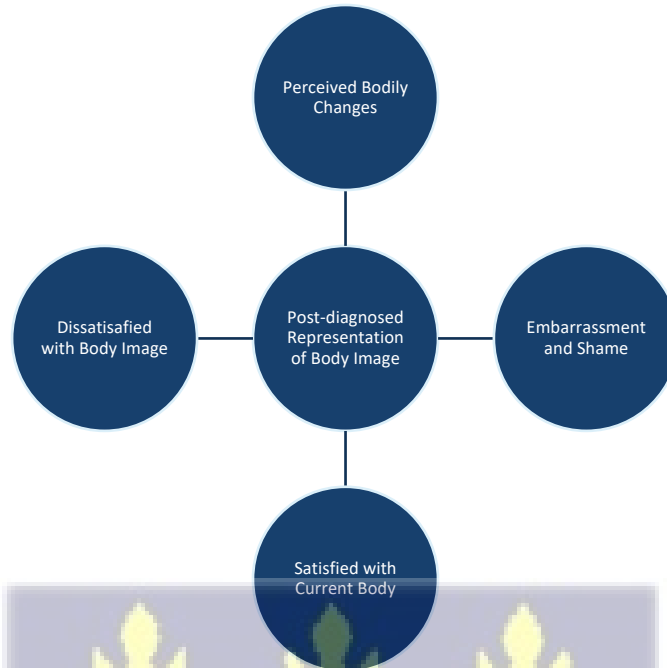


Figure 5: Themes of Body Image after Diagnosis



Perceived Bodily Changes

Post-diagnosis, the individuals with chronic conditions reported more significant bodily changes that often marked a visible shift in their physical state. These changes included darkening of the skin, hair loss, amputation of affected limbs or organs (such as breast removal), eye color changes, and weight fluctuations. These physical transformations led to noticeable alterations in the way individuals with chronic conditions saw and interacted with their bodies.

“I used to be heavier than this, but I reduced in weight after I got diabetes. I asked myself why I was losing weight, so I visited Korle Bu where I was diagnosed with diabetes and that it was responsible for my weight loss.” [ICC, Effie, 59yrs, Hypertension, Diabetes, Legon]

“I initially had a lot of weight, but diabetes has caused me to shed a lot of it, which is why I picked F. Without diabetes, I would have a physique the size of an ‘F’.” [ICC, Naa, 39yrs, Diabetes, Ussher Town].

The caregivers, while observing these changes, reported seeing a significant deterioration in the appearance of their care recipients, including changes to weight, skin color, hair loss, and the visible consequences of surgeries like amputation or mastectomy. For the caregivers, these bodily changes highlighted the severity of the chronic condition and its impact on the care recipients' physical and emotional well-being.

“When he walks for some time, then he is tired. He doesn’t walk well. We always have to assist him to move from here to there. A lot has changed about him.” [CG, Skiddo, 28yrs, Hypertension, Diabetes, Legon]

“He cannot do what he used to do. He used to wash his own clothes, go to the farm, go to work, and do everything for himself but now, it is very hard for him to do all these things.” [CG, Celine, 30yrs, Hypertension, Diabetes, Legon]

“He is not as fair-skinned as he used to be. He has changed.” [CG, Esaaba, 40yrs, Stroke, Ussher Town]

Dissatisfaction with Body Image

Individuals with chronic conditions reported significant dissatisfaction with their body image following diagnosis. The visible signs of illness, such as weight loss, skin discoloration, and other physical alterations, led to a decrease in body confidence and self-esteem. Many individuals with chronic conditions expressed discomfort with how their bodies no longer aligned with their self-perceptions, particularly in relation to physical development and the limitations in activities of daily living (ADL).

“Those who knew me from the onset would ask if I was unwell. I would not have reduced in weight if I weren’t diagnosed with this disease. I was told that losing weight is a symptom of the disease. I don’t feel happy about my body size.” [Beryl, 63yrs, Breast Cancer, Legon]

“I also prefer how I was before as well because I was obese but could do everything, do you understand? I could wash, sweep, and cook without facing any problems even though I was obese, but now that I have lost weight, I am unable to do anything. So, I would prefer to be the way I was before, ...” [ICC, Caitlin, 56yrs, Hypertension/Arthritis, Jamestown]

The caregivers, reflecting on their observations of their care recipients noted that the dramatic changes in appearance often led to a sense of helplessness and emotional distress in the individuals they cared for. Caregivers observed that their loved ones became increasingly dissatisfied with their altered bodies, particularly as functional limitations intensified.

“The amputation made her reduce weight compared to her previous size because she couldn’t walk.” [CG, Komle, 20yrs, Stroke, Jamestown]

“He was not as lean as he is now. He was not as bony as he is now, he was fine.” [CG, Portia, 64yrs, Diabetes, Prostate, Hypertension, Stroke, Jamestown]

Embarrassment and Shame

These emerged as significant emotional responses in the post-diagnosis period for both individuals with chronic conditions and their caregivers. The individuals with chronic conditions frequently described feeling ashamed or embarrassed by their visible changes, such as amputation or hair loss, and the accompanying physical limitations, such as chronic pain and

fatigue. These changes made them feel exposed and vulnerable, contributing to a sense of social isolation.

I didn't feel embarrassed or ashamed then [before-diagnosis]. My body was fine, and I didn't notice any problems until later [after diagnosis]. My legs became swollen. When I press my foot, the skin falls in as if something has happened. This has really disturbed me. The disturbing and embarrassing part is when I have to go to a check-up with a stick due to the nature of my legs. [ICC, Aku, 60yrs, Diabetes, Hypertension, Jamestown]

"I always want to walk barefoot because I cannot wear my shoes or slippers. My legs have been affected, sometimes this makes me feel embarrassed." [ICC, Hazel, 75yrs, Hypertension, Jamestown]

"Look at me now, I am unable to go anywhere; I am like a child now. I can't even dress nicely so I don't even go to church, I don't walk normally, and I will be looked at in the church premises, they will stare at me, it will make me feel uncomfortable. 'Is this really Auntie Caitlin?' This makes me shed tears." [ICC, Caitlin, Hypertension/Arthritis, Jamestown, 56yrs]

Caregivers observed these emotional responses, noting that their loved ones often expressed feelings of shame regarding their appearance or incapacity. In some cases, caregivers themselves felt a sense of sorrow or frustration as they saw their care recipients struggle with these feelings of pain, and self-consciousness.

"He doesn't go out now, sometimes he refuses to sit outside for fresh air because he feels people will look at him and talk about him." [CG, Portia, 64yrs, Diabetes, Prostate, Hypertension, Stroke, Jamestown]

“Body pains, he even complains of headaches or pain in his ribs.” [CG, Akorfa, Diabetes, Hypertension, Legon, 51yrs]

“When they are in crisis, they complain of pains in their knee joints or the leg bones and they cannot stand on their feet. Then they shout in pain; unable to sleep; they do not react to the injection given to them; the pain doesn’t reduce.” [CG, Mina, Sickle cell disease Legon, 44yrs].

“She reduced in size after her leg was amputated. She was frustrated severely after that.” [CG, Komle, 20yrs, Stroke, Jamestown]

Satisfaction with current body

Despite the many challenges, a few individuals with chronic conditions reported moments of acceptance or satisfaction with their current bodies. Some found peace with their physical appearance, even in the face of significant changes such as amputation or weight loss. “I like my body. Now, I can see that my granddaughter is fatter than me and as old as I am I can go to places she cannot go because of her size. I like my current body size because I can freely walk anywhere.” [ICC, Hazel, 75yrs, Hypertension, Jamestown]

I like how I am now even though people make funny statements about my current state by comparing me to a skeleton and saying my face looks like a dead person’s face. I used to be very fat but now I have drastically lost weight because of diabetes and I like my current state. Meanwhile, some people are using my current state against me. I don’t feel any regret but I’m happy the way I am. [ICC, Aku, 60yrs, Diabetes, Hypertension, Jamestown]

5.2.3 Changes in pre-diagnosis and post-diagnosis body image

This section explores changes between pre- and post-diagnosis body image experiences. The pre-diagnosis experiences of body image were characterized by a sense of normalcy and physical stability for both individuals with chronic conditions and CGs. However, post-diagnosis, both groups noted significant changes in bodily appearance and function, with individuals with chronic conditions experiencing more profound physical and emotional distress. Dissatisfaction with body image, embarrassment, and shame were more pronounced post-diagnosis, with bodily changes often becoming a source of distress for both individuals with chronic conditions and their caregivers. While some individuals with chronic conditions reported moments of satisfaction with their bodies, particularly in the face of major challenges, the overall post-diagnosis experience reflected a complex mix of acceptance, adjustment, and emotional struggle. Therefore, six thematic changes emerged from the findings: physical changes, functional changes, emotional changes, psychological changes, social changes, existential changes and Sexual health changes. Each of the themes are described below.

Physical changes

Individuals with chronic conditions reported significant negative physical changes between their pre-diagnosis and post-diagnosis body image. Pre-diagnosis, individuals with chronic conditions felt relatively stable in terms of their body size, weight, and skin color. However, after diagnosis, they experienced noticeable changes such as scars, weight loss or gain, dark skin, and other visible signs of their condition. These changes led to feelings of discomfort, frustration, and dissatisfaction with their appearance. Many individuals with chronic conditions

expressed concern over the visible alterations to their bodies, which disrupted their previous sense of physical normalcy. These views are expressed in the following narratives.

“I cannot carry myself about; I am unhappy about the way I have turned out. I do not like my body like this. I could walk well when I was not sick but now, I get tired easily when I walk.”

[ICC, Kafa, 60yrs, Stroke, Hypertension, Jamestown]

“There was nothing wrong with my body, I was beautiful, I had shape, but now I have changed.”

[ICC, Eloise, 75yrs, Hypertension, Jamestown]

“I had a normal body size before the surgery, but I changed drastically and gradually from time to time after I had the surgery.” [ICC, Beryl, 63yrs, Breast Cancer, Legon]

“I became slimmer and the chemotherapy also caused my body size and skin to change. All my hair went off.” [ICC, Beryl, 63yrs, Breast Cancer, Legon].

The caregivers observed these same physical changes and expressed concern for the visible changes in their care recipients. Caregivers noted that their care recipients' body size, weight, and skin color had changed significantly, often becoming a source of distress for both the individuals with chronic conditions and their families. While some caregivers acknowledged these changes as part of the illness, they also noted the negative emotional impact it had on the individuals with chronic conditions' body image. The physical changes between pre- and post-diagnosis were largely perceived negatively by both the individuals with chronic conditions and their caregivers.

“He has grown slimmer than how he was. He was bigger than now. He has reduced drastically.”

[CG, Skiddo, 28yrs, Hypertension, Diabetes, Legon].

“She complains about swollen feet and a numb face, so because of that, she doesn't go out, even to group meetings.” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown].

“She looks darker in complexion now.” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown].

“Her leg was amputated as a result of the condition.” [CG, Komle, 20yrs, Stroke, Jamestown]

Functional changes

Individuals with chronic conditions experienced significant functional changes following their diagnosis. Pre-diagnosis, their mobility was not significantly hindered, and they were generally able to perform activities of daily living (ADL) (Katz, 1963) with ease. However, post-diagnosis, many reported increased tiredness, reduced mobility, and difficulties in performing daily tasks. These functional changes caused frustration, as the individuals with chronic conditions could no longer engage in activities that once were a part of their routine. The decline in physical functioning and the increased dependency on others were perceived negatively by most individuals with chronic conditions.

I also prefer how I was before I fell ill, even though I was obese, I could do everything, do you understand? I could wash, sweep, and cook without facing any problems even though I was obese, but now that I have lost weight, I am unable to do anything, so I would prefer to be the way I was before ... [Caitlin, 56yrs, Hypertension, Arthritis, Jamestown]

“I was smart. in just a few steps, I can get to any destination, with no laziness. I can walk to Madina in just about 20 minutes. When I wasn’t sick, I could walk to Madina, and it’s not a joke.” [Alex, 69yrs, Diabetes, Stroke, Hypertension, Legon]

“When you are in crisis, you will just need someone to get certain things done for you; you are restricted on what to do. Even movement. It makes movements a little bit difficult, and even if you are able to do it, you will not be able to do it at the pace you would have normally.” [Celia, 22yrs, Sickle cell disease, Legon].

Caregivers observed the decline in mobility, tiredness, and limitations in their care recipients' ability to perform ADLs. CGs noted that the post-diagnosis functional abilities of individuals with chronic conditions were significantly reduced compared to their pre-diagnosis state. This change was viewed negatively, as caregivers expressed concerns about their loved ones' growing dependence and the loss of independence they had previously enjoyed. For caregivers, the functional changes between pre- and post-diagnosis highlighted the severe impact of the illness on their loved ones' quality of life.

It was the asthma she contracted first. With the asthma, when it becomes serious, she is unable to do anything. I come here every morning to make sure I bath her and brush her teeth, and I also make sure I prepare her breakfast, so if you come and you call her, she has a way of raising her hand to indicate to me whether she is in pain or not.” [CG, Adorkor, 43yrs, Stroke, Hypertension, Diabetes, Jamestown]

“He cannot do what he used to do. He used to wash his own clothes, go to the farm, go to work, and do everything for himself, but now, it is very hard for him to do all these things.” [CG, Skiddo, 28yrs, Hypertension, Diabetes, Legon]

“Oh, prior to getting the condition, he was strong; he went to work and back. He did steel works, ... He could do everything. He even used to do steelwork, so he could do that and everything else, till he became... till he got the diabetes. A lot has changed.” [CG, Portia, 64yrs, Diabetes, Prostate cancer, Stroke, Hypertension, Jamestown]

Emotional changes

Individuals with chronic conditions reported a range of negative emotional changes post-diagnosis, including grief, sadness, shock, fear, anxiety, disappointment, regret, and worry.

These negative emotions contrasted sharply with more positive and stable emotional states pre-diagnosis. Many individuals with chronic conditions expressed feelings of loss, particularly as their bodies changed and their physical capabilities diminished. The emotional toll of adapting to a new reality marked a significant shift from their pre-diagnosis emotional state, which was generally more positive or neutral.

“To be honest, I used to get sad. I used to think about how I was going to work and also take care of my children. You get it? But upon advice and counselling, I stopped getting sad. So I used to get sad.” [Jason, 38yrs, Hypertension, Stroke, Ussher town]

After they said that, I asked myself whether I was going to pass through all these things.

Was I going to get joint pains, leg ulcers, priapism and yellow eyes? So, I will be slim when I go into a crisis. A mosquito bite with joint pains triggers a crisis. This made me realise that I have to take care of myself very well because I was going to pass through all these effects. [Stephen, 37yrs, Sickle cell disease, Legon]

“I kept thinking about it so I couldn't sleep when I went to bed. And if I wasn't able to sleep, my blood pressure rose in the morning.” [Joana, 65yrs, Stroke, Ussher town].

Caregivers observed similar emotional shifts in the individuals with chronic conditions, noting that the diagnosis and subsequent changes in the body and functioning were accompanied by heightened emotional distress. Caregivers reported seeing their loved ones experience intense emotions such as grief, anxiety, and sadness, which were largely absent before the diagnosis. For CGs, the emotional changes highlighted the toll the chronic condition had taken, not only on the physical body but also, on the emotional well-being of the individuals with chronic conditions. These emotional changes were perceived negatively, as caregivers struggled to support their loved ones through such profound emotional changes.

“I don’t feel fine and he is not fine too about this stroke because he is supposed to be in good shape to live. So, stroke is not a sickness you should feel fine about.” [Esaaba, 49yrs, Stroke, Ussher Town]

“We were really disturbed. But you can’t do anything about what God has done.” [Portia, 64yrs, Diabetes, Prostate, Hypertension, Stroke, Jamestown]

“To be honest, the day I was called and informed by the chief doctor, I didn’t find it easy at all, I wept, my son also wept. I wept and felt very sorry.” [Joy, 59yrs, Asthma/Stroke/Hypertension, Ussher Town]

Psychological Changes

Individuals with chronic conditions reported a notable decrease in self-esteem after diagnosis. Pre-diagnosis, many individuals had a relatively stable sense of self-worth, but post-diagnosis, this was significantly affected by changes to their physical appearance and functional capabilities. The loss of body image and independence, coupled with the emotional toll, led to feelings of inadequacy and reduced self-esteem for many individuals with chronic conditions.

You have lost your breast so you're not a complete woman again because of how much attachment we give to the female breast. So, once you lose the breast, you're considered less of a woman so that is why most people would rather die with the disease in the breast than have it removed for them to have a chance to live. [ICC, Brenda, 35yrs, Breast cancer, Legon]

"I had very low self-esteem; it really affected my self-esteem. I used to think I wasn't good for anything at all, and I didn't use to see the point of life." [Celia, 22yrs, Sickle cell disease, Legon].

Caregivers similarly noticed a decline in self-esteem in their loved ones. They observed that their care recipients, who had once been confident and independent, now struggled with a diminished sense of self-worth, particularly due to the visible changes in their bodies and the limitations in their daily activities. This psychological change was largely seen as a negative shift by both individuals with chronic conditions and CGs, as it reflected the profound emotional and psychological impact of living with a chronic condition.

"She is always thinking, she doesn't go out like she used to do. I can see her self-esteem has come down a little bit." [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown]

"She does not allow to touch the other breast now. I realized this after the surgery. I think she feels uncomfortable about it now. It has affected her psychologically." [Kweku, Breast Cancer, Legon, 40yrs]

Social changes

Post-diagnosis, individuals with chronic conditions often experienced social isolation and stigma, which was in stark contrast to their pre-diagnosis social lives. Many individuals with chronic conditions reported withdrawing from social activities due to embarrassment over their physical changes, such as hair loss, amputation, or visible skin changes. Stigma related to their condition further exacerbated these feelings of isolation, as they felt increasingly alienated from others.

“I just want to be strong in my body so that I can go along with people when there is a need. Now, I’m unable to go anywhere. I have reduced in size but am still unable to do a lot of things, which means my condition has not been cured.” [ICC, Caitlin, 56yrs, Hypertension, Arthritis, Jamestown]

“What I’m saying is that because of the condition that is why I don’t go to church. So when they are going to the funeral, I don’t go, or to a party I don’t go. Like the other time a friend died, they just had the funeral, I didn’t go.” [ICC, Nkunim, 43yrs, Sickle cell disease, Legon]

I saw him, but I didn’t want him to see me. We were going out together those days. I feel so down when I see them, and I can’t walk, can’t do anything for myself. Moreover, where can I go with this catheter in my pocket, if the urine is full, where will I pour and wash myself? I sometimes feel our bodies can disgrace us. [ICC, Jack, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer, Jamestown]

Caregivers observed that their loved ones experienced greater social isolation and stigma after the diagnosis. CGs noted that the physical changes and the condition itself often led to a distancing from family, friends, and the wider community. The social changes between pre- and

post-diagnosis were seen as largely negative, with caregivers expressing sadness over the emotional toll of this isolation on their loved ones.

He liked women. So when it happened, I said to him, 'Have you seen? You like women. Have you seen what you have brought upon yourself?' He kept mute and didn't respond because he knew he was guilty. 'You don't listen to me when I advise you' He really likes women. He would go to work and come back around 10-11 pm, sometimes 12 am. Now he can't go anywhere; he is paralyzed. [Portia, Diabetes/Prostate Cancer/Hypertension/Stroke, Jamestown, 64yrs]

"I got a little worried because she normally comes to my place for a chat, but all of a sudden, she got sick, and things changed. Now, I would have to come every morning to take care of her."
[CG, Adorkor, 43yrs, Stroke, Hypertension, Diabetes, Jamestown]

Existential changes

Following the diagnosis, individuals with chronic conditions reported a sense of incompleteness or "loss of self," a concept explored by Charmaz (1995). This phenomenon refers to the way in which chronic illness can disrupt an individual's identity, leading to an existential crisis. Some individuals with chronic conditions expressed that their identity, which was previously not defined by health or physical appearance, became increasingly intertwined with their condition. This shift in identity created feelings of existential loss—a sense of disconnection from their previous self and purpose—which had not been present before the onset of the illness.

If you have chronic diseases, you won't be able to live the way you used to; things change, so you deal with whatever comes your way as a result of the condition. It makes you feel like you are a different person. You are not your own man anymore. How can you be a man in this state? Such is life. Just adjust to it. [ICC, Owen, 66yrs, Stroke, Hypertension, Jamestown].

“I am human and this is the current circumstance (amputated limb) I find myself in. I can't kill myself but rather wait to die naturally. What is my use if I cannot walk or go out? Why do I have to live? It will be better for me to die. After all, everyone will die.” [ICC, Mia, 78yrs, Diabetes, Hypertension, Jamestown]

“At the moment. prostate cancer doesn't make me enjoy being a man.” [Jack, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer, Jamestown]

Charmaz (1995) identified several dimensions of this loss, including a disruption in the person's self-concept, social roles, and future aspirations, all of which were salient in the experiences of individuals in this study. The chronic condition became a defining feature of their lives, changing not only how they saw themselves but also how they engaged with the world around them.

The caregivers, while more focused on the immediate care needs of their loved ones, also noticed a shift in the sense of self and purpose of their care recipients. They observed that the chronic condition left the individuals with chronic conditions feeling incomplete, with some caregivers expressing that their loved ones had become less engaged with life due to the ongoing health challenges. However, this existential change was less pronounced in CGs' observations compared to the emotional and physical changes they noted.

“I got a little worried because she normally comes to my place for a chat, but all of a sudden, she got sick, and things changed. Now, I would have to come every morning to take care of her.”

[CG, Adorkor, 43yrs, Stroke, Hypertension, Diabetes, Jamestown]

Sexual health concerns

Prior to their diagnosis, individuals generally perceived themselves as sexually healthy and capable. After the onset of chronic illness, sexual difficulties became more pronounced, with some men describing impotence and some women noting reduced desire or only slight satisfaction. These changes were acknowledged as sources of emotional distress and tension within relationships. Nevertheless, such concerns did not entirely overshadow the gradual acceptance and adjustment that some individuals, both men and women, developed toward their altered bodies and sexual selves over time.

“It has affected my sexual life; I'm not interested in sex anymore because I can't even walk well.”

[ICC, Joana, 65yrs, Stroke, Ussher Town]

Just when I decided to give birth, they aren't working anymore because of the drugs. I went to the hospital and they gave me a drug to revive it but the priapism came again and I had to go back to those previous drugs. This is actually worrying me because I am told I may not be able to have erections again. [ICC, Stephen, 37yrs, Sickle cell disease, Legon]

“At the moment, prostate cancer doesn't make me enjoy being a man. Everyone has stimulation but the prostate is hindering mine. I can't do what real men are supposed to sex. My sexual life is dead, I can't satisfy my wife, it is not easy”. (Jack, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer, Jamestown))

5.3 Causal attributions of changes

This section investigates the causes and attributions of changes in body image and embodiment experienced by individuals living with chronic illness. It explores how participants perceive and explain the changes in their bodies. The data was drawn from individuals with chronic conditions, caregivers (CGs), healthcare providers (HCPs), and focus group discussion (FGD) participants. Four main themes emerged: biological and medical explanations, psychological and lifestyle attributions, social attributions, and spiritual attributions. These themes provide an understanding of how individuals perceive the causes of their bodily changes, and the psychological states associated with them.

Biological and medical explanations

The individuals with chronic conditions frequently attributed their bodily changes to biological and medical factors directly related to their chronic condition. These explanations were primarily focused on the progression of the disease or the side effects of treatment. For example, individuals with diabetes and hypertension associated their changing body size and appearance (e.g., weight loss, bloating, or swelling) with the natural course of the illness and the medications they were prescribed. Many individuals with chronic conditions expressed that their physical transformations, such as hair loss or fatigue, were inevitable consequences of treatments like chemotherapy or dialysis. This medical perspective highlighted the role of the disease itself in causing physical changes, often accompanied by feelings of helplessness or resignation. “I know it’s the cause of the sickness is biological issues. Something is not working in my body. That is what has affected my skin and body. It can knowingly or unknowingly make you look beautiful and also destroy you.” [ICC, Aku, 60yrs, Diabetes, Hypertension, Jamestown].

I think it is a mixture of biomedical, scientific and physical. I don't really think it is spiritual, at least for sickle cell crisis. I think that there are sicknesses that are spiritual attacks. That I believe, but when it comes to sickle cell and other chronic ailments, I don't think it's spiritual. I think changes in the body are scientific changes, biomedical changes, physical changes, even social changes. [ICC, Jeremy, 25yrs, Sickle cell disease, Legon]

Caregivers also emphasized biological and medical causes for bodily changes. For instance, caregivers of individuals with sickle cell, cancer or stroke often cited the direct impact of the disease and its treatment on physical appearance and function. They acknowledged that the bodily changes, such as altered mobility or weight gain, were a result of medical factors, including medications or complications from the illness. Caregivers noted that these changes were expected outcomes of the disease but still caused significant distress for both the patient and themselves as caregivers.

"I was informed at the hospital that high blood pressure can cause that. They confirmed my child's condition was due to high blood pressure. His pressure went too high." [CG, Joy, 59yrs, Asthma, Stroke, Hypertension, Ussher Town]

"Honestly, I have also been thinking about it. I don't understand why we are all human beings but why is it that others can marry and give birth, then this can happen? I do not understand. What I heard is that, when the child picks S from the father, that is how it happens. What is that S?" [CG, Mina, 44yrs, Sickle cell disease, Legon]

Healthcare providers consistently pointed to medical explanations for bodily changes, framing them within the context of the illness and its treatment. They explained that the physical

alterations experienced by patients were either a result of the disease's progression (e.g., the wasting associated with cancer or the changes in body composition from diabetes) or the side effects of treatment. HCPs also discussed the medical necessity of certain physical changes, such as weight gain in patients receiving corticosteroid treatment, or the functional impairments resulting from neurological conditions like stroke.

“Then in terms of weight be it for either of them, if it is a condition and they are losing weight they are quite disturbed about it so they wouldn't want to lose too much. Gaining too much weight is an issue for them.” [HCP-5, 37yrs, Clinical Psychologist, Legon]

“With Diabetes for example, if you don't take care of yourself and you get sore and you don't treat it well then, your leg can be amputated or the affected part of the body or exactly where the sore will be.” [HCP-1, 26yrs, Nurse, Ga-Mashie]

Some participants, particularly the lay healthy community members who took part in the FGDs, largely attributed bodily changes to the medical nature of the chronic conditions.

Commonly mentioned conditions included diabetes, hypertension, obesity, and cancer, with physical changes such as weight fluctuations, skin discoloration, and reduced mobility often viewed as inevitable byproducts of these diseases. The FGDs reinforced the idea that chronic illnesses lead to bodily transformations that are medically justified, even if emotionally difficult to accept.

“I have seen diabetes. Diabetes affects them with body sores. The sore can spread within your leg and cause your leg to be amputated at the end of the day. I saw this in my family.” [FGD-21-F-GM-Cynthia]

“A disease like diabetes can make you thin. You lose weight.” [FDGS-15-M-GM-Painful]

“The one I have witnessed, the leg of the person became sore and got rotten, and within that time, they amputated the leg because he was suffering and wasn’t able to do anything with it.”

[FGD-6-F-L-Ama L.].

Psychological and lifestyle attributions

Psychological and lifestyle factors were frequently mentioned by individuals with chronic conditions as contributing to their bodily changes. Many individuals with chronic conditions acknowledged that their lifestyle choices—such as poor diet, lack of exercise, and high stress—could exacerbate their health condition and its physical manifestations. In some cases, individuals with chronic conditions linked their changing bodies to their emotional states, such as anxiety or depression, which often led to unhealthy behaviours like overeating or neglecting physical activity. Additionally, individuals with chronic conditions noted that the psychological toll of living with a chronic illness—such as sadness, worry, and frustration—could lead to further physical decline, creating a cycle of deterioration in both body and mind.

It made me somehow restricted to certain activities, even to the extent that when I’m laughing, I should be careful, because if I laugh excessively beyond a particular threshold, there would be a problem. If I am too sorrowful beyond a particular threshold there would be a problem, more or less, I do not want to use the word caged. [ICC, Evans, 41yrs, Asthma, Legon].

“I kept thinking about it, so I couldn’t sleep when I went to bed. And if I couldn’t sleep my blood pressure rose in the morning. So, I took the advice I was given: to bear in mind that my condition would get better.” [ICC, Joana, 65yrs, Stroke, Ussher town].

“For my condition, I try my best to do anything that can make me feel better. I cannot do anything about my hair loss. I do not understand why somebody would say anything about it. I do not care if they do.” [ICC, Beryl, 63yrs, Breast Cancer, Legon].

Caregivers similarly highlighted the role of lifestyle factors in the changing bodies of individuals with chronic conditions. They mentioned that unhealthy habits, including poor eating and lack of physical activity, might contribute to the worsening of their loved ones' conditions. Caregivers also noted the emotional toll of caregiving, which could lead to stress and unhealthy coping mechanisms for both the patient and themselves. In some instances, caregivers pointed out how emotional distress, such as grief or fear, could manifest physically, contributing to the changes in their loved ones' appearance or health.

“In the initial stages, when she was diagnosed, I don't know whether she was thinking about it or not, so she lost weight.” [CG, Kweku, 40yrs, Breast Cancer, Legon]

“There are people who self-medicate without doctor's advice, and this causes various kinds of diseases.” [CG, Komle, 20yrs, Stroke, Jamestown]

I think he thinks too much. He thinks about where he comes from, where he is, the car he will have, and how he couldn't reach anywhere in life, which was supposed to be a different case. He thinks about how he couldn't make it in life to help build his family and take care of them. He also thinks of his future and how his family members are suffering. He thinks of why he is not living on his own land. He thinks every day. He didn't prosper in life. He thinks a lot and we have complained a number of times, but he doesn't want to stop. [CG, Celine, 30yrs, Hypertension, Diabetes, Legon].

Healthcare providers recognized that lifestyle choices, such as diet, exercise, and stress management, could significantly affect the course of chronic conditions and their associated physical changes. HCPs often emphasized the importance of maintaining a healthy lifestyle to mitigate the negative impact of chronic illnesses on the body. They discussed how psychological states, such as chronic stress, depression, or anxiety, could worsen the physical symptoms of conditions like obesity, diabetes, and hypertension. Healthcare providers also encouraged psychological support alongside medical treatment to help patients manage both their emotional and physical health.

From what I have come to know, they don't attribute it to spiritual stuff anymore. They know they're supposed to stop whatever lifestyles they are living, but the environmental factors are not helpful to them because there is a funeral almost every other weekend, and there will be free drinks and free food. They don't really drink the Club Beers; "Akpeteshi" is cheaper in these areas, so they drink that more than the expensive ones. [The thinking is,] 'If I am going to buy the club at GHC10.00, I can get Akpeteshi at GHC2.00 or I think, GHC1.00.' They can drink a lot and get waster earlier than taking so many bottles of the club. They eat a lot late, and they eat a lot of spices in the foods here. So, they don't really attribute it to spiritual stuff. They know it's more or less like their own doings. [HCP-4, 34yrs, Medical Officer, Ga-Mashie]

"Most times, diabetic patients go to their functions all the same. They drink what they want to drink, eat what they are not supposed to eat, and they come back and face the consequences on their own." [HCP-4, 34yrs, Medical Officer, Ga-Mashie]

In focus groups, some participants often discussed how lifestyle factors—such as eating habits, sedentary behaviour, and stress—contributed to the physical changes they experienced. They acknowledged that unhealthy habits were sometimes the result of the emotional distress caused by living with a chronic illness. Additionally, participants spoke about the psychological impact of their condition, such as feelings of sadness and anxiety, which in turn influenced their body's response to the illness.

My brother, the one who came after me, was not the sick type and also didn't like going for check-ups, so he thought his fatness was normal. At one point in time, he started growing slim, and I asked him what it was about, and he said it was nothing. I asked him whether he had gone in for a check-up, he said no, and all he stated was that he was feeling fatigued when working. After checking, the sugar and B.P. levels were really high. He was eating badly; he wasn't having a good diet and the time he eat was bad and also liked eating a lot of meat, he could fry 4 eggs, add sardines, add tomatoes and eat that. He even eats fufu with plenty of meat. He thought he was eating well, not knowing it was causing harm. After the test, I took him to a dietitian at Legon Hospital and prepared a meal table for him. [FGD-5-F-L-Hellen]

I also think that you can get it from outside by drinking too much alcohol, smoking cigarettes and “weed” can also cause these diseases. If you drink alcohol or you are a womanizer, when you reach that point, you must stop doing it because you are causing your own death so, if there are some small things that we know will cause harm, we must stop and we will live a healthy life. [FGD-25-M-L-Akwesi]

Social Attributions

Social attributions to changing bodies were less commonly discussed but still significant for some individuals with chronic conditions. Stigma and stereotyping were mentioned as contributing factors to the emotional burden of bodily changes. The following quotes capture participants' experiences of stigma and stereotyping.

“Most people in the community have been saying I have had an abortion and that is why I am losing weight.” [ICC, Naa, 39yrs, Diabetes, Ussher Town].

“They have bad notions that these diseases are evil, and you’re definitely in your final days when you have a stroke. They make negative comments about people affected by such diseases.” [ICC, Alex, 69yrs, Diabetes, Stroke, Hypertension, Legon].

Some individuals with chronic conditions felt that society viewed them negatively due to their physical appearance, leading to feelings of social isolation and shame. For example, individuals with visible signs of illness, such as hair loss from chemotherapy or the use of mobility aids, often feel judged or misunderstood. This social perception of their changing bodies further contributed to their psychological distress.

“Some have also said I have contracted a deadly disease. They have been mentioning different diseases, but I don't listen to them.” [ICC, Naa, 39yrs, Diabetes, Ussher Town].

“People say a lot of this issue. They will murmur and might speculate that you have HIV/AIDs. They always gossip about it.” [ICC, Hazel, 75yrs, Hypertension, Jamestown].

Caregivers noted the social impact of the disease on their loved ones' bodies. They observed that stigma and misconceptions about chronic illness led to social isolation for the individuals with chronic conditions, particularly when their physical changes were visible. Caregivers acknowledged that the emotional toll of being stigmatized could be as significant as the physical changes themselves, sometimes leading to neglect or withdrawal from social activities. The caregivers also discussed the societal burden placed on families, including financial strain and the emotional burden of caregiving.

“As I said earlier, some people stigmatize and discriminate against others with chronic diseases, which in turn prevents some of them engaging in activities.” [CG, Adorkor, 43yrs, Stroke, Hypertension, Diabetes, Jamestown]

“Some of the community members gossip about her reduction in weight, and this has affected her badly.” [CG, Adorkor, 43yrs, Stroke, Hypertension, Diabetes, Jamestown]

Healthcare providers acknowledged that social stigma and misconceptions about illness could influence how patients perceived their changing bodies. While medical professionals typically focused on clinical aspects of bodily changes, many recognized the importance of addressing social factors in the care process. Some HCPs noted that patients with visible signs of illness often faced social exclusion, which compounded their emotional distress. HCPs emphasized the need for supportive environments and reducing stigma in healthcare settings.

Sample quotes are presented below.

People have stopped going out, and people have stopped attending meetings that require trips where you have to sleep in a group like church conventions or some social events that require that people sleep in one area because they can't tell if they have to take their

bath in a general washroom. How are they going to bath for everyone to see that they have one breast? And there is equally stigma associated with breast cancer. [HCP-5, 37yrs, Clinical Psychologist, Legon]

“What I have come to learn in this area is that you’d see some people who are ... with too many people around them. It shows that probably he or she helped those people when they were in need or is a good person.” [HCP-4, 43yrs, Medical Officer, Jamestown]

Some participants discussed how societal perceptions of illness and the stigma surrounding certain conditions (e.g., obesity, HIV, or cancer) played a role in shaping their body image. The physical manifestations of these conditions were often linked to negative stereotypes, which contributed to feelings of shame and social exclusion. The fear of judgment from others about their appearance or health made it difficult for some individuals to engage socially or maintain relationships.

“Some do not treat them well. They have a mindset that they can be infected with the disease.” [FGD-13-M-GM-Bob]

“Some people withdraw or dissociate themselves from the diseased to prevent themselves from being infected. An example is stroke.” [FGD-16-M-GM-Momo Lord]

“People withdraw from them so that they will not contract those diseases—something like epilepsy, people withdraw from them because they think they will contract the illness.” [FGD-28-M-L-Agya Manu F]

Spiritual attributions

Spiritual explanations, including the belief in curses or spiritual causes, were cited by some individuals with chronic conditions as contributing to their bodily changes. These attributions were often rooted in cultural or religious beliefs that linked illness to moral or spiritual factors. For instance, some individuals with chronic conditions reported that they had heard comments claiming that their changing bodies were a punishment for past wrongdoings or a result of spiritual forces beyond their control.

“They can say that you have been affected by a disease or attach a spiritual meaning to it by saying that you have probably been cursed.” [ICC, Marie, 44yrs, Asthma, Ussher Town].

“They perceive it as a spiritual sickness in the first place. So, number one, people will begin to ask if you have done something to somebody, making the patient feel more guilty. Guilty that the person may feel he or she is directly responsible for whatsoever is happening to him or her.”

[ICC, Brenda, 35yrs, Breast cancer, Legon]

Caregivers also mentioned spiritual attributions in relation to the physical changes observed in their loved ones. They sometimes attributed the bodily changes to spiritual causes, such as curses or divine punishment, which were culturally ingrained beliefs. Some caregivers felt that addressing these spiritual factors through prayer or religious rituals might help mitigate the physical symptoms or improve the patient’s overall well-being. Here are some sample quotes from the participants.

“Yes, I suspected it was a spiritual condition when it first happened but after observing it closely, I was like...” [CG, Portia, 65yrs, Diabetes, Prostate, Hypertension, Stroke, Jamestown]

“We could attribute it to spiritual meanings in extreme situations.” [CG, Adorkor, 43yrs, Stroke, Hypertension, Diabetes]

This is because of how it happened to him suddenly. The thing suddenly happened to his arm when we were seated, so I thought to myself, ‘I hope someone didn’t do this to him.’ So, I sat down and thought to myself, ‘It has happened to a lot of people so maybe it’s not spiritual but something that has just happened to him. It may be physical, not spiritual. [CG, Portia, 65yrs, Diabetes, Prostate, Hypertension, Stroke, Jamestown].

Healthcare providers were aware of the spiritual beliefs that patients held regarding their bodily changes. While most providers focused on medical and biological explanations, they recognized the importance of acknowledging and respecting patients' spiritual beliefs in the care process. Some HCPs worked with spiritual leaders or provided counselling that addressed both the medical and spiritual aspects of chronic illness.

“They have a lot. Some actually say it’s a witch in the family, or some will say somebody has cursed you. They say a lot about it.” [HCP-7, 35yrs, Nurse, Gam-Mashie].

In focus group discussions, spiritual attributions were frequently mentioned, particularly in the context of chronic diseases that resulted in visible changes, such as cancer or obesity. Some participants attributed their physical changes to spiritual factors, such as curses or divine punishment, which reflected the strong cultural influence of religion and spirituality in their communities. These beliefs often shaped how individuals coped with their illness and their changing bodies. These excerpts demonstrate how spiritual attributions shaped the participants views.

“Some chronic diseases like epilepsy can be bought spiritually and given to someone. The reason I am saying this is because I am a pastor, and when we are doing deliverance, people confess to giving the illness to people because their future will be bright so they give the sickness to you to destroy your future.” [FGD-33-M-L-Fred]

“When you get affected, people may say you are cursed. They will be like, ‘This man was fat but now losing weight, has he offended someone or something of such sort? Instead of them checking why, they won’t.” [FGD-5-F-L-Hellen].

5.4 Implications for everyday body image management and embodiment

Living with chronic conditions significantly alters individuals' relationships with their own bodies and their perceptions of embodiment. These changes have profound implications for how they manage their everyday body image and navigate the embodied experience of illness. This section draws on narratives and observations to highlight key themes around body image (e.g., altered appearance), embodiment (e.g., reduced mobility), and the ways these aspects intersect with the challenges of chronic illness.

Body image and changed appearance

Chronic conditions often result in visible changes to physical appearance, which profoundly impact individuals' self-perception and social interactions. Participants frequently expressed distress over changes such as weight loss, scarring, or aging attributed to their illness, and these changes sometimes became sources of stigma or altered relational dynamics. For instance, one participant, Beryl, revealed the strain her altered appearance placed on her marriage:

“For my partner, he used to complain about the change in my body; he couldn’t bear it.” [ICC, Beryl, 63yrs, Breast Cancer, Legon].

Others faced ridicule or gossip from friends, leading to social alienation:

“I was very surprised because these people are my friends, and I do not expect them to make certain utterances like the disease has made me look old.” [ICC, Aku, 60yrs, Diabetes/Hypertension, Jamestown].

For some, maintaining self-worth amidst these changes became a significant challenge, influencing their interactions with both loved ones and the broader social network. Brenda, however, shared how her relationship remained stable despite losing a breast to cancer:

“Even having lost a breast in the fight has not affected my relationship with my husband in any way.” [ICC, Brenda, 35yrs, Breast Cancer, Legon].

Reduced mobility

Reduced mobility emerged as a critical dimension of embodiment, reshaping participants' lived experiences and how they engaged with their environments. Participants described grappling with physical limitations, often requiring assistance with basic tasks such as bathing or walking. This dependency not only redefined their sense of autonomy but also strained their relationships with caregivers.

“Now he cannot walk like he used to. When he walks for some time, he gets tired... we always have to assist him to move from here to there.” [CG, Skiddo, 28yrs, Hypertension, Diabetes, Legon].

For caregivers like Portia, managing the physical needs of loved ones involved significant adaptation:

“I used to bathe him at home in a pan... as time went on, I began to bathe him in the bathroom.” [CG, Portia, 64yrs, Diabetes/Prostate/Stroke, Jamestown]

Embodied Intimacy

Intimacy and sexual relationships were profoundly affected among individuals with chronic diseases, often leading to significant adjustments or cessation of sexual activities. Participants spoke about the emotional toll of sexual dysfunction or discomfort, which reshaped their sense of embodiment within intimate relationships.

“I don’t feel for sex... my husband now understands my predicaments, and we don’t even think about sex.” [ICC, Joana, 56yrs, Stroke, Ussher Town]

“Yes, anytime I lay with a woman, I feel pains in my legs for a long time. I sometimes feel relief after 3 or 4 days.” [ICC, Jason, 38yrs, Hypertension, Stroke, Ussher town].

Caregivers also highlighted the impact of illness on sexual dynamics, such as impotence resulting from medical treatments or physical changes:

“The stroke also makes some people impotent, so they don’t have the strength to do anything [sexual].” [CG, Esaaba, 40yrs, Stroke, Ussher Town].

For others, intimacy required negotiating new forms of physical and emotional closeness:

“He couldn’t get an erection when it first started, but now that he can move his legs, he gets erections.” [CG, Portia, 64yrs, Diabetes, Prostate Cancer, Stroke, Jamestown]

These narratives highlight the complexity of navigating intimacy while coping with chronic conditions, highlighting the interplay between embodiment, physical limitations, and emotional resilience in sustaining relationships.

5.5 Discussion

Objective two focused on representations of body image among individuals living with chronic conditions, examining the changes between their pre-diagnosis and post-diagnosis perceptions, and understanding their causal attributions for changes in body image. The results provide valuable insights into the challenges faced by ICCs in relation to body image, as well as some areas where strengths remain.

5.5.1 Embodiment and Chronic Illness: pre-diagnosis, post-diagnosis and changes

The findings show that before the diagnosis of chronic illness, participants expressed high satisfaction with their bodies, often describing themselves as physically active, fit, and energetic. They reported engaging in a variety of activities, from basic daily tasks to more physically demanding activities and viewed their bodies as strong and healthy. This positive self-image reflected not only physical health but also high levels of self-esteem and confidence.

Previous studies support similar findings, as individuals who maintain active lifestyles prior to the onset of chronic illness are often better equipped to cope with subsequent health challenges

(Borowiec et al., 2023; Gyasi & Phillips, 2020; Hahn et al., 2010). The ability to participate in social and physical activities has been shown to be a buffer against psychological distress, contributing to a sense of overall well-being (Borowiec et al., 2023).

In examining post-diagnosis representations of body image, it was clear that individuals with chronic conditions experience significant changes in how they perceive their bodies. These changes are often negative, with many participants reporting a decline in body satisfaction and a more critical view of their appearance. These shifts were characterized by impairments in physical functioning, physical distress, and changes in appearance, leading to a marked decline in their overall sense of self. Many participants expressed feelings of frustration and sadness as their ability to perform certain previous tasks diminished. The loss of autonomy and sense of physical restriction were particularly pronounced, with participants unable to engage in activities they once enjoyed, such as walking or performing basic household tasks. The functional decline is consistent with findings in the literature, where chronic conditions, such as cancer and cardiometabolic diseases, are linked to impaired physical functioning and severe disability (Morgan et al., 2019; Ofei-Dodoo et al., 2018; Otieno et al., 2023). Such impairments often contribute to a reduced quality of life, with emotional distress following closely behind.

Furthermore, the participants frequently described experiences of pain and fatigue, which exacerbated their functional limitations and led to a sense of dependency on caregivers. Chronic pain, such as that observed in sickle cell disease (SCD) patients, was particularly debilitating, affecting various body parts and contributing to a cycle of fatigue and physical distress. These physical struggles were compounded by emotional and psychological challenges, including depression and anxiety, which have been documented in other chronic illness studies (Poku et al., 2020; Singer et al., 1999). The emotional toll of these changes often led to emotional

breakdowns and detachment from social activities, as individuals struggled to manage their reactions to their changing bodies.

However, there are still areas where individuals with chronic conditions exhibit resilience. For instance, some participants maintained a positive sense of self despite changes in physical appearance. They demonstrated an ability to focus on their bodies' functional capabilities rather than solely on aesthetic appearance. These patients demonstrate a possible shift from appearance-based self-esteem to function-based self-worth, following the diagnosis of chronic illnesses. This suggests that, although chronic illness may negatively affect body image and embodiment, some individuals can still draw strength from their bodies' ability to perform essential daily tasks, thus preserving some aspects of body positivity. These findings align with previous studies that emphasized the potential for adaptive coping strategies, such as focusing on functionality, to serve as a buffer for the negative effects of chronic illness on body image (van Lankveld et al., 2018).

A key finding was that the changes between pre- and post-diagnosis body image were perceived and experienced in largely negative terms. This reflects the profound impact of chronic conditions on individuals' physical, emotional, psychological, and social well-being. Physical and functional changes were marked by significant decline in body size, weight, and mobility, with corresponding changes to body image. Emotional, psychological, and social changes also highlighted the struggle of adjusting to a new reality, characterized by feelings of isolation, diminished self-esteem, and existential crisis. These findings underscore the complex and often painful journey individuals with chronic conditions face as they navigate the profound shifts in their body image and overall sense of self after diagnosis.

The negative change has been documented in previous literature on chronic illness and body image (Cash, 2005; Watson et al., 2019). For example, individuals with chronic conditions often report feeling as though they no longer recognize their own bodies, a phenomenon linked to both visible physical changes and the emotional toll of adjusting to a new self-concept (Clarke & Griffin, 2008). The stress of managing a chronic illness often exacerbates this dissatisfaction, with physical symptoms or treatments (e.g., weight gain, scarring, hair loss) seen as indicators of illness rather than as part of the body's natural adaptation process. The negative impact of these changes on self-esteem and emotional well-being is well documented and underscores the need for supportive interventions aimed at improving body image and embodiment among individuals with chronic conditions (Filej et al., 2018).

5.5.2 Causal attributions for body image changes

The study also examined the causal attributions that the participants make regarding their body image changes. The findings showed that the participants attributed altered body image to a variety of factors, including biological and medical explanations, psychological and lifestyle attributions, social attributions, and spiritual beliefs. The most frequently cited attributions for changes in body image were biological and medical. Participants often linked changes in body image to the physical manifestations of their chronic conditions, such as weight fluctuations, fatigue, and visible scars from medical procedures. These physical alterations were seen as directly resulting from their illness or treatment, with little control over the outcomes. This finding aligns with research suggesting that medical treatments, such as chemotherapy or corticosteroid use, can lead to visible changes that disrupt body image and self-esteem (Williams, 2021). Participants also recognized that chronic conditions could impact metabolic processes and body function, which in turn affected their physical appearance.

Some participants also attributed changes in body image to the psychological burden of living with a chronic illness. Stress, depression, and anxiety were often cited as exacerbating body dissatisfaction. Moreover, lifestyle changes necessitated by the illness, such as reduced physical activity, dietary changes, and altered social interactions, were also identified as contributors to negative body image. These psychological and lifestyle attributions are consistent with existing literature on the role of mental health and lifestyle factors in shaping body image perceptions (Griffiths et al., 2017). The participants also highlighted the role of social factors, such as the reactions of family, friends, and the broader community, in shaping their body image. Negative societal attitudes towards illness-related changes in appearance, especially stigmatization against persons with visible disabilities or scars, were frequently mentioned as exacerbating feelings of self-consciousness and body dissatisfaction. This is in line with literature that emphasizes the role of social comparison and societal standards of beauty in influencing body image (Grogan, 2006, 2021a).

Some of the participants reported that within their communities, bodily changes are often attributed to spiritual factors. These individuals viewed illness as a test of faith or a manifestation of spiritual growth, which allowed them to maintain a positive body image despite physical changes. Spirituality has been highlighted in previous studies as an important coping mechanism for individuals facing chronic illness, helping them to reframe their experiences and find meaning in the physical and emotional challenges they encounter (Zhang, 2013).

5.5.3 Implications for everyday body image and embodiment

The implications of chronic illness on everyday body image and embodiment were multifaceted, reflecting both positive and negative dimensions. On the positive side, support

provided by spouses, family members, and social networks played a significant role in helping individuals adapt to changes in their bodies and daily lives. Spousal support, in particular, was highlighted as essential for emotional well-being and acceptance of bodily changes. Supportive partners often reinforced a sense of self-worth and helped individuals navigate the embodied challenges of chronic illness, such as physical limitations or altered appearances (Attinger & Brown, 2012; Iddrisu et al., 2020). Practical assistance with daily activities and financial support further helped mitigate the embodied impacts of the illness, fostering a sense of normalcy and stability in everyday life.

However, not all experiences were affirming. Some participants described feeling judged or criticized by significant others due to changes in their physical appearance, such as weight gain, scarring, or other visible markers of illness. These feelings had a profound impact on everyday body image, often undermining self-esteem and amplifying the emotional toll of chronic illness. Such experiences highlight the challenges individuals face in reconciling their sense of self with their altered bodies, often leading to feelings of alienation and distress. This aligns with broader literature that documents the ways chronic illness disrupts embodied self-identity, creating tension between how individuals perceive their bodies and how they believe others view them (Bowie et al., 2022; Schulman-Green et al., 2012).

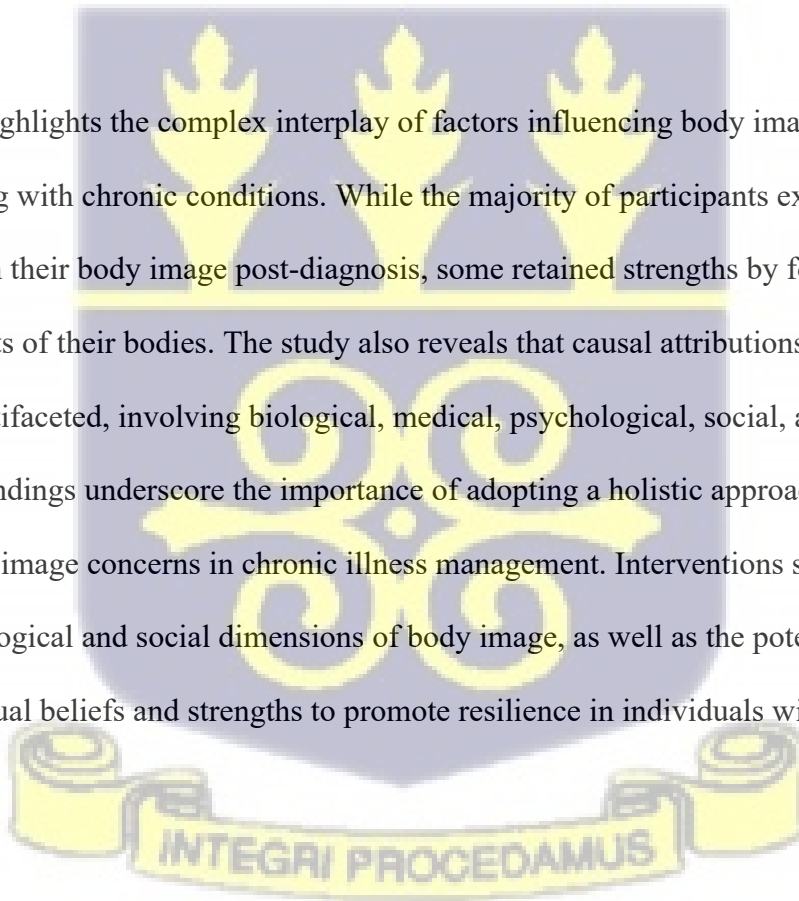
Moreover, the caregiving role brought its own complexities to everyday embodiment. For caregivers, the physical and emotional demands of supporting someone with a chronic illness often led to exhaustion and, in some cases, resentment. This dynamic could further complicate how individuals experiencing chronic illness felt about their own bodies, as the strain on their caregivers could be interpreted as an additional burden their illness had imposed on loved ones. These findings echo evidence suggesting that caregiving responsibilities, particularly in the

context of chronic illness, can strain relationships and intensify the challenges of embodied living (Litzelman et al., 2018; Redjem et al., 2011).

Taken together, these findings underscore the dual burden of chronic illness on body image and embodiment not only through personal struggles with physical changes but also through relational dynamics that shape how individuals experience and inhabit their bodies in everyday life. This highlights the need for interventions that promote positive body image and supportive caregiving practices, fostering resilience and mutual understanding in navigating the embodied realities of chronic illness.

5.6 Conclusion

This study highlights the complex interplay of factors influencing body image among individuals living with chronic conditions. While the majority of participants experienced negative shifts in their body image post-diagnosis, some retained strengths by focusing on functional aspects of their bodies. The study also reveals that causal attributions for body image changes are multifaceted, involving biological, medical, psychological, social, and spiritual factors. These findings underscore the importance of adopting a holistic approach when addressing body image concerns in chronic illness management. Interventions should consider both the psychological and social dimensions of body image, as well as the potential for leveraging spiritual beliefs and strengths to promote resilience in individuals with chronic conditions.



CHAPTER SIX

FINDINGS ON BODY IMAGE, EMBODIMENT AND CHRONIC ILLNESS MANAGEMENT

6.1 Introduction

This chapter focuses on objective three, which investigates the interplay between social representations of body image and lived experiences in shaping management of both body image and chronic illness. It explores the functions of representations to understand how these representations influence management strategies, maintaining ideal body image and chronic conditions. Section 6.2 focuses on body image and embodiment and its relation to chronic illness management, Section 6.3 discusses the sources of treatment and management options, and Section 6.4 presents challenges with treatment and management. Section 6.5 synthesizes the findings and reflects on their implications for understanding body image and chronic illness management and 6.6 concludes the chapter.

6.2 Chronic illness management

This section presents strategies employed by individuals living with chronic conditions to manage their conditions, which were influenced by their body image and embodiment. Two dominant themes emerged, namely, physical management practices and aesthetic practices, which reflect approaches to managing chronic illness while addressing body image and embodiment concerns.

Physical management practices

This included strategies aimed at alleviating the physical effects of chronic conditions while improving mobility and comfort. Some individuals with chronic conditions frequently reported the importance of getting enough rest to conserve energy and promote recovery. Massage therapy was another popular practice, often provided by caregivers, to relieve pain and improve circulation. For individuals with significant mobility challenges, the use of assistive devices like wheelchairs and walking sticks was prominent, ensuring some amount of partial independence and a semblance of normalcy in their daily lives. During the ethnographic observations, one participant's reliance on her wheelchair was noted as a means of reducing her reliance or dependence on others. Using it allowed her to move with some level of independence, positioning her as semi-dependent rather than fully reliant on a caregiver.

‘As part of my field observations, I recorded that Mia, [ICC, 78yrs, Diabetes, Hypertension, Jamestown] expressed more joy and independence while using her wheelchair than when confined to bed, which left her immobile and overly dependent on others. She seemed happy and attempted to wheel herself, though she still needed occasional assistance’.

Aesthetic practices

This emerged as an important strategy for individuals with chronic conditions seeking to address the physical effects of their conditions on their appearance. Many individuals with chronic conditions used camouflage techniques, such as wearing sunglasses to conceal eye conditions, oversized clothing to mask changes in body shape, and wigs to address hair loss. Accessories like padded bras and oversized footwear were also used to mitigate the visual impact of swelling or asymmetry. These practices were informed by a desire to align their appearance with societal standards of beauty. These aesthetic adjustments were alluded to by all participant

groups as part of efforts made by individuals with chronic conditions to manage the psychosocial impact of their conditions. Participants echoed these points:

“Sometimes when I go out people ask me whether I am sick because of my eye color. I mostly like wearing shades a lot to prevent people from asking me questions. Formerly, it was bad, but it is better now.” [ICC, Stephen, 37yrs, Sickle cell disease, Legon]

“I wear a wig cap sometimes; this was to make up for the hair loss.” [ICC, Brenda, 35yrs, Breast cancer, Legon]

“Some of them try to hide their body image. For example, people with diabetes who have a wound on their leg try to dress in such a way that people don't notice the wound.” [HCP-2, 59yrs, Clinical Pharmacist, Ga-Mashie]

“Have you seen those buttocks pads for instance? I have bought some for those who may have lost weight, and they are wearing them so that at least they can have the symmetry and shape in there.” [HCP-5, Clinical Psychologist Legon].

6.3 Sources of Information for Treatment and Management of Chronic Illness

This section focuses on the various sources through which individuals accessed information to guide the treatment and management strategies for chronic conditions and body image. These sources provided knowledge about available therapies, practical strategies for ongoing care, and in some cases, direct access to medicines. The findings revealed the diversity of sources and multifaceted nature of health-seeking behaviour among individuals with chronic conditions, informed by their personal experiences, cultural beliefs, and access to resources. Specifically, there were seven main themes regarding the sources from which individuals living with chronic conditions sought treatment and management for their conditions: orthodox, traditional, medical

pluralism, communal, religious, media, and educational sources. In Figure X presents a system of map of information sources mobilized for treatment and self-management of chronic illness in the study communities.

Orthodox sources

This theme emerged as the most common source of information and guidance for treatment and management. Hospitals and clinics were the primary locations where individuals with chronic conditions accessed medical advice and information, relying on doctors, nurses, and other healthcare professionals for instructions on diagnosis, prescribed medications, and therapeutic interventions. Pharmacies and drug stores also served as important sources of information where individuals not only purchased prescribed medications, over-the-counter drugs, and health supplies but also received advice on proper usage and management. Healthcare professionals confirmed that individuals with chronic conditions frequently relied on the orthodox system as their initial and primary source of information on how to manage their conditions. Caregivers reinforced this reliance by facilitating hospital visits and ensuring medication adherence.

“I only take the medicines prescribed to me because it’s only the doctors who know how I will be able to recover.” [ICC, Beryl, 63yrs, Breast Cancer, Legon].

“I also take prescription drugs from the hospital then my children buy them for me.” [ICC, Alex, 59yrs, Diabetes, Stroke, Hypertension, Legon].

“I just take my drugs. I just focus on taking the drugs I’m given when I go to the hospital.” [ICC, Effie, 59yrs, Hypertension/Diabetes, Legon].

Traditional sources

This source was widely reported as a complementary or alternative option for orthodox systems. Herbal medicine practitioners and sellers served as key providers of information, advising individuals with chronic conditions and their caregivers on remedies that were believed to address the root causes of the illness. Traditional sources were often valued for their cultural familiarity, perceived natural composition, and affordability, which made them a trusted source of guidance for some of them. Caregivers explained that individuals with chronic conditions often sought herbal remedies after getting limited results from orthodox medicine, with community members actively recommending particular practitioners or products. At the same time, healthcare professionals raised concerns about the unregulated nature of traditional sources and the potential risk of combining herbal medicine with prescribed medications.

“I usually take ‘bowhine and Nunum (Basil)’. These are traditional medicines. I mix them in my blended kenkey and drink it.” [ICC, Hazel, 75yrs, Hypertension, Jamestown]

“I went to buy rooter tonic, and I bought some herbs from a herbalist and boiled it and that is what I have been drinking.” [ICC, Sonia, 29yrs, Hypertension, Ussher town]

We tried to get some herbal medicines for him to try for improvement because we didn’t see any improvement in his recovery when he was on the hospital treatment. We have bought a number of herbal medicines for him. It has been good, but we still haven’t seen much improvement. [CG, Celine, 30yrs, Hypertension, Diabetes, Legon]

Medical pluralism

This theme involved the combined use of both orthodox and herbal medicine, serving as a channel through which individuals accessed information and guidance from multiple systems.

It highlighted the pragmatic approaches adopted by some individuals with chronic conditions. Some of them sought to leverage the perceived benefits of both systems to maximize their health outcomes. Some caregivers supported this integrative approach, and the focus group discussion revealed that this dual strategy was a common community practice, often driven by social norms and cultural perceptions of health.

“Yes, we also buy some drugs in addition to the ones prescribed by the hospital. We buy another drug for him when the hospital drugs are finished. Something like herbal medicines like Koa mixture and others.” [CG, Skiddo, 28yrs, Hypertension, Diabetes, Legon]

“He is given traditional medicine, and when that finishes, I have to buy him drugs from the pharmacy to focus on his care. Treatment can be gotten at the hospital and also by a herbalist.” [CG, Esaaba, 40yrs, Stroke, Ussher Town]

“I occasionally prepare some local herbs for him. But he takes it at particular times. You understand? If he takes his medications in the morning, he waits till about four hours later before taking the herbs. This is because he doesn’t have to take both at the same time.” [CG, Akorfa, 51yrs, Diabetes, Hypertension, Legon]

Communal sources

This theme emerged as another significant source for treatment and management, particularly in resource-limited settings. Friends, family members, colleagues, and other community members offered either solicited or unsolicited advice where they were consulted for advice and recommendations regarding treatment options. This reliance on communal knowledge was influenced by social trust and the ease of access to informal health networks. The

participants frequently shared personal experiences and endorsed specific remedies, contributing to the widespread adoption of certain practices within the community.

They do talk about it in the community. Some recommend that I take him to the herbalist. Others also say his body can be fixed with a machine. I always tell them it's a matter of money. You can't go to the herbalist for medication if you don't have money. People in the community talk, they wonder why a young boy would get such a sickness; could it be a spiritual attack? [CG, Esaaba, 40yrs, Stroke, Ussher Town]

Religious and spiritual sources

This theme was prominent in the health-seeking behaviour of individuals with chronic conditions and caregivers, reflecting the intersection of spirituality and health. Spiritual healers, including prophets and pastors, were often approached for prayers and spiritually inspired interventions. Some of the participants highlight the deep-rooted belief in the spiritual dimensions of illness and the role of religious leaders in providing guidance and assurance. Therefore, some of the individuals with chronic conditions and their caregivers cited faith-based healing as a source of hope and emotional support, especially in cases where medical explanations were insufficient or inconclusive.

After I was diagnosed, I couldn't see properly with one of my eyes. I started seeing clearly after I went to Adom Kyei Duah's place and I was given the grace ointment and a certain spray to apply on my eye. I saw webs come off my eye when I used it. I would not have been able to see you clearly if I hadn't gone there. [ICC, Joana, 65yrs, Stroke, Ussher town]

My sisters. Upon their arrival, they advised us to take him to church instead, so we did. The pastor did his part, but the condition only got worse. He could not talk or walk. We stayed in the church for about a week. The pastor then advised that we take him to the “Korle Bu” polyclinic, so we did. [CG, Esaaba, 40yrs, Stroke, Ussher Town]

Media sources

This source emerged as influential in shaping treatment-seeking behaviour. Advertisements on traditional media platforms, such as television, radio, and newspapers, frequently promoted over-the-counter medications and herbal remedies. Social media platforms were also significant, with many of the participants indicating that they encounter treatment options through digital advertisements, influencers, and user testimonials. While some individuals with chronic conditions viewed media sources as informative and accessible, others expressed scepticism about the credibility of advertised treatments.

“I watch the television and see all the herbalists and how they’re healing people.” [ICC, Alex, 69yrs, Diabetes, Stroke, Hypertension, Legon]

“From YouTube, I watch it and it explains it better because it’s a video.” [ICC, Evans, 41yrs, Asthma, Legon]

Okay, so I would often go online and then speak to health personnel—those who are willing to help in this field. But most often, I consult Google. It helped me in a lot of ways because what the physician would fail to let me know I get that online, and if

there's any confusion, that is when I come back to ask, to enquire from them for further explanation. [ICC, Brenda, 35yrs, Breast cancer, Legon]

Educational sources

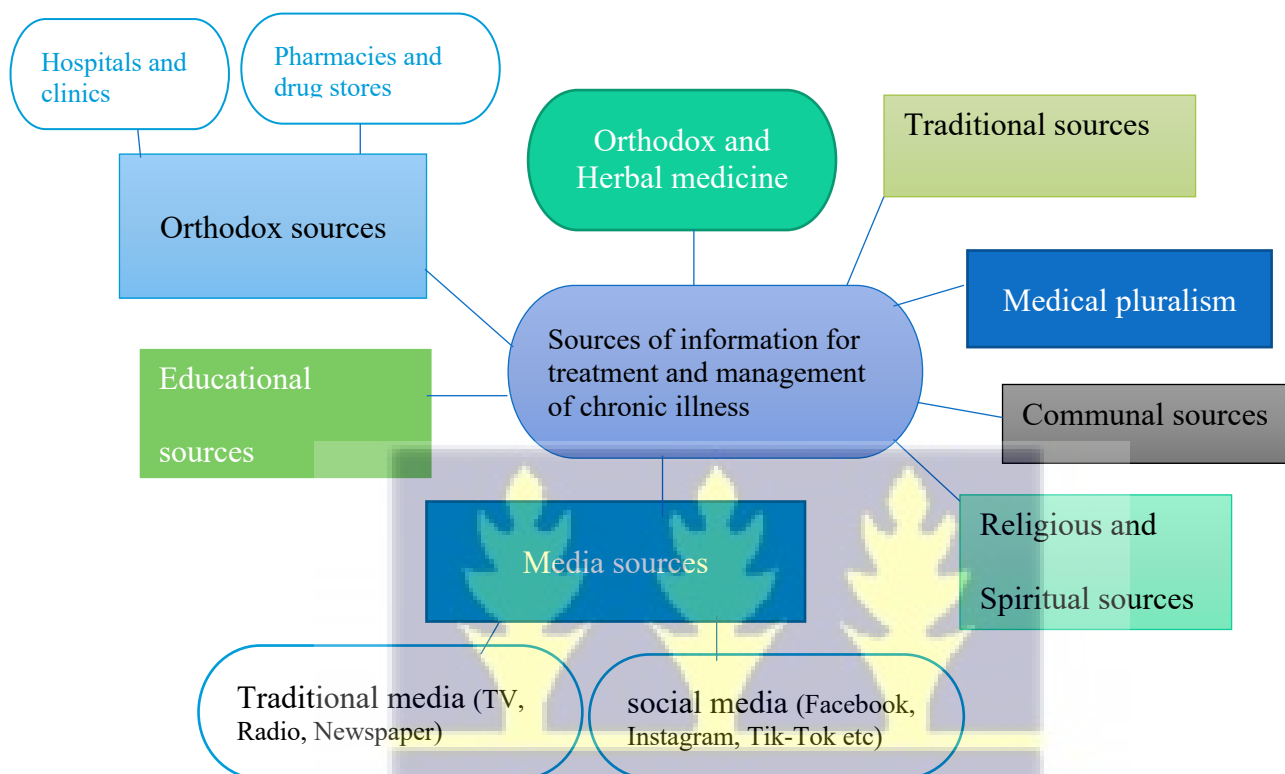
This theme emerged as a source that is being utilized by a smaller but notable group of individuals with chronic conditions and caregivers. Health-related books, blog posts, leaflets, and other informational materials were sometimes consulted to gain a deeper understanding of chronic conditions and potential management strategies. Individuals with chronic conditions and caregivers who could read relied on educational sources often, exhibiting a proactive approach to their health, by seeking evidence-based information to complement other treatment methods.

So, I look at the pathophysiology, what really precipitates its effect on the body—so the whole asthma cycle, from a trigger through to inflammation through to wheezing, and then if the wheezing is too much, the body begins to collapse because of excess carbon dioxide in the body. So, I got all this information from the literature. [ICC, Evans, 41yrs, Asthma, Legon]

“We attend continuing education from time to time. That is part of our continuing education point. For you to renew your license annually, you need to get a certain mark in terms of your attendance at some of the seminars.” [HCP-7, 35yrs, Nurse, Ga-Mashie]

“There are a lot of journals and research. As a dietitian, I deal with evidence-based scientific facts from research, so we do a lot of reading.” [HCP-6, 37yrs, Dietician, Ga-Mashie].

Figure 6: System Map of Information Sources for Treatment and Self-Management of Chronic Illness



Note: The map synthesizes information channels described in the study.

6.4 Challenges with treatment and management

This section presents findings on challenges faced by individuals living with chronic conditions in their treatment and management efforts. The data highlights the complexities and multifaceted nature of managing chronic illnesses, reflecting the interplay of personal, systemic, and contextual factors. These challenges were grouped into two primary themes: treatment effects and barriers to effective management and treatment.

Treatment effects

This theme emerged as a critical concern, with participants describing both positive and negative outcomes of their treatment regimens. On the positive side, individuals with chronic conditions reported improvements in symptom management and overall functionality when they adhered to prescribed treatments. Healthcare professionals affirmed that effective treatments, such as medications and therapeutic interventions, significantly enhanced the quality of life for many individuals with chronic conditions.

“It makes me feel fine in my body, it helps my blood to flow into my hand and makes it easier for me to open my hands.” [Sonia, Hypertension, Ussher town, 29yrs]

“Our blood doesn’t flow well. We take them (blood tonic, folic acid) to help us during a crisis so that it can cause the blood to flow well.” [ICC, Fiifi, 44yrs, Sickle cell disease, Legon]

“The medication is good for her; it reduced the sugar levels, and she started gaining some weight” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown]

However, some negative treatment effects also emerged. Many individuals with chronic conditions and caregivers reported distressing side effects, such as reduced sexual drive, which significantly impacted their emotional well-being and personal relationships. The participants echoed these sentiments, with community members noting that the burden of managing side effects often discouraged individuals with chronic conditions from continuing treatments. Healthcare professionals acknowledged the difficulty of balancing treatment efficacy with minimizing adverse effects.

“Your menstrual cycle changes and you could wake up, and it’s like your body is not yours.” [ICC, Brenda, 35yrs, Breast cancer, Legon].

“The drug I am using has reduced things. It is not supposed to make my manhood ineffective, but to stop the priapism. Instead, it has stopped my penis from erecting.” [ICC, Stephen, 37yrs, Sickle cell disease, Legon]

“I felt bad because I just got married. I used to have erections before getting married and the medicine didn’t have an immediate effect on me. I suffered the effects after I started taking it and increasing its dosage continually.” [ICC, Stephen, 37yrs, Sickle cell disease, Legon]

Barriers to effective management and treatment

This theme constituted the second overarching theme, encompassing a range of systemic and personal obstacles. *Financial constraints* were identified as the most pervasive barrier. Some of the individuals with chronic conditions and their caregivers reported frequent struggles to afford medications, hospital visits, and associated costs of chronic illness management. The participants revealed that financial difficulties often forced individuals with chronic conditions to choose between essential needs and healthcare expenses, leading to irregular treatment adherence.

“I have not taken any steps on it because I will need money to go to the hospital and I didn’t have any money.” [ICC, Chloe, 59yrs, Hypertension, Jamestown]

“Also, for the medication, it means that almost every month, we’ve been spending money to get medication, and that can be strenuous.” [ICC, Jeremy, 25yrs, Sickle cell disease, Legon].

“The stress is in the pocket, because, for instance, let’s say I have GHS 50, I’ve planned that I’m going to use the GHS 50 tomorrow for another thing, and then there is an attack now I have to use this money.” [ICC, Evans, 41yrs, Asthma, Legon]

The side effects of medications were another prominent barrier. Some individuals with chronic conditions and their caregivers expressed reluctance or fear toward orthodox treatments due to perceived or experienced adverse effects. A sense of distrust in the healthcare system and discomfort with medication regimens further exacerbated this issue, leading some individuals with chronic conditions to turn to alternative forms of treatment. This dual reliance on orthodox and traditional treatments often created confusion and inconsistencies in managing their conditions.

As part of my field observations I recorded Akosua, [C, 64yrs, Diabetes, Prostate, Hypertension, Stroke, Jamestown] Jack's wife, had been given herbal medicine for Jack to drink. This normally takes place between 7 and 8 a.m. I asked Akosua about the medicine, and she confirmed it was herbal and explained that although they had taken Jack to the hospital for treatment, they hadn't seen much improvement. As a result, they decided to try herbal, where he was provided with herbal medicines in large quantities, about four gallons. They got to know about the place through their neighbor, who decided to send him to the herbalist for alternative treatment. Akosua confirmed that they had seen improvement in his body and in his weight gain, as well as his overall recovery. Meanwhile, they continue seeking treatment from Korle-Bu. Akosua added that the same approach is being used for his diabetes, prostate cancer, stroke and hypertension. All four gallons contained different medicines but all serve the same purpose. She further indicated that one of the reasons they turned to herbal medicine was the side effects of the prescribed hospital medicine, which had caused her husband to develop some rashes on his skin.

She also confirmed that the drugs were changed after she reported the side effects to the health providers

Dietary management

This has posed significant challenges. Some of the participants with chronic conditions reported frustration with dietary guidelines, which were often perceived as restrictive and difficult to follow. They explained as follows:

“There are times you feel like taking something very spicy, but you can’t because if you try it, you will have an attack, so, somehow, it affects your diet, restricts your diet to an extent.” [ICC, Evans, 41yrs, Asthma, Legon]

“Where people are taking this ‘momoni’ with okro stew, ‘momoni’ has been added to okro stew and it is giving it this flavour, and it is mouth-watering. You know you are going to take some ‘banku’ and okro soup, because of the ‘momoni’ in it, you can’t eat it.” [ICC, Evans, 41yrs, Asthma, Legon]

Caregivers noted that individuals with chronic conditions frequently struggled to balance these guidelines with their cultural food preferences and financial limitations. The participants highlighted that the lack of culturally sensitive and affordable dietary recommendations made adherence even more challenging.

“Like in terms of food... for instance, if we are going to eat fufu, we would add ten fingers of plantain to just half a piece of cassava, then we eat it. Or Akpele, that one has no starch.” [CG, Portia, 64yrs, Diabetes, Prostate Cancer, Hypertension, Stroke, Jamestown].

“I don’t want to burden them with my preferences all the time, so I always eat what they make available. I’m mostly silent about my food preferences because they don’t have money.” [ICC, Alex, 69yrs, Diabetes, Stroke, Hypertension, Legon]

“It’s my children who contribute to my upkeep. Sometimes they don’t have enough money to spare, but sometimes they buy me the food I wish to eat, sometimes too, what they have is what they give me, even if I’m not supposed to eat it, that is what they have.” [ICC, Alex, 69yrs, Diabetes, Stroke, Hypertension, Legon]

Maintaining regular eating times and adhering to dietary plans proved difficult for many individuals with chronic conditions. Participants described feeling hungry outside prescribed meal time. Some of these challenges made it hard to follow dietary recommendations, as personal needs and daily routines frequently conflicted with the structured eating schedules advised by healthcare providers. Caregivers also reported difficulties ensuring that dietary plans were followed consistently, noting that irregular eating habits and competing household demands often disrupted adherence to recommended meal routines.

“I feel hungry very late at night, so I eat bread and water, and then I feel okay. So, paying attention to your diet is about checking what you eat. It is sometimes difficult because, say, we were told we shouldn’t eat late, but I get hungry and eat light, such as food, bread and water or sometimes a soda biscuit.” [ICC, Aku, 60yrs, Diabetes, Hypertension, Jamestown].

“Sometimes, it gets really hard as I can’t eat at a certain time and I also can’t eat when it is 5:30 p.m. so, sometimes, I go and buy light food like Koko, rice water. I just get something to eat before I sleep.” [ICC, Ferdinand, 64yrs, Diabetes, Jamestown].

Finally, a pervasive sense of emotional and psychological frustration emerged across all groups. Some of the individuals with chronic conditions and their caregivers reported feelings of helplessness and fatigue stemming from the constant demands of managing a chronic condition. The participants noted that this emotional toll often led to disengagement from treatment, with individuals with chronic conditions expressing doubt about the long-term benefits of their efforts.

“Yeah, it does in different ways, including weight gain and mood swings, so it affects you psychologically. Forgetfulness.” [ICC, Brenda, 35yrs, Breast cancer, Legon]

“Just when I decided to give birth, they weren’t working anymore because of the drugs. I went to the hospital, and they gave me a drug to revive it but the priapism came again, and I had to go back to those previous drugs. This is actually worrying me because I am told I may not be able to have erections again.” [ICC, Stephen, 37yrs, Sickle cell disease, Legon]

6.5 Discussion

6.5.1 Chronic illness management

The findings reveal that while managing chronic illness is a multifaceted process, strategies specifically related to body image management were more limited, primarily focusing on aesthetic and physical adjustments. This contrast highlights that while body image concerns are central to the chronic illness experience, the emphasis on body image management is often overshadowed by the practical demands of managing the illness itself. Participants reported engaging in aesthetic practices to cope with visible changes in their bodies caused by chronic illness, such as weight loss, scarring, or other bodily alterations.

Common strategies included the use of clothing, makeup, and accessories to conceal visible changes, aiming to maintain an appearance of normalcy and self-esteem. These practices were viewed as psychological buffers, helping individuals manage the distress caused by changes in their appearance. Such findings align with literature suggesting that aesthetic adjustments can positively influence self-perception and social interactions in individuals with chronic conditions (Cash & Deagle, 1997; Tylka & Wood-Barcalow, 2015). However, these practices were not universally employed and appeared to be limited to those who experienced visible changes, indicating that body image management strategies were primarily aesthetic and physical in nature.

The primary focus of participants was on managing their chronic conditions, and this frequently took precedence over concerns about body image. Medical management strategies included adherence to prescribed medications, medical check-ups, and necessary lifestyle modifications such as dietary adjustments. However, participants expressed frustration with restrictive dietary guidelines that often conflicted with their cultural or personal preferences, highlighting a tension between medical efficacy and personal/cultural relevance. This tension underscores the importance of designing patient-centered dietary plans that balance medical requirements with cultural and personal preferences to enhance adherence and overall well-being.

Despite the evident concerns about body image, the overwhelming emphasis was on managing the chronic illness itself. This often involved dealing with multiple barriers, including the high cost of treatment, variable levels of social support, and the side effect of medical treatment. These barriers added complexity to the already challenging process of managing the illness, often overshadowing the emotional and social dimensions of body image. The struggle to

manage illness within this context further reinforced the limited scope of body image management strategies.

6.5.2 Sources of Information for Treatment and Management of Chronic Illness

The study reveals that the treatment and management of chronic illnesses are shaped by a diverse range of sources. The sources include the interplay of cultural, social, and economic factors in influencing health-seeking behaviours. While orthodox and traditional medical systems remain dominant, the findings highlight the significance of communal, religious, media, and educational influences as additional layers of support. Orthodox medical care, encompassing hospitals, clinics, and healthcare professionals, remains a primary source of treatment. However, participants noted challenges such as the cost of care, fear of treatment outcomes, and side effects of medications, including sexual dysfunction, which discouraged exclusive reliance on this system. These barriers often prompt individuals to seek alternative or complementary treatments.

Traditional medicine emerged as a significant parallel source of treatment. Participants reported using herbal remedies and consulting traditional healers for symptom management, often motivated by cultural familiarity, perceived affordability, and accessibility. The pluralistic medical environment, where individuals navigate between traditional and orthodox systems, reflects a pragmatic approach to care. Religious institutions and practices also play a pivotal role in the treatment and management of chronic conditions. Prayer camps, church-based support systems, and reliance on faith were highlighted as sources of psychological and spiritual relief. Some participants expressed a belief in divine intervention and found comfort and resilience through prayer, which complemented other forms of treatment. The emphasis on spirituality

aligns with the cultural and religious fabric of the communities studied, where health is often seen as interconnected with spiritual well-being.

Communal support systems further shape health-seeking behaviours. Family members, caregivers, and community networks provide emotional and financial support, bridging gaps in healthcare access. Focus group discussions revealed that communal solidarity often mitigates the financial and logistical challenges of accessing orthodox care, particularly in resource-constrained settings. This collective approach highlights the role of community in sustaining long-term chronic illness management. The influence of media and educational sources, though less dominant, also emerged as notable. Participants acknowledged that public health campaigns, social media, and educational workshops provided critical information on disease management and prevention. These sources serve to demystify chronic illnesses, encourage early treatment, and challenge stigmatizing beliefs within the community.

The diverse sources of treatment and management for chronic illnesses reflect the complexity of navigating pluralistic health systems in resource-limited settings. This practice aligns with findings from de-Graft Aikins (2003) and de-Graft Aikins et al. (2014), who observed that individuals with chronic conditions often combine healer shop and blend biomedical, traditional and religious sources as means to attaining holistic healing. The findings emphasize the need for integrative approaches that bridge orthodox, traditional, and communal practices while leveraging media and educational tools to enhance awareness and reduce barriers. Recognizing and respecting these diverse sources of care is essential for developing culturally sensitive and effective interventions.

6.5.3 Challenges with Treatment and Management

The findings from this study highlight the interplay between the hopeful aspects of treatment and the significant hurdles faced in navigating chronic illness care, emphasizing the need for more accessible, affordable, and culturally sensitive healthcare solutions. The challenges in managing chronic illnesses are multifaceted, reflecting a complex intersection of personal, social, and systemic factors. These obstacles not only complicate treatment adherence and management but also contribute to a sense of frustration, emotional distress, and physical suffering for those affected.

A key challenge identified by participants is the financial burden associated with managing chronic conditions. The costs of medical care, including medications, hospital visits, surgeries, and rehabilitation, were cited as significant barriers to effective management. For many patients and their caregivers, these costs represent a substantial strain on household finances, particularly in resource-poor households living with conditions where health insurance coverage is limited or non-existent. The direct costs of treatment, combined with indirect costs such as the loss of income due to illness or the inability to perform daily activities, further exacerbate the financial pressures faced by the participants. This aligns with existing research that highlights financial strain as a key barrier to accessing and adhering to treatment regimens (Clarke & Griffin, 2008; de-Graft Aikins et al., 2014; Rumsey & Harcourt, 2004).

Another critical challenge reported by participants is the side effects of treatment, particularly the negative impact of medications on sexual drive and overall quality of life. These side effects were not only physically distressing but also emotionally burdensome, as they interfered with personal relationships and contributed to feelings of diminished self-worth and identity. Participants expressed reluctance in continuing treatment due to these adverse effects,

which also prompted them to seek alternative forms of care, such as herbal treatments or spiritual healing practices. Pluralistic medical environments—where participants navigate between orthodox and traditional medicine—also present a unique set of challenges.

While many participants turn to traditional healers for complementary treatment, the lack of coordination between medical systems can create confusion, delays in treatment, and even adverse interactions between different forms of care. The competing demands of conventional and alternative treatments can result in inconsistent adherence to prescribed regimens and a lack of clarity in managing complex conditions. The importance of integrating these approaches within a cohesive healthcare framework, while respecting cultural beliefs, is critical to addressing the treatment challenges faced by patients. The psychological implications of these side effects highlight the need for healthcare providers to address both the medical and emotional aspects of treatment, to ensure that patients are fully informed and supported in managing such challenges (de-Graft Aikins et al., 2014).

Furthermore, dietary and lifestyle factors emerged as additional barriers to effective illness management. The frustration with dietary guidelines and lifestyle changes prescribed by healthcare providers reflects the difficulty in adhering to treatment plans that require significant alterations to one's routine. Many participants reported that the prescribed changes to diet and activity were not only hard to implement but were also difficult to sustain due to limited access to appropriate foods, socioeconomic constraints, and lack of social support. These barriers are particularly challenging in communities where healthy food options may be scarce, and individuals rely on affordable but nutritionally inadequate options.

Finally, participants also described fear and mistrust of orthodox medicine as significant deterrents to seeking timely care. Fear of diagnosis, treatment outcomes, and the social

implications of living with a chronic illness were recurring themes across the study. Many individuals with chronic conditions reported delaying treatment or avoiding healthcare altogether due to these fears. This fear is often compounded by the stigma associated with certain chronic conditions, particularly in communities where illness is perceived as occurring because of moral or lifestyle failings. Gendered stigma was highlighted by women who underwent mastectomy or other body-altering treatments. These women felt that the loss of their physical appearance, which is culturally associated with femininity and attractiveness, led to shame and a sense of social isolation. Such stigma can result in reduced self-esteem and hinder individuals from seeking the necessary medical care, further perpetuating the cycle of neglect and poor health outcomes.

The challenges in managing chronic conditions are complex and deeply rooted in financial, social, and psychological factors. While treatment effects can offer hope, the barriers to effective management such as high costs, side effects, fear, stigma, and limited access to culturally appropriate care highlight the urgent need for a more comprehensive, patient-centered approach. Addressing these challenges requires not only improving the affordability and accessibility of healthcare but also integrating social and psychological support systems that consider the broader context in which individuals live (de-Graft Aikins et al., 2014, 2021). Holistic, culturally sensitive, and multi-dimensional interventions are essential to improving the management and quality of life of individuals living with chronic conditions.

6.6 Conclusion

This chapter has highlighted the complex, multifaceted nature of managing chronic illness. The findings have shown the intersections of body image, treatment approaches, and the

challenges patients and their caregivers face. While body image issues are central to the chronic illness experience, body image management strategies adopted are limited—aesthetic and physical mainly, it seems. By extension, the findings show that the overwhelming focus is on managing the illness itself within a context of multiple barriers. These challenges point to the need for healthcare systems that are more accessible, affordable, culturally sensitive, and holistic. The healthcare system should integrate medical, social, and psychological support to improve outcomes and quality of life for individuals living with chronic illness.



CHAPTER SEVEN

FINDINGS ON CARE NEEDS, EXPERIENCES AND IMPROVEMENT

7.1 Introduction

This chapter addresses the fourth objective, which examines the care needs, experiences, and suggestions for improvement. In this chapter, significant emphasis is placed on ethnographic data, drawing on detailed observations made during months of fieldwork with four individuals in their home environments. This approach allows for a nuanced understanding of the evolving care needs, offering deeper insight into the day-to-day realities of managing chronic illness. The chapter is structured into six sections: Section 7.1 introducing the chapter, Section 7.2 focusing on care needs, Section 7.3 delving into care experiences, Section 7.4 discussing care improvement, Section 7.5 synthesizing the findings and reflecting on their implications for improving care and support, and Section 7.6 concluding the chapter.

7.2 Care Needs

This section highlights the diverse care needs of individuals with chronic conditions. Four thematic care needs emerged: physical care needs, psychological and emotional care needs, social care needs, and spiritual care needs. Each of the themes is presented below.

Physical care needs

Physical care needs were widely recognized by participants and healthcare providers as crucial for the effective management of chronic conditions. Key aspects identified included medication adherence, regular hospital visits, surgeries, rehabilitation, physical therapy, and wound care. Participants emphasized the importance of following prescribed medication regimens to manage symptoms and prevent complications. One participant noted, “Without the medications, I cannot manage my condition; I have to keep taking them.” [ICC, Aku, 60yrs,

Diabetes, Hypertension, Jamestown]. Hospital visits were also seen as critical for monitoring the condition and receiving timely medical intervention. Several individuals with chronic conditions mentioned the need for frequent rehabilitation sessions and physical therapy, particularly those with chronic mobility issues or recovering from surgeries. Rehabilitation was often perceived as essential for restoring functional independence. One caregiver [CG, *Celine, Stroke*] stated, “Rehabilitation gives them the strength to do things on their own again.” Additionally, wound care was highlighted by individuals with conditions such as diabetes, where proper care of ulcers was noted as vital for preventing infections and promoting healing.

Medication-taking practices varied across participants, influenced by financial, physical and social support factors.

As part of my field observations, I noted that Mia, Jack, and Aurora adhered to their medication schedules, often with reminders from family members. Jack [ICC, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer] reported occasionally missing doses due to side effects and admitted to combining prescribed orthodox medications with herbal remedies because of mistrust towards the orthodox treatment.

Aurora [ICC, 44yrs, Breast Cancer, Legon] was particularly consistent in taking her prescribed drugs.

Mia [ICC, 7yrs, Diabetes, Hypertension, Jamestown] takes her medication judiciously, as her grandchildren ensure that the medicines are purchased, and her caregiver administers them on time as prescribed.

In contrast, Owen [ICC, 66yrs, Hypertension, Stroke, Jamestown] had never been able to obtain the full set of his prescribed medicines. His adherence was significantly constrained by financial

challenges and lack of family support, relying instead on voluntary assistance from church members and neighbours.

Hospital attendance was a common strategy for ongoing management, though challenges emerged. Observations showed:

All four participants made an effort to attend regular hospital check-ups. Owen, though punctual, could not afford treatment for his swollen foot and sores, which he attempted to manage at home with incomplete supplies and without family assistance. Aurora reported visiting the hospital when fluid began leaking from her surgical wound, but she complained that healthcare providers had not informed her that such symptoms were normal, leaving her terrified until she sought clarification. Jack attended less frequently because his family could not afford transportation and hospital-based wound care every two days, leading them to take over the dressing of his sores at home. Mia initially relied on her daughter and grandchildren to take her for wound care, but over time they also began managing the dressing at home to avoid costs.

Psychological and Emotional Care Needs

Psychological and emotional care needs were equally important. Many individuals with chronic conditions and their caregivers expressed the toll their conditions had taken on their mental well-being. Emotional support and counselling were identified as key needs, particularly for those experiencing depression, anxiety, or fear of disease progression. One participant shared, “Sometimes, I feel like I am losing control over my life. When it comes like that, I need someone to talk to, someone who understands.” [ICC, Aurora, 44yrs, Breast Cancer, Legon]. Participants frequently discussed coping strategies that helped them manage emotional distress, such as talking to themselves, praying, and talking with family members. Fear of the future, especially related to worsening health or potential loss of mobility, was a recurring theme, and participants

emphasized the need for more emotional support systems within the healthcare environment to help them process these fears.

As part of my field observations, I noted that emotional struggles were frequently expressed among the ethnographic participants, particularly the women. Field notes indicated that, Aurora [ICC, 44yrs, Breast Cancer, Legon] called on different occasions and, instead of engaging in long conversations, she simply cried, reflecting the weight of emotions she carried silently. She was subsequently advised to see a hospital psychologist, and the psychologist in charge was informed to follow up on her.

Mia's [ICC, 78YRS, Diabetes, Hypertension, Jamestown] was chastised by her daughter when she questioned why she should continue living after losing her leg. She was told, "Why are you not grateful that you are alive? You should be okay by now." Similar attitudes were observed among the relatives of other participants, who often downplayed or dismissed their expressions of sadness. Such responses reinforced feelings of isolation and pressured participants to repress their emotions.

Social Care Needs

Social care needs were a significant area of concern, as chronic conditions often led to social isolation and strained relationships. Many individuals with chronic conditions described feeling disconnected from their communities due to the physical limitations imposed by their illness. One participant shared, "I can't attend social gatherings anymore because I don't have the energy, and I feel like people have forgotten me." [ICC, Alex, Diabetes/Stroke/Hypertension, Legon, 69yrs]

I observed that social isolation was a common occurrence and an important concern for participants.

Aurora [ICC, 44yrs, Breast Cancer, Legon] explained that she avoided outings and social programmes because she feared people might notice that she had only one breast. She added that her breast form might shift in public, which would expose her condition, and this possibility kept her away from many gatherings.

Mia [ICC, 78yrs, Diabetes, Hypertension, Jamestown] also expressed feelings of exclusion and sadness. She revealed that she often remained at home while her family, particularly her children and grandchildren, left for social events such as naming ceremonies and funerals, which deepened her sense of isolation.

Family support was a central theme within social care needs. Many individuals with chronic conditions depend on their caregivers for instrumental, physical and emotional support. However, the burden on caregivers was often overwhelming. One caregiver, for instance, expressed, “It’s hard for me to balance taking care of her and managing my own responsibilities.” [CG, Mina, 44yrs, Sickle cell disease, Legon]. The involvement of the extended family was also identified as essential, with participants noting that caregiving duties were often shared among family members to alleviate the burden.

“I am loved by all my family members, and they advise that I take good care of myself in order to be healthy. They support me a lot.” [ICC, Jayden 44yrs, Diabetes, James town]

“She tells me, ‘It will be well, Mom. It will be well, Mom. Someone also got sick for a very long time but eventually recovered.’ She encourages me so I don’t think too much.” [ICC, Caitlin, 56yrs, Hypertension, Arthritis, Jamestown]

Marital support was particularly emphasized for individuals with chronic conditions experiencing physical changes such as amputations or paralysis.

“I told her about my condition right after I was diagnosed so we all got to understand that this was the condition. She cooks what I am supposed to eat and makes sure I don’t eat what I am not supposed to.” [ICC, Jayden, 44yrs, Diabetes, Jamestown]

Oh, this man! Do you know the wonderful things he has done? He calls me about ten times whenever he goes to work. The man has done really well, and everyone says he has done very well. My relatives from Cape Coast wanted to come for me, but he told them he didn’t like the idea and that he would take care of me. So, he didn’t let me go. [ICC, Joana, Stroke, 65yrs, Ussher Town]

“Even having lost a breast in the fight has not even affected my relationship with my husband in any way.” [ICC, Brenda, 35yrs, Breast cancer, Legon]

Some participants reported challenges in maintaining intimate relationships due to altered body image and sexual abilities. Participants noted:

“My husband can’t look at me the same way after the surgery; it’s been hard for us.” [ICC, Aurora, 44yrs, Breast Cancer, Legon]

My wife told me that, if I don’t treat myself then I don’t come near her. ...She will say, “you make sure you are ready to make up with your spouse and your medications are around. Make sure medications are not far away in case of anything. You treat yourself and continue whatever you are doing”. Otherwise don’t come near me. [ICC, Evans, 41yrs, Asthma, Legon]

The importance of community involvement, especially through group support networks and public health initiatives, was also highlighted as crucial for combating isolation and building resilience.

“I have a good relationship with everyone. We sometimes do things in groups; we eat and do everything together. They also like me a lot; they sometimes even invite me for parties and I go with them.” [ICC, Jason, 38yrs, Hypertension, Stroke, Ussher Town].

“Most people advise me to stick to my diet and also do what the doctor instructs me to do.”
[ICC, Naa, 39yrs, Hypertension, Ussher Town,]

Spiritual Care Needs

Spiritual care emerged as an essential component of care needs for many individuals with chronic conditions. This was more so, particularly in the context of religious beliefs and practices. Prayers and religious rituals were deeply integrated into the coping strategies of participants. One ICC remarked, “I believe God is in control of my illness; I trust in His plan for me.” [ICC, Owen, 66yrs, Hypertension, Stroke, Jamestown] Participants often sought spiritual healing through church services, prayer camps, and other religious activities.

I observed that spiritual care was central to all four participants, who consistently turned to God as their source of strength and hope, believing in His healing power. Aurora [ICC, 44yrs, Breast Cancer, Legon] often attended a prayer camp to seek intervention for both her health and financial challenges. On one of my scheduled visits, she had left home early in the morning, after sending her children to school, and returned around 4 p.m. During our conversation, she

remarked, “God has disappointed me,” explaining that she believed her faith and service to God should have brought healing.

Mia [ICC, 78yrs, Diabetes, Hypertension, Jamestown] similarly drew on spiritual expressions, but with a tone of despair. On several occasions, she asked me, “Why didn’t God take me but rather allowed me to suffer this way?” She frequently repeated that she prayed for God to take her home. (to die).

Many individuals with chronic conditions and caregivers also spoke of the psychological comfort they derived from the support of church members. “My church members visit me regularly and pray with me; it gives me strength,” said one participant. Some individuals with chronic conditions reported turning to prayer camps for physical healing and, hopefully, to receive divine intervention for their condition. Although this was not universally accepted by all participants, those who engaged in spiritual healing practices often felt it was integral to their overall well-being. Additionally, the emotional support provided by religious communities was identified as critical to helping individuals with chronic conditions manage their conditions, providing a sense of belonging and reducing feelings of abandonment.

“Yes, I go to church, and I am prayed for because most of my church people know this was not my situation sometime back. They know I used to be nice and I was often invited to join church activities. I was very neat, carried myself well and dressed nicely.” [ICC, Caitlin, 56yrs, Hypertension, Arthritis, Jamestown]

“If any of my friends are looking for me urgently, then they will realize that I am in the hospital and tell the others to visit and pray for me. My friends know I have a sickle cell so they pray for God to heal me.” [ICC, Stephen, 37yrs, Sickle cell disease, Legon]

“Maybe I have been admitted and with that, probably my church people will know and the people I work with in church will know and they will be praying for me.” [ICC, Jeremy, 25yrs, Sickle cell disease, Legon]

7.3 Care Experiences

This section explores the care experiences of individuals with chronic conditions and their caregivers. The participants shed light on the diversity and complexity of the chronic illness care journey. The findings highlight experiences within four thematic areas: experiences in pluralistic treatment sources, caregiving dynamics, management of body image and conditions, and psychological impact of the experiences. These themes are discussed below.

Plurality of treatment sources

The plurality of treatment sources reflects the broad spectrum of care that individuals with chronic conditions and their caregivers seek to manage their chronic conditions. As has been highlighted earlier, participants described utilizing both orthodox and traditional medical systems, often blending the two approaches in search of relief and healing. Orthodox medicine, including consultations with doctors, hospital visits, and pharmacy-based treatments, was widely regarded as a primary source of care, particularly for symptom management and disease monitoring.

Field notes revealed that some participants adopted pluralistic approaches, drawing on both biomedical and traditional knowledge to guide treatment decisions:

After the removal of his catheter at Korle-Bu, Jack [ICC, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer] sought assistance from a herbalist to manage his prostate cancer. He expressed the belief that while orthodox medicines are effective in treating certain illnesses, they are not the best option for conditions such as stroke and cancer. According to him, this belief is widely shared within the community. His wife and children, particularly his primary caregivers, did not object to his decision, which further motivated him to explore traditional sources for additional treatment.

Owen [ICC, 66yrs, Hypertension, Stroke, Jamestown] frequently listens to the radio, switching between stations to follow news, health talks, and football commentary. He is especially attentive to health-related announcements and testimonies about traditional medicine. Whenever he hears such stories, he often calls my attention to them and initiates conversations about their effectiveness, expressing a strong interest in their potential benefits. He repeatedly emphasized that if he had the financial means, he would pursue traditional treatments to improve his health. Owen also referred to community members who, according to him, had recovered through such methods. His particular interest lies in consulting a traditional herbalist located at Teshie-Nungua. Owen's sisters, especially his primary caregiver, hold a different perspective. While Owen is eager to explore traditional medicine, his sister strongly disagrees and frequently voices her opposition. She often cites examples of community members who, in her view, suffered adverse consequences or even lost their lives as a result of using herbal medicines.

However, some also sought out traditional medicine, including herbal remedies from healers and spiritual practices offered by local herbalists. For some, traditional medicine offered emotional

comfort and a sense of hope. Field notes revealed how family members also facilitated the use of traditional remedies alongside orthodox treatment. For instance:

Jack's wife Akosua, regularly administered herbal medicine to him, usually between 7:00 and 8:00 in the morning. When asked about the treatment, she confirmed that it was herbal and explained that although Jack had been taken to the hospital for care, they had not observed much improvement. Consequently, the family decided to consult a herbalist, who provided large quantities of medicine—approximately four gallons. Akosua further explained that the decision to seek alternative treatment was influenced by a neighbour's recommendation.

The dual approach to treatment was not without its challenges, as several individuals with chronic conditions and caregivers mentioned the tension between traditional beliefs and modern medical advice. One caregiver remarked, "I don't always know what to believe—sometimes the herbal treatment seems to help, and other times the doctor's advice makes more sense." [CG, Adorkor, 43yrs, Stroke, Hypertension/Diabetes, Jamestown]

This coexistence of treatment sources highlights the complex decision-making processes of individuals with chronic conditions and caregivers in managing their chronic conditions, driven by both cultural beliefs and practical needs.

Caregiving dynamics

Caregiving dynamics were integral to the experiences of both individuals with chronic conditions and their caregivers. The role of caregivers, often family members, was described as vital in managing the day-to-day challenges of chronic illness. The role of the family was frequently discussed in terms of its significance in providing both direct care and emotional

support. Participants frequently emphasized the emotional and physical labour involved in caregiving.

Jack described how his family members bear the emotional, psychological, and physical stress of caring for him. They attend to his daily needs, assist with his medical care, manage financial responsibilities, and provide emotional support. Reflecting on his past, Jack admitted that he had not invested in building strong family relationships. He shared that he had spent much of his life prioritising drinking, socialising with friends, and womanising, rather than nurturing his children. Paradoxically, these same children are now the ones carrying the burden of his care. Jack expressed deep appreciation to his family for their support, while also conveying a sense of guilt for his past neglect. [ICC, Jack, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer].

Many caregivers expressed feelings of duty and responsibility, although some reported feeling overwhelmed by the demands placed on them. As noted by some caregivers:

“She was overweight and not active; she often lay down just after eating and always sent people to do stuff for her. This put a burden on us.” [CG, Korkor, 30yrs, Diabetes, Hypertension, Jamestown]

“I got a little worried because she normally comes to my place for a chat, but all of a sudden, she got sick, and things changed. Now, I would have to come every morning to take care of her, and even if I’m tired, I still have to come.” [CG, Adorkor, 43yrs, Stroke, Hypertension/Diabetes, Jamestown]

“As I am sitting now, I’m supposed to have bathed and fed him by now. He can’t go and get food by himself; I have to get him food and dress him. If he can do all these things by himself, there

won't be much burden on me. I can go and run some errands.” [CG, Esaaba, 40yrs, Stroke, Ussher Town]

The sharing of caregiving responsibilities was an important theme, with extended family members and neighbours contributing to the overall support system. A participant noted, “We all take turns in caring for her. The community helps too—sometimes people bring food, or just visit to keep her company.” This shared responsibility highlighted the communal living that underpins caregiving in chronic illness, emphasizing collective care rather than solely individual burdening

Management of body image

The management of body image emerged as another significant theme in the care experiences. As already highlighted, the majority of the individuals with chronic conditions experience both visible and invisible changes to their bodies because of their chronic conditions. These groups of individuals with chronic conditions discussed the psychological effects of body changes, including alterations in appearance due to surgery, weight changes, or mobility issues. One ICC remarked, “Since I lost my leg, it's been hard to look at myself in the mirror. It feels like I am no longer who I was.” [ICC, Mia, 78yrs, Diabetes, Hypertension, Jamestown]. The visible changes often led to a sense of identity disruption, with participants expressing feelings of loss, shame, and sometimes social withdrawal.

Body image adjustment was a central coping mechanism, and many individuals with chronic conditions worked to redefine their sense of self, considering their new physical realities. A participant noted, “I try not to focus too much on the scars. I've learned to accept them as part of me now.” [ICC, Brenda, 35yrs, Breast Cancer, Legon]. The management of visible and invisible changes, such as chronic pain or fatigue, was another important consideration. Invisible changes

were often more difficult to communicate to others, leading to a sense of isolation. One ICC said, “People can’t see my pain, so they don’t understand why I can’t do certain things.” [ICC, Jeremy, 25yrs, Sickle cell disease, Legon]. This theme highlights the complex psychological and emotional work that individuals with chronic conditions engage in to manage both visible and invisible body changes, which significantly impact their self-image and social interactions.

Psychological impact

Psychological impact was profound in the care experiences of individuals with chronic conditions and their caregivers. This is because, as has been highlighted earlier, chronic illness often brings about emotional distress, identity changes, and existential reflection. Emotional distress was commonly reported, with feelings of regret, fear, and uncertainty about the future. One participant shared, “Sometimes, I regret not taking better care of myself when I was younger. Now, it’s too late, and I fear the pain I might experience.” [ICC, Owen, 66yrs, Hypertension, Stroke, Jamestown].

The fear of disease progression, as well as the potential loss of independence, were sources of significant anxiety. Several participants spoke of grieving for the life they had before the onset of illness. One participant stated, “I miss the freedom I had before I became sick. Now, everything is different.” [ICC, Mia, 78yrs, Diabetes, Hypertension, Jamestown]. Identity changes were a major experience, as some of the patients often felt that their illness had altered how they viewed themselves and how they were perceived by others. One caregiver explained, “He used to be so active, but now he is mostly in bed, and I see him as a different person, [CG, Esaaba, 40yrs, Stroke, Ussher Town].

Existential reflection, or a re-evaluation of life's meaning and purpose, was also common. Some individuals with chronic conditions found solace in religious or philosophical reflection, while others struggled to find meaning in their suffering. A participant shared, "I think about life more now—I wonder if this is what I'm meant to experience, or if there's something I'm supposed to learn." [ICC, Mia, 78yrs, Diabetes, Hypertension, Jamestown]. These psychological realities highlight the deep emotional and cognitive processes that individuals with chronic conditions undergo in navigating their chronic illness journeys, influencing their overall care experiences.

7.4 Care Improvement

This section delves into the ways in which care for chronic conditions can be improved. The themes that emerged are accessibility of treatment, the quality of care received, the need for culturally sensitive care, the importance of education and awareness, and the systemic changes required for more effective chronic illness management. These themes are discussed below.

Accessibility of treatment

One of the most significant barriers to care improvement highlighted by the data was the issue of accessibility. Many individuals with chronic conditions and their caregivers reported encountering financial challenges when seeking treatment. The high cost of medical consultations, medications, and transportation to healthcare facilities was consistently cited as a barrier to consistent care. A caregiver shared, "The cost of getting treatment is too much for us. Sometimes, I have to choose between buying medicine and buying food for my family." [ICC, Owen, 66yrs, Hypertension, Stroke, Jamestown].

Transportation issues also played a key role in limiting access to healthcare. Some individuals with chronic conditions and caregivers, in particular, struggled with the high cost of

transportation and long traffic to healthcare facilities. Transportation to access care is therefore both time-consuming and expensive. One participant said, “I live far from the hospital, and the buses don’t always run on time. Sometimes, I miss my appointments because I can’t afford to travel.” [ICC, Joana, 65yrs, Stroke, Ussher Town].

The cost of treatment and medication was a recurring theme, with many individuals with chronic conditions reporting that they could not afford long-term care. One participant shared, “I wish I could afford to buy all my medications, but I can’t. So, I stop taking them when I run out of money.” [ICC, Owen, 66yrs, Hypertension, Stroke, Jamestown]. These barriers highlight the need for more accessible and affordable healthcare options for chronic illness management.

Quality of Care

Participants indicated that the quality of care they received varied significantly, with timeliness and resource adequacy being key determinants of care satisfaction. Many individuals with chronic conditions and caregivers expressed frustration with long waiting times at healthcare facilities. One ICC described, “I waited for hours before I could see a doctor, and by the time I got in, I was too tired to even explain my problems properly.” [ICC, Evans, 41yrs, Asthma, Legon].

The availability of medical resources, such as medications and medical staff, also played a role in the quality of care. When resources were insufficient, patients often felt neglected or dissatisfied. A participant noted, “The health workers are good, but sometimes they don’t have the medicine I need. It makes me feel like I’m not getting the best care.” [ICC, Brenda, 35yrs, Breast cancer, Legon]. On the other hand, individuals with chronic conditions who received timely, resource-rich care were more likely to report higher satisfaction levels. The satisfaction

with healthcare professionals was also tied to the perceived competence and empathy of doctors, nurses, and support staff. Many individuals with chronic conditions appreciated healthcare professionals who took the time to explain treatments, listen to concerns, and offer personalised advice. “The doctor really listens to me. It makes a huge difference in my treatment”, shared one participant. [ICC, Aurora, 44yrs, Breast Cancer, Legon]. The findings suggest that improving both the timeliness and adequacy of resources, as well as the interpersonal quality of healthcare, is essential for enhancing the overall care experience for individuals with chronic conditions.

Cultural Sensitivity of Care

The integration of traditional and orthodox medicine emerged as a key factor in improving care. Many individuals with chronic conditions and caregivers reported that care would be more effective if healthcare providers respected and incorporated traditional healing practices alongside modern medical treatments. One ICC shared, “I go to the hospital for my regular check-ups, but I also use herbal medicine to help with my pain. It works for me.” [ICC, Jack, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer, Jamestown]. The participants noted that respect for cultural beliefs could foster a stronger therapeutic alliance between healthcare providers and individuals with chronic conditions, improving compliance and satisfaction. A caregiver explained, “If they respect our traditions, I think we’ll trust them more, and the treatment will be more effective.” [ICC, Jack, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer, Jamestown].

However, there were also concerns about the potential conflict between traditional and orthodox medicine, particularly when healthcare professionals dismissed or were sceptical of traditional healing methods. One participant remarked, “Some doctors don’t take traditional medicine

seriously, and that makes it harder for us to trust them.” [ICC, Jack, 65yrs, Diabetes, Hypertension, Stroke, Prostate Cancer, Jamestown]. The findings indicate that culturally sensitive care, which includes the integration of traditional practices and respect for cultural beliefs, is essential for improving health outcomes for individuals with chronic conditions, particularly in communities where such practices hold significant value.

Health Education and Awareness

Health literacy and public health education were identified as important components of improving chronic illness care. Some individuals with chronic conditions and their caregivers often expressed the need for more information on how to manage chronic conditions effectively. Many participants felt that a lack of understanding about their illness or treatment options hindered their ability to make informed decisions. One ICC stated, “I don’t fully understand how my condition works, and sometimes the doctor does not explain things in a way I can understand.” [ICC, Mia, 78yrs, Diabetes, Hypertension, Jamestown].

“The need for better informational resources was echoed by caregivers, who expressed frustration over the limited access to educational materials about chronic illness management. A caregiver shared, “We need more pamphlets or videos on what to do when the illness gets worse. We feel like we are on our own.” [CG, Kweku, Breast Cancer, Legon, 40yrs]

Empowering individuals with chronic conditions and caregivers with accurate and easily understandable health information is crucial for improving self-management and treatment adherence.

This suggests that public health campaigns and targeted education programs could play a key role in enhancing health literacy. Additionally, providing platforms for patient education, including workshops and community-based informational sessions, could help foster a more informed and proactive approach to chronic illness care.

Systemic Healthcare Improvements

Systemic healthcare improvements were viewed as essential for ensuring that chronic illness care is accessible, affordable, and effective. Participants identified the need for policy changes, particularly around the cost of treatment and the availability of healthcare services. One ICC commented, “Healthcare should not be too expensive. Everyone should have access to good treatment, no matter how much money they make.” [ICC, Brenda, Breast cancer, Legon, 35yrs]. Another ICC also indicated, “If there will be a system in place that will ensure we start paying for our health insurance at an early stage in life, it will be better because not everyone can afford quality health when they grow.” [ICC, Aurora, 44 yrs, Breast Cancer, Legon]. Affordable healthcare, including subsidised treatment and medication, as well as coverage by health insurance, were mentioned as key recommendations for improving care. Additionally, the integration of mental health services into chronic illness care was highlighted as an area requiring attention. A good number of individuals with chronic conditions struggled with managing the psychological impact of chronic illness, and they believed that psychological services should be an integral part of their care. A healthcare professional noted, “Chronic illness affects more than just the body. We need to pay attention to the mental health of our patients, too.” [HCP-5, 37yrs, Clinical Psychologist, Legon]. Another participant also said, “I have benefited from the help of the psychologist and will advocate for more psychologists to be at the

hospital to assist people deal with difficult situations.” [ICC, Aurora, 44yrs, Breast Cancer, Legon]. Finally, healthcare system reforms, including the improvement of healthcare infrastructure and the training of healthcare workers in chronic illness management, was considered essential for long-term improvements. The need for a more robust healthcare system that addresses both the physical and psychological aspects of chronic illness was a common theme across the data.

7.5 Discussion

7.5.1 Care needs

The findings from this study highlight the multifaceted nature of care needs for individuals living with chronic conditions, showing the importance of addressing physical, psychological, social, and spiritual dimensions in their care regimen. These dimensions are intricately interconnected and reflect the complex, holistic needs that individuals with chronic conditions face in managing their conditions. The physical care needs, such as medication adherence, hospital visits, surgeries, and rehabilitation, are central to the management of chronic illnesses. However, the psychological and emotional care needs are equally critical, as many patients experience emotional distress, fear, and anxiety related to the long-term nature of their conditions. These emotional struggles often require counselling, coping strategies, and consistent emotional support, suggesting a need for mental health integration in chronic illness care. Social care needs further complicate the care landscape, as patients often rely on family members and caregivers for support. The role of caregivers is vital, but it is also challenging, as many caregivers face their own emotional and physical burdens in supporting care recipients. This highlights the necessity of providing caregiver support, as well as the importance of fostering

community involvement to reduce social isolation. The presence of a robust social support network can significantly alleviate some of the emotional and physical strains that accompany chronic illness, as well as caregiving.

Spiritual care also emerged as an essential component of care, with many participants drawing on religious practices, prayers, and spiritual healing as a means of coping with their illness. This dimension speaks to the deeply ingrained cultural values in many communities, where faith-based practices play a role in health and healing. Integrating spiritual care into treatment plans could therefore improve the holistic well-being of patients, particularly in communities where spirituality is central to individuals' lives.

The findings from this section align with existing research that emphasize the need for a comprehensive approach to chronic illness care—one that does not solely focus on physical health but also addresses the psychological, social, and spiritual needs of patients (Jung & Chin, 2015; Samraj et al., 2020).

Furthermore, the complex interplay between these care needs points to the necessity of multi-disciplinary care teams that can offer tailored interventions to meet the diverse needs. This approach could enhance both the quality of life and the effectiveness of treatment for chronic conditions. This will ensure that care is not just focused on managing the illness but also on improving overall well-being. Addressing these care needs within a culturally sensitive framework is also crucial, as cultural beliefs significantly influence how care needs are perceived and met (Aziato & Clegg-Lampsey, 2015; Salifu et al., 2021; Van Wilder et al., 2021). The findings suggest that health systems should take a more integrated and patient-centred approach to care, to ensure that all aspects of an individual's life are considered in the management of chronic conditions.

7.5.2 Care experiences

The care experiences of individuals with chronic conditions and their caregivers are deeply influenced by a combination of treatment choices, caregiving dynamics, body image management, and psychological challenges, each contributing to the overall impact of living with chronic illness. The plurality of treatment sources, ranging from orthodox medicine to traditional healing practice, reflects a desire to find the most effective combination of solutions for managing their conditions. The plurality of care approach highlights the need for a more integrative model of healthcare that can combine the strengths of both conventional and alternative practices. This will ensure that individuals with chronic conditions are supported in a way that aligns with their cultural and personal preferences (Asante & Avornyo, 2013). The blending of treatment methods also illustrates the adaptability of patients as they navigate the complex terrain of chronic illness, often seeking a sense of control and empowerment over their healthcare decisions.

Equally significant are the caregiving dynamics, which play a pivotal role in shaping the daily experiences of individuals with chronic conditions. The involvement of family members, caregivers, and the community in providing physical, instrumental and emotional support is essential for patients' well-being. Nonetheless, it also introduces challenges. The role of caregivers, often as primary supporters, can lead to shared responsibility, but also to potential caregiver burnout (Liu et al., 2020). The psychological and emotional toll of caregiving on family carers and the patients themselves is profound, with many caregivers expressing a sense of stress and fatigue due to the demands of managing both the illness and its emotional impact. This highlights the importance of providing support not only for patients but also for their

caregivers, ensuring that they have the resources and coping mechanisms to handle their responsibilities.

Another significant theme in care experiences is the management of body image, which often becomes a source of psychosocial distress. The visible changes associated with chronic illnesses—such as weight fluctuations, scars, and physical limitations—can disrupt a person's sense of identity and self-worth. Many patients struggle with the psychological effects of these changes, including feelings of loss, shame, and isolation (Clarke & Griffin, 2008; Okop et al., 2016; Ribeiro et al., 2021). The adjustment to a new body image, coupled with identity disruption, requires a supportive care environment that fosters acceptance and self-compassion. The visible and invisible changes in chronic illness further complicates the experience, as patients may face difficulties in conveying the depth of their challenges to others, particularly when symptoms are not outwardly visible. This aligns with previous studies that highlight the need for healthcare professionals to address body image concerns and offer psychological support as part of a comprehensive treatment plan (Clarke & Griffin, 2008; Okop et al., 2019).

The psychological impact of chronic illness, including emotional distress, fear, and grieving, further exacerbates the care experience. Individuals with chronic conditions often confront existential questions and uncertainty about their future, grappling with the emotional weight of their condition. These psychological challenges highlight the necessity for mental health support in chronic illness management. Counselling, emotional support, and coping strategies are crucial for helping individuals with chronic conditions navigate the emotional complexities of living with a chronic condition (Holmes & Deb, 2003). Moreover, the grief associated with the loss of pre-illness identity and the fear of what the future holds may require long-term psychological care, where individuals with chronic conditions are offered a space to

process their emotions and adjust to their new reality. These care experiences of patients highlight the need for a holistic, integrated approach to chronic illness management. The complex interplay of medical, social, and emotional factors requires that healthcare systems move beyond solely addressing physical symptoms to also providing psychological support and addressing the emotional and social dimensions of care. By fostering a care environment that supports both the body and the mind, healthcare providers can improve the quality of life for individuals with chronic conditions, ensuring that they are not only treated for their physical conditions but are also supported in their emotional and psychological well-being.

7.5.3 Care Improvement

The findings highlight several areas where care for chronic conditions can be improved, particularly through enhancing accessibility, quality, and cultural sensitivity, as well as increasing education and awareness. Addressing these issues at the individual, community, and systemic levels can lead to more effective and holistic care, and ultimately improve their health outcomes and quality of life. These areas represent key factors that can significantly enhance the overall care experience for individuals with chronic conditions, and addressing them can lead to more effective, comprehensive, and culturally relevant care.

The accessibility of treatment remains a prominent challenge for many patients, particularly in low-resource settings. Financial barriers, transportation issues, and the high cost of medication are significant obstacles that prevent patients from receiving the care they need in a timely manner. This is compounded by systemic issues such as long traffic, inadequate infrastructure and insufficient healthcare coverage, which create disparities in care availability. The findings suggest that addressing these issues requires targeted effort at both the individual

and community levels. Strategies such as improving access to affordable medication and transportation services, as well as expanding healthcare coverage to individual with chronic condition(s). Healthcare policies that prioritize financial assistance, reduce out-of-pocket expenses, and support the equitable distribution of resources across urban and rural areas are essential steps toward improving accessibility and care (de-Graft Aikins et al., 2014; Hunter-Adams, 2019). Additionally, innovative solutions such as telemedicine and mobile healthcare services could help overcome geographic barriers due to long traffic, ensuring that patients, regardless of their location, have access to timely medical care.

Quality of care is another area for improvement. Patients often experience delays in treatment and dissatisfaction with the resources available. Timeliness of care is crucial, especially in managing chronic conditions, where early intervention can prevent complications and improve long-term outcomes. The findings highlight the need for healthcare professionals to deliver timely, efficient, and patient-centered care. Ensuring that healthcare providers are adequately trained, supported, and equipped with the necessary resources to deliver high-quality care is critical to improving patient satisfaction and health outcomes. Moreover, enhancing the quality of care can be achieved through the establishment of standards for care delivery that emphasize the importance of consistent, evidence-based practices in chronic illness management (de-Graft Aikins et al., 2021; Gonzaga, 2013; Ibanez-Gonzalez et al., 2014).

Cultural sensitivity is an essential component of chronic illness care that has often been overlooked in conventional medical models. Many patients turn to traditional healing practices, such as herbal treatments and spiritual healing, alongside or instead of conventional medical care, because these practices align more closely with their cultural values and provide a sense of empowerment. The findings suggest that integrating these cultural practices into formal

healthcare settings, with the collaboration of traditional healers and healthcare professionals, can bridge the gap between modern and traditional healthcare approaches. This would not only improve care outcomes but also foster trust between patients and healthcare providers, which can lead to more effective treatment and better health outcomes (Asante & Avornyo, 2013).

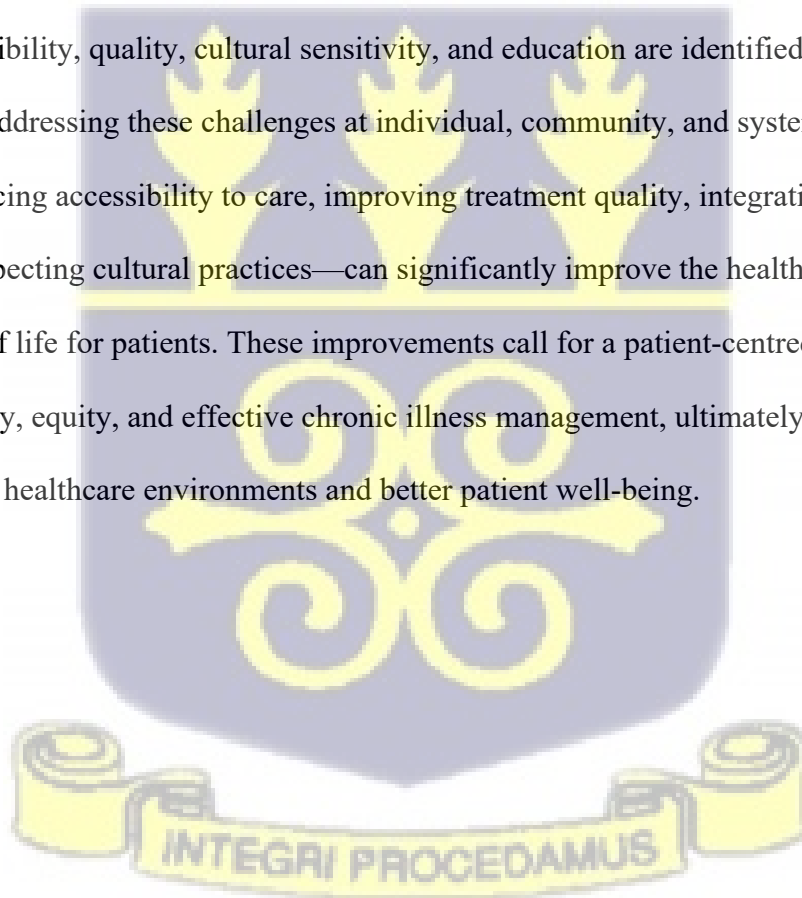
Public health education and awareness also play a critical role in improving care for individuals with chronic conditions, both for patients and healthcare providers. Health literacy is crucial for empowering patients and caregivers to make informed decisions about their treatment options and manage their conditions effectively. Providing comprehensive educational resources, both in the form of printed materials and digital platforms, can enhance patients' understanding of their conditions, treatment plans, and self-care strategies. Additionally, public health education programs aimed at raising awareness about chronic illness management and prevention are essential to promoting healthier communities. The findings indicate that patient empowerment through education can lead to improved self-management, reduced emotional distress, and enhanced quality of life for individuals with chronic conditions (de-Graft Aikins et al., 2010).

Finally, systemic healthcare improvements, including policy changes and reforms in the healthcare system, are necessary to address the challenges identified in this study. Policies that promote affordable healthcare, integrate mental health services into chronic illness care, and comprehensive healthcare reform can enhance the overall healthcare system and improve the management of chronic conditions. The findings suggest that mental health services are an often-overlooked aspect of chronic illness care, and their integration into the healthcare system is vital for addressing the psychological impacts of chronic illness (McInnes et al., 2022). As part of systemic improvements, it is also crucial to address the shortage of healthcare workers in certain

regions and provide ongoing training and support to ensure that all patients receive high-quality care.

7.6 Conclusion

This chapter has emphasized the multifaceted nature of care for individuals with chronic conditions, highlighting the physical, psychological, social, and spiritual dimensions of care needs, experiences, and improvements. The findings reveal that patients require comprehensive, holistic care that integrates medical, emotional, and social support, with caregiving dynamics and the management of body image playing crucial roles in their daily lives. Additionally, challenges related to accessibility, quality, cultural sensitivity, and education are identified as key areas for improvement. Addressing these challenges at individual, community, and systemic levels—including enhancing accessibility to care, improving treatment quality, integrating mental health support, and respecting cultural practices—can significantly improve the health outcomes and overall quality of life for patients. These improvements call for a patient-centred approach that fosters inclusivity, equity, and effective chronic illness management, ultimately contributing to more supportive healthcare environments and better patient well-being.



CHAPTER EIGHT

SYNTHESIS AND GENERAL DISCUSSION

8.1 Introduction

This final chapter provides a synthesis and general discussion of the study's findings and draws connections between the various themes explored in previous chapters. The chapter highlights the key insights into how body image, embodiment, and chronic illness intersect and influence the experiences of individuals living with chronic conditions. It also examines the implications of these findings for chronic illness care and management and proposes ways to enhance care delivery and support for individuals with chronic health challenges. Additionally, the chapter reflects on the study's contribution to the existing body of knowledge and acknowledges its limitations. Finally, it offers recommendations for future research that could further explore the complexities of chronic illness management, body image, and caregiving. This discussion focuses on how the findings from this study can inform clinical practice, policy development, and future studies in the field of chronic illness care.

8.2 Body Image, Embodiment and Chronic Illness Experiences

The experience of chronic illness is deeply interwoven with the complexities of body image and embodiment, as discussed in Chapters 4 and 5. Social representations of body image play a significant role in how individuals with chronic conditions perceive and experience their bodies. Chapter 4 highlights how cultural and societal ideals of beauty, health, and physical appearance shape people's body image and expectations of themselves. These ideals, however, often conflict with the reality of chronic illness, leading to a process of renegotiating their own body image. As chronic illness changes the body in visible and invisible ways, it disrupts the embodied self and

the social representations that underpin personal identity. This phenomenon aligns with the findings of Alexias et al. (2016) and Joachim and Acorn (2000), who emphasized that body image involves not just the perception of one's body but also its social meaning and the emotional reactions to it.

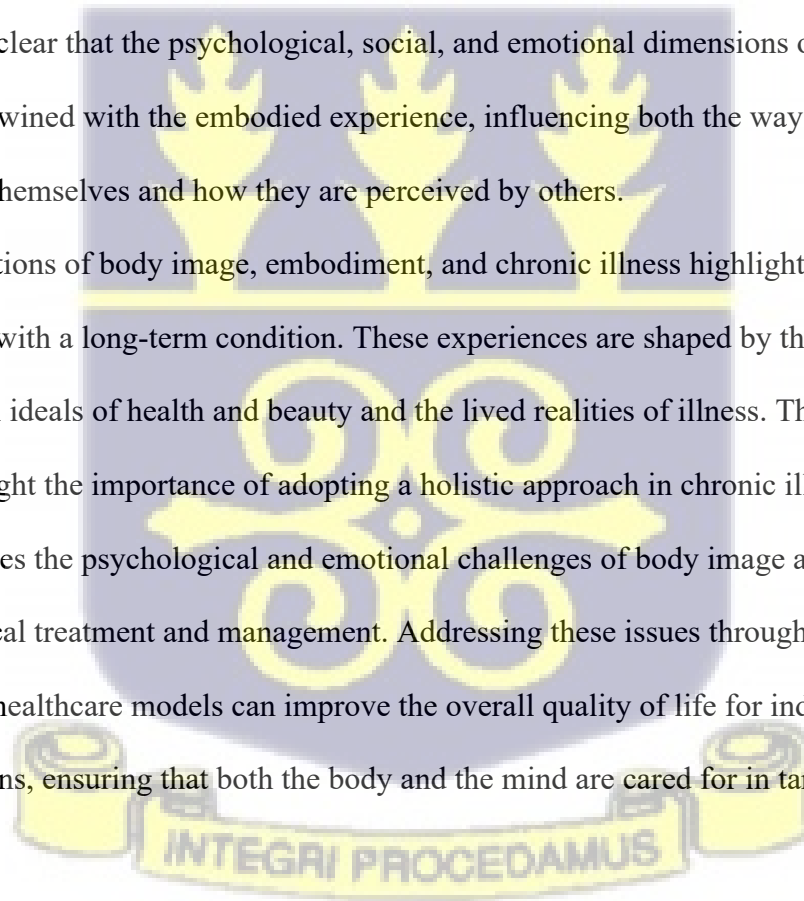
In Chapter 5, representations of body image in the context of chronic illness further deepen our understanding of how physical alterations due to illness—such as weight loss, scars, or fatigue—influence individuals' sense of self. Chronic illness challenges the normative expectations of bodily appearance and functionality, resulting in an embodied experience that is often at odds with the cultural ideal of a healthy, active body. As discussed by Grogan (2006) (2021a), the visible and invisible symptoms of chronic illness provoke a psychological dissonance or change between how individuals once experienced their bodies and how they perceive their bodies while dealing with chronic illness. The largely negative changes and accompanying perceptions often lead to emotional distress, identity confusion, and self-stigma, as the patients navigate the reality of a body that is perceived as different or deficient from societal norms.

The concept of embodiment, which refers to the lived experience of the body (Swami & Chamorro-Premuzic, 2008), further illustrates the complexity of chronic illness. Chronic illness is not only a physical condition but an embodied process that requires individuals to adapt to their altered bodies and reframe their identity considering these changes (Foster et al., 2003). This ongoing process of embodiment can lead to a sense of alienation from the body, as individuals struggle to accept changes such as the loss of physical ability, disfigurement, or exhaustion. As noted by Clarke and Griffin (2008) and de-Graft Aikins (2006), the body, in this sense, becomes a site of constant negotiation where physical health, emotional well-being, and

social interaction intersect. This embodiment of chronic illness thus extends beyond the individual experience to include the broader social context in which illness is understood and represented.

The findings from both chapters suggest that body image in chronic illness is not static but is constantly negotiated within a framework of cultural, personal, and social meanings. As individuals with chronic conditions attempt to manage their bodies, they must also confront societal judgments, expectations, and stigmas surrounding illness (de-Graft Aikins, 2006; Morrison et al., 2016). The intersection of body image and embodiment, therefore, has profound implications for how individuals with chronic conditions experience and cope with their conditions. It is clear that the psychological, social, and emotional dimensions of chronic illness are deeply intertwined with the embodied experience, influencing both the ways in which individuals see themselves and how they are perceived by others.

The intersections of body image, embodiment, and chronic illness highlight the complex nature of living with a long-term condition. These experiences are shaped by the ongoing tension between cultural ideals of health and beauty and the lived realities of illness. The findings from this study highlight the importance of adopting a holistic approach in chronic illness care, one that acknowledges the psychological and emotional challenges of body image and embodiment, alongside physical treatment and management. Addressing these issues through more inclusive and empathetic healthcare models can improve the overall quality of life for individuals with chronic conditions, ensuring that both the body and the mind are cared for in tandem.



8.3 Implications for Chronic Care and Management

The findings from Chapter 6 on body image management and chronic illness management, as well as from Chapter 7 on care needs, experiences, and improvements, highlight several critical intersections that provide valuable insights into improving chronic care and management in Ghana. These chapters demonstrate the multi-layered and multifaceted nature of care for individuals living with chronic conditions. These findings highlight the need for integrated, holistic, and culturally sensitive healthcare approaches that address not only the physical aspects of illness but also the psychological, emotional, and social dimensions of living with a chronic condition.

First, the importance of body image management in chronic illness care cannot be overstated. As revealed in Chapter 6, individuals with chronic conditions face significant challenges in managing the physical manifestations of chronic illness, which often include visible changes to their bodies such as weight fluctuations, scars, and other visible markers of disease. These physical changes can have profound psychological effects, leading to distress, identity disruption, and a diminished sense of self-worth. Therefore, chronic illness care in Ghana must prioritize body image management by providing emotional and psychological support that helps individuals cope with these changes. This could include offering counselling services, support groups, and patient education on managing both the physical and emotional impacts of body changes. Psychological support should be integrated into the routine management of chronic conditions, emphasizing the importance of mental health in the broader scope of chronic illness care (Barnett et al., 2010; de-Graft Aikins et al., 2014; Grogan, 2021a).

Moreover, as discussed in Chapter 7, care needs are diverse, encompassing physical, psychological, social, and spiritual dimensions. The intersection of these needs demands a

comprehensive care model that considers not just the physical aspects of chronic illness but also the broader emotional and social experiences. For instance, the social care needs highlighted in Chapter 7, such as the need for family support and community involvement, indicate that caregivers play a critical role in chronic illness management. Therefore, improving care in Ghana requires greater attention to caregiver education and support, recognizing their essential role in facilitating both the physical and emotional well-being of care recipients. The healthcare system in Ghana should incorporate training of caregivers, provide them with resources to better manage the daily challenges of caregiving and create community-based programs to facilitate social connections that reduce isolation.

Additionally, the integration of spiritual care is particularly relevant in the Ghanaian context, where religious and spiritual beliefs play a significant role in health and illness perceptions (Quaidoo et al., 2018). As shown in Chapter 7, spiritual care needs such as prayers, religious practices, and support from faith-based communities can provide emotional comfort and strengthen resilience in the face of chronic illness. Therefore, healthcare providers in Ghana should collaborate with religious and spiritual leaders to incorporate spiritual care into the healthcare process, ensuring that patients' spiritual well-being is attended to alongside their physical and psychological needs.

Addressing the challenges related to treatment and management, as highlighted in Chapter 6, will also require systemic changes. Barriers to effective care, including financial constraints, transportation issues, and access to medication, were recurrent themes in both Chapter 6 and Chapter 7. These systemic issues hinder the timely and efficient treatment of chronic conditions and contribute to poorer health outcomes. To improve chronic care in Ghana, policymakers must focus on enhancing accessibility to affordable healthcare, improving

infrastructure for transportation to healthcare facilities, and ensuring the availability of essential medications. Furthermore, the quality of care must be enhanced by providing adequate resources, training healthcare professionals, and improving the patient-provider relationships to ensure patient satisfaction and better treatment adherence.

Cultural sensitivity in healthcare, as discussed in Chapter 7, is another crucial component of improving chronic illness care. The blending of traditional and orthodox medicine is a common practice in Ghana, with many patients seeking treatments from both sources. This calls for a more inclusive approach to care that integrates traditional healing practices with modern medical treatments. Incorporating cultural beliefs and practices into healthcare interventions ensures that practitioners can build trust and enhance the effectiveness of treatment plans. Furthermore, public health education and patient empowerment, as emphasized in Chapter 7, are essential for improving health literacy and encouraging patients to take an active role in their treatment. This could be achieved through community health programs, educational campaigns, and accessible informational resources that help individuals understand chronic illness management and the importance of medication adherence. The findings from this study highlight the need for a holistic, culturally sensitive, and integrated approach to chronic illness care in Ghana. These changes require collaboration between healthcare professionals, caregivers, policymakers, and community members to create a more inclusive, patient-centred care environment that acknowledges and addresses the complexities of living with chronic illness.

8.4 Contribution of the Study to Knowledge

This study makes important contributions to the subfields of social and health psychology, while also offering innovative insights into chronic illness, body image, and embodiment within

the Ghanaian context. The study makes theoretical, methodological, interdisciplinary and policy contributions to the body of knowledge. Theoretically, the findings of this research contribute to the body of research that applies SRT to illness representations, experiences and care. In exploring the intersection of chronic illness and body image, the current study provides insights into how these elements are experienced and understood by individuals, caregivers, and healthcare providers. This research expands upon existing theories of body image and embodiment in chronic illness, adding a new layer of understanding through the integration of SRT and levels of explanation. As discussed in previous studies such as Clarke and Griffin (2008) and Stenzel et al. (2006), body image concerns have been explored in relation to chronic illness, but this study is unique in its synthesis of how multiple knowledge sources—scientific, cultural, religious, and personal—shape the experiences of individuals living with chronic conditions in Ghana. This study highlights the profound impact that social representations of body image and illness have on how individuals interpret their condition and negotiate their identities, care needs and experiences. This theoretical lens allows for a nuanced understanding of the complex ways in which body image is influenced by not only medical perspectives but also by cultural norms, personal experiences, and spiritual beliefs. These findings challenge traditional biomedical approaches to chronic illness management, calling for a more inclusive and culturally sensitive framework for understanding the intersection of body image, embodiment, and chronic illness.

This study also advances the fields of social and health psychology by emphasizing the importance of considering cultural, social, and personal dimensions when studying chronic illness and body image. The findings challenge conventional medical approaches by highlighting the significance of non-medical sources of knowledge, such as cultural beliefs and spiritual

perspectives, in shaping individuals' understanding and management of their illness. The research calls for healthcare providers to adopt a more holistic and culturally responsive approach to treatment, integrating biomedical, traditional, and spiritual practices. This pluralistic approach not only enhances patient adherence to medical treatment but also fosters a more inclusive healthcare environment that respects the diverse beliefs and practices of individuals living with chronic illness. As Kpobi et al. (2024) argue, this integration of traditional and modern healing practices is vital for improving healthcare outcomes in settings like Ghana, where cultural beliefs play a central role in health perceptions. Furthermore, the study sheds light on the psychological distress caused by chronic illness, particularly in relation to body image disruptions. These disruptions—whether through changes in physical appearance, mobility limitations, or societal stigma—were found to significantly affect participants' self-esteem, social interactions, and mental well-being. This finding contributes to the social psychology literature by illustrating how societal perceptions and the stigma surrounding chronic illness exacerbate psychological distress, leading to social withdrawal and isolation. The study calls for broader public health initiatives that not only address medical needs but also tackle the social and psychological aspects of living with chronic illness.

In terms of methodology, this study employs a mixed-qualitative methods approach, specifically through the triangulation of in-depth individual interviews, dyadic interviews, focus group discussions and ethnographic observation. This methodological pluralism, informed by qualitative research literature (Fusch et al., 2018; Poth & Shannon-Baker, 2022) enabled the researcher to capture the complexity of lived experiences from multiple perspectives—individuals living with chronic illness, caregivers, and healthcare providers. The integration of these diverse data sources enhances the richness of the findings and strengthens the value of the

study. The use of ethnographic observation, in particular, allowed for a deeper understanding of participants' experiences in real-world settings. For example, observing a participant's limited mobility during a home visit provided a vivid and tangible illustration of how chronic illness physically, environmentally and socially impacts the individual's life. The triangulation of methods also ensured that the themes of stigmatisation and body image disruptions were consistently observed across various data collection methods, thus adding robustness to the study's conclusions.

Finally, from a policy-practice perspective, the study offers valuable implications for chronic illness management in Ghana and other similar contexts. The multilevel framework proposed in the findings—addressing intrapersonal, interpersonal, community/social, and structural factors—provides a comprehensive approach to improving care for persons battling chronic illness. This holistic approach is essential for designing public health strategies and interventions that address the diverse and intersecting needs of individuals living with chronic conditions. The study's findings advocate for healthcare systems that integrate mental health support, social care, and spiritual care alongside conventional medical treatment, ensuring that all aspects of an individual's well-being are addressed.

8.5 Limitations of the Study

This study employed a qualitative research approach to explore the lived experiences of individuals, caregivers, and healthcare providers in relation to chronic illness, body image, and embodiment. While qualitative methods excel at providing rich, contextualized insights, they also have inherent limitations that influence the scope and depth of findings. One limitation of

the study is that it did not reach full meaning saturation on certain core themes. This was partly due to constraints related to the study timeline.

Another limitation involves the ethnographic component. Observations were limited to times when participants were available, which may have constrained opportunities to capture the full spectrum of their everyday behaviours and interactions. While these visits provided valuable insights, they were not conducted at different times of day or during spontaneous, unplanned moments. This reduced the opportunity to observe dynamic aspects of participants' lives, including how they navigate healthcare-seeking behaviours or respond to environmental challenges in real-time. For instance, there was a lack of shadowing participants during healthcare-seeking processes. Following participants as they sought healthcare could have added a critical dimension to understanding the interplay between chronic illness, body image, and institutional care practices, providing insights into systemic barriers or facilitators encountered in real-world healthcare settings. Despite these limitations, the study successfully provides nuanced and contextually grounded insights into the complex interplay of chronic illness, body image, and embodiment.

8.6 Recommendations for Future Research

The following recommendations are proposed to guide future research on chronic illness, body image, and embodiment. First, future research should collaborate with participants to co-create a schedule of structured ethnographic visits. These visits should span various timepoints—such as mornings, afternoons, and evenings—across multiple days to capture the temporal variations in participants' experiences. This approach would allow researchers to observe how

participants navigate body image concerns, their sense of embodiment, and the challenges of living with chronic illness at different moments of the day. For example, participants may experience heightened body image distress in the morning when preparing for the day or during social interactions in the afternoon. This can provide deeper insights into how chronic illness intersects with perceptions of the self and body across time periods of the day.

Second, future research should incorporate shadowing participants during healthcare-seeking activities in the structured scheduled visits. These activities—such as attending medical appointments, visiting pharmacies, or consulting with traditional healers—offer a unique window into how individuals navigate the healthcare system while grappling with perceptions of their body and illness. Shadowing allows researchers to observe firsthand the barriers and facilitators encountered in these settings, such as stigma from healthcare providers or supportive interactions that affirm participants' sense of worth. These real-time observations are critical to understanding how participants' healthcare experiences influence their body image and broader sense of embodiment. For example, how a participant interprets a provider's response to their condition can shape their self-perception, either reinforcing or challenging internalized stigma associated with their illness. Additionally, shadowing can illuminate the strategies participants use to advocate for themselves within the healthcare system, which can offer insights into how chronic illness shapes their identity and body image in institutional contexts. For example, participants may modify their appearance, language, or behaviours to mitigate stigma or elicit empathy from providers. These findings can provide a more nuanced understanding of the relational and institutional dynamics that influence body image and embodiment in the context of chronic illness.

8.7 Conclusion

This study explores the intersection of chronic illness, body image, and embodiment through the lens of SRT. First, the study provides insights into the social representations of body image, revealing how societal norms, media portrayals, and personal experiences collectively shape individuals' perceptions of their bodies. Second, the study outlines how chronic illness alters these representations, demonstrating that body image disruptions, including changes in physical appearance and function, can lead to psychological distress. These disruptions are not only a source of distress for individuals with chronic illness, but also for their caregivers.

The study's findings also illuminate the care needs and experiences of individuals living with chronic illness. Participants emphasized the importance of addressing body image concerns as part of comprehensive chronic care management. This study highlights the necessity of integrating cultural, spiritual, and biomedical knowledge systems into healthcare practices to foster more effective and personalized care.

This research significantly contributes to the theoretical understanding of chronic illness and body image by applying a social representation framework in the Ghanaian context, building on previous studies on chronic illness representations and experiences. The use of a mixed-methods approach, including in-depth interviews, dyadic interviews, and ethnographic observation, provides a rich and nuanced account of how individuals navigate chronic illness in their social environments. Furthermore, the study contributes to health psychology and social psychology by highlighting the role of social stigma, cultural norms, and personal beliefs in shaping chronic illness experiences and body image. The findings of this study emphasize the need for holistic, culturally sensitive interventions that address not only the physical aspects of chronic illness but also the psychological, social, and cultural dimensions. Moving forward, it is

crucial to expand research on the diverse factors influencing body image in chronic illness and explore the ways in which healthcare systems can integrate these insights to improve care and support for individuals with chronic conditions. The study contributes to a deeper understanding of how these factors influence individuals' experiences and management of chronic conditions.

References

- Adam, A., & Koranteng, F. (2020). Availability, accessibility, and impact of social support on breast cancer treatment among breast cancer patients in Kumasi, Ghana: A qualitative study. *PLoS ONE*, 15(4), 1–15. <https://doi.org/10.1371/journal.pone.0231691>
- Adams, J., Hollenberg, D., Lui, C. W., & Broom, A. (2009). Contextualizing Integration: A Critical Social Science Approach to Integrative Health Care. *Journal of Manipulative and Physiological Therapeutics*, 32(9), 792–798. <https://doi.org/10.1016/j.jmpt.2009.10.006>
- Adams, W. C. (2015). Conducting Semi-Structured Interviews. *Handbook of Practical Program Evaluation: Fourth Edition, August*, 492–505. <https://doi.org/10.1002/9781119171386.ch19>
- Addo, I. Y., Brener, L., Asante, A. D., & de Wit, J. (2021). Socio-cultural beliefs about an ideal body size and implications for risk of excess weight gain after immigration: a study of Australian residents of sub-Saharan African ancestry. *Ethnicity and Health*, 26(8), 1209–1224. <https://doi.org/10.1080/13557858.2019.1607261>

- Agyei-Mensah, S., & De-Graft Aikins, A. (2010). Epidemiological transition and the double burden of disease in Accra, Ghana. *Journal of Urban Health*, 87(5), 879–897. <https://doi.org/10.1007/s11524-010-9492-y>
- Agyei, F., de-Graft Aikins, A., Osei-Tutu, A., & Annor, F. (2024). Creating communities that care: social representation of mental health in two urban poor communities in Ghana. *Discover Mental Health*, 4(1). <https://doi.org/10.1007/s44192-024-00089-y>
- Agyemang, C., Meeks, K., Beune, E., Owusu-Dabo, E., Mockenhaupt, F. P., Addo, J., de Graft Aikins, A., Bahendeka, S., Danquah, I., Schulze, M. B., Spranger, J., Burr, T., Agyei-Baffour, P., Amoah, S. K., Galbete, C., Henneman, P., Klipstein-Grobusch, K., Nicolaou, M., Adeyemo, A., ... Stronks, K. (2016). Obesity and type 2 diabetes in sub-Saharan Africans - Is the burden in today's Africa similar to African migrants in Europe? The RODAM study. *BMC Medicine*, 14(1), 1–12. <https://doi.org/10.1186/s12916-016-0709-0>
- Agyemang, C., Owusu-Dabo, E., De Jonge, A., Martins, D., Ogedegbe, G., & Stronks, K. (2009). Overweight and obesity among Ghanaian residents in the Netherlands: How do they weigh against their urban and rural counterparts in Ghana? *Public Health Nutrition*, 12(7), 909–916. <https://doi.org/10.1017/S1368980008003510>
- Akinyede, A., Olusanya, A., Mohammed, H., Fasipe, O., & Arikawe, A. (2022). A comparative cross-sectional study investigating prevalence and patterns of sexual dysfunction among hypertensive and non-hypertensive men. *Istanbul Journal of Pharmacy*, 52(3), 324–331. <https://doi.org/10.26650/istanbuljpharm.2022.975375>
- Akuoko, C. P., Chambers, S., & Yates, P. (2022). Healthcare providers' perspectives of the supportive care needs of women with advanced breast cancer in Ghana. *BMC Women's Health*, 22(1). <https://doi.org/10.1186/s12905-022-01931-7>

- Alexias, G., Savvakis, M., & Stratopoulou, I. (2016). Embodiment and biographical disruption in people living with HIV/AIDS (PLWHA). *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 28(5), 585–590. <https://doi.org/10.1080/09540121.2015.1119782>
- Amoah, P. A., & Phillips, D. R. (2018). Health literacy and health: rethinking the strategies for universal health coverage in Ghana. *Public Health*, 159, 40–49. <https://doi.org/10.1016/j.puhe.2018.03.002>
- Anand, R. R. (2024). Healthcare and Disease Burden in Africa: The Impact of Socioeconomic Factors on Public Health, by Ilha Niohuru. In *Africa Review* (Vol. 16, Issue 3). <https://doi.org/10.1163/09744061-bja10153>
- Arday, M., De-Gaulle, V. F., Agyabeng, K., & Aryeetey, R. (2019). “I Did Not Choose to Be Obese”—Experiences of Stigma among Market Women in Kaneshie, Ghana. *OALib*, 07(05), 1–13. <https://doi.org/10.4236/oalib.1106281>
- Aryeetey, R. N. O. (2016). Perceptions and Experiences of Overweight among Women in the Ga East District, Ghana. *Frontiers in Nutrition*, 3(June), 1–8. <https://doi.org/10.3389/fnut.2016.00013>
- Asante, E., & Avornyo, R. (2013). Enhancing Healthcare System in Ghana through Integration of Traditional Medicine. *Journal of Sociological Research*, 4(2), 256. <https://doi.org/10.5296/jsr.v4i2.4224>
- Atkinson, P., & Pugsley, L. (2005). Making sense of ethnography and medical education. *Medical Education*, 39(2), 228–234. <https://doi.org/10.1111/j.1365-2929.2004.02070.x>
- Attinger, C. E., & Brown, B. J. (2012). Physical Exercise as therapy for type II diabetes. *Diabetes/Metabolism Research and Reviews*, 28(suppl 1), 93–96. <https://doi.org/10.1002/dmrr.2236>

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research.

Qualitative Research, 1(3), 385–405. <https://doi.org/10.1177/146879410100100307>

Awotidebe, A. W., Inglis-Jassiem, G., & Young, T. (2019). Does low-level laser therapy provide additional benefits to exercise in patients with shoulder musculoskeletal disorders? A meta-analysis of randomised controlled trials. *Ortopedia Traumatologia Rehabilitacja*, 21(6), 407–420. <https://doi.org/10.5604/01.3001.0013.7398>

Awuah, R. B., Anarfi, J. K., Agyemang, C., Ogedegbe, G., & De-Graft Aikins, A. (2014).

Prevalence, awareness, treatment and control of hypertension in urban poor communities in Accra, Ghana. *Journal of Hypertension*, 32(6), 1203–1210.

<https://doi.org/10.1097/HJH.0000000000000165>

Awuah, R. B., de-Graft Aikins, A., Dodoo, F. N. A., Meeks, K. A. C., Beune, E. J. A. J.,

Klipstein-Grobusch, K., Addo, J., Smeeth, L., Bahendeka, S. K., & Agyemang, C. (2019).

Psychosocial factors and hypertension prevalence among Ghanaians in Ghana and Ghanaian migrants in Europe: The RODAM study. *Health Psychology Open*, 6(2).

<https://doi.org/10.1177/2055102919885752>

Aziato, L., & Clegg-Lamptey, J. N. A. (2015). Breast Cancer Diagnosis and Factors Influencing Treatment Decisions in Ghana. *Health Care for Women International*, 36(5), 543–557.

<https://doi.org/10.1080/07399332.2014.911299>

Balis, L. E., Sowatey, G., Ansong-Gyimah, K., Ofori, E., & Harden, S. M. (2019). Older

Ghanaian adults' perceptions of physical activity: An exploratory, mixed methods study.

BMC Geriatrics, 19(1), 1–16. <https://doi.org/10.1186/s12877-019-1095-1>

Barber, D., & Williams, J. L. (2021). Invisible Chronic Illness in Female College Students.

Journal of Postsecondary Education and Disability, 34(4), 311–330.

- Barnett, A. H., Cradock, S., Fisher, M., Hall, G., Hughes, E., & Middleton, A. (2010). Key considerations around the risks and consequences of hypoglycaemia in people with type 2 diabetes. *International Journal of Clinical Practice*, 64(8), 1121–1129.
<https://doi.org/10.1111/j.1742-1241.2009.02332.x>
- Basson, R., & Gilks, T. (2018). Women's sexual dysfunction associated with psychiatric disorders and their treatment. *Women's Health*, 14.
<https://doi.org/10.1177/1745506518762664>
- Bauer, M. W. (2006). Book Review: Everyday Discourse and Common Sense: The Theory of Social Representations. *Public Understanding of Science*, 15(3), 377–378.
<https://doi.org/10.1177/0963662506067629>
- Begovic-Juhant, A., Chmielewski, A., Iwuagwu, S., & Chapman, L. A. (2012). Impact of body image on depression and quality of life among women with breast cancer. *Journal of Psychosocial Oncology*, 30(4), 446–460. <https://doi.org/10.1080/07347332.2012.684856>
- Borowiec, J., Król-Zielińska, M., & Kantanista, A. (2023). Cross-cultural adaptation of the Contextual Body Image Questionnaire for Athletes for young physically active Polish adults. *Annals of Agricultural and Environmental Medicine*, 30(3), 543–548.
<https://doi.org/10.26444/aaem/162686>
- Bosire, E. N., Mendenhall, E., & Weaver, L. J. (2020). Comorbid Suffering: Breast Cancer Survivors in South Africa. *Qualitative Health Research*, 30(6), 917–926.
<https://doi.org/10.1177/1049732320911365>
- Bowie, J., Brunckhorst, O., Stewart, R., Dasgupta, P., & Ahmed, K. (2022). Body image, self-esteem, and sense of masculinity in patients with prostate cancer: a qualitative meta-synthesis. *Journal of Cancer Survivorship*, 16(1), 95–110. <https://doi.org/10.1007/s11764->

021-01007-9

Broom, A., Kenny, K., Page, A., Cort, N., Lipp, E. S., Tan, A. C., Ashley, D. M., Walsh, K. M., & Khasraw, M. (2020). The paradoxical effects of COVID-19 on cancer care: Current context and potential lasting impacts. *Clinical Cancer Research*, 26(22), 5809–5813.

<https://doi.org/10.1158/1078-0432.CCR-20-2989>

Bruce, A., Beuthin, R., Sheilds, L., Molzahn, A., & Schick-Makaroff, K. (2020). Holding Secrets While Living With Life-Threatening Illness: Normalizing Patients' Decisions to Reveal or Conceal. *Qualitative Health Research*, 30(5), 655–665.

<https://doi.org/10.1177/1049732319887714>

Brunet, J., Price, J., & Harris, C. (2022). Body image in women diagnosed with breast cancer: A grounded theory study. *Body Image*, 41, 417–431.

<https://doi.org/10.1016/j.bodyim.2022.04.012>

Burr, V. (2015). Social Constructionism. In *International Encyclopedia of the Social & Behavioral Sciences: Second Edition* (Second Edi, Vol. 22). Elsevier.

<https://doi.org/10.1016/B978-0-08-097086-8.24049-X>

Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health & Illness*, 4(2), 167–182. <https://doi.org/10.1111/1467-9566.ep11339939>

Cash, T. F. (2004). Body image: Past, present, and future. *Body Image*, 1(1), 1–5.

[https://doi.org/10.1016/S1740-1445\(03\)00011-1](https://doi.org/10.1016/S1740-1445(03)00011-1)

Cash, T. F. (2005). The influence of sociocultural factors on body image: Searching for constructs. *Clinical Psychology: Science and Practice*, 12(4), 438–442.

<https://doi.org/10.1093/clipsy/bpi055>

Cash, T. F., & Deagle, E. A. (1997). The nature and extent of body-image disturbances in

- anorexia nervosa and bulimia nervosa: A meta-analysis. *International Journal of Eating Disorders*, 22(2), 107–126. [https://doi.org/10.1002/\(SICI\)1098-108X\(199709\)22:2<107::AID-EAT1>3.0.CO;2-J](https://doi.org/10.1002/(SICI)1098-108X(199709)22:2<107::AID-EAT1>3.0.CO;2-J)
- Cassin, S. E., & Friedman, A. (2017). Psychiatric Care in Severe Obesity. *Psychiatric Care in Severe Obesity*, 93–105. <https://doi.org/10.1007/978-3-319-42536-8>
- Chang, H., Hawley, N. L., Kalyesubula, R., Siddharthan, T., Checkley, W., Knauf, F., & Rabin, T. L. (2019). Challenges to hypertension and diabetes management in rural Uganda: A qualitative study with patients, village health team members, and health care professionals. *International Journal for Equity in Health*, 18(1), 1–14. <https://doi.org/10.1186/s12939-019-0934-1>
- Charmaz, K. (1995). THE BODY, IDENTITY, AND SELF: Adapting To Impairment. *Sociological Quarterly*, 36(4), 657–680. <https://doi.org/10.1111/j.1533-8525.1995.tb00459.x>
- Charmaz, K. (2006). Constructing grounded theory. A practical guide through qualitative analysis. In *Expanding Approaches to Thematic Analysis*. SAGE Publications Ltd. <https://doi.org/10.4324/9781003389149-4>
- Charmaz, K. (2017). The Power of Constructivist Grounded Theory for Critical Inquiry. *Qualitative Inquiry*, 23(1), 34–45. <https://doi.org/10.1177/1077800416657105>
- Charmaz, K. (2020). Experiencing Stigma and Exclusion: The Influence of Neoliberal Perspectives, Practices, and Policies on Living with Chronic Illness and Disability. *Symbolic Interaction*, 43(1), 21–45. <https://doi.org/10.1002/symb.432>
- Charmaz, K., & Rosenfeld, D. (2016). Reflections of the body, images of self: Visibility and invisibility in chronic illness and disability. In D. Waskul & P. Vannini (Eds.),

Body/Embodiment: Symbolic Interaction and the Sociology of the Body (pp. 35–50).

Ashgate Publishing Limited.

Clarke, L. H., & Griffin, M. (2008). Failing bodies: Body image and multiple chronic conditions in later life. *Qualitative Health Research*, 18(8), 1084–1095.

<https://doi.org/10.1177/1049732308320113>

Cluley, V., Trivedi, A., & Burton, J. O. (2024). Chronic illness as cultural disruption: The impact of chronic illness on religious and cultural practice. *Sociology of Health and Illness*, 46(8), 1901–1922. <https://doi.org/10.1111/1467-9566.13816>

Coates, M. M., Kintu, A., Gupta, N., Wroe, E. B., Adler, A. J., Kwan, G. F., Park, P. H., Rajbhandari, R., Byrne, A. L., & Casey, D. C. (2020). Burden of non-communicable diseases from infectious causes in 2017: a modelling study. *The Lancet Global Health*, 8(12), e1489–e1498.

Coleman, S. E., & Caswell, N. (2020). Diabetes and eating disorders: an exploration of ‘Diabulimia.’ *BMC Psychology*, 8(1), 1–7. <https://doi.org/10.1186/s40359-020-00468-4>

Cortini, M., Galanti, T., & Fantinelli, S. (2019). Focus group discussion: How many participants in a group? *Encyclopaideia*, 23(54), 29–43. <https://doi.org/10.6092/issn.1825-8670/9603>

Davis, C., Tami, P., Ramsay, D., Melanson, L., MacLean, L., Nersesian, S., & Ramjeesingh, R. (2020). Body image in older breast cancer survivors: A systematic review. *Psycho-Oncology*, 29(5), 823–832. <https://doi.org/10.1002/pon.5359>

de-Graft Aikins, A. (2003). Living with diabetes in rural and urban Ghana: A critical social psychological examination of illness action and scope for intervention. *Journal of Health Psychology*, 8(5), 557–572. <https://doi.org/10.1177/13591053030085007>

de-Graft Aikins, A. (2006). Reframing applied disease stigma research: a multilevel analysis of

diabetes stigma in Ghana. *Journal of Community & Applied Social Psychology*, 6, 426–441.
<https://doi.org/10.1002/casp.892>

de-Graft Aikins, A., Awuah, R. B., Pera, T. A., Mendez, M., & Ogedegbe, G. (2014).

Explanatory models of diabetes in urban poor communities in Accra, Ghana. *Ethnicity and Health*, 20(4), 391–408. <https://doi.org/10.1080/13557858.2014.921896>

de-Graft Aikins, A., Dodoo, F., Awuah, R. B., Owusu-Dabo, E., Addo, J., Nicolaou, M., Beune, E., Mockenhaupt, F. P., Danquah, I., Bahendeka, S., Meeks, K., Klipstein-Grobusch, K., Afrifa-Anane, E., Smeeth, L., Stronks, K., & Agyemang, C. (2019). Knowledge and perceptions of type 2 diabetes among Ghanaian migrants in three European countries and Ghanaians in rural and urban Ghana: The RODAM qualitative study. *PLoS ONE*, 14(4), 1–23. <https://doi.org/10.1371/journal.pone.0214501>

de-Graft Aikins, A., Sanuade, O., Baatiema, L., Asante, P. Y., Agyei, F., Asah-Ayeh, V., Okai, J. A. O., Osei-Tutu, A., & Koram, K. (2021). COVID-19, Chronic Conditions and Structural Poverty: A Social Psychological Assessment of the Needs of a Marginalized Community in Accra, Ghana. *Journal of Social and Political Psychology*, 9(2), 577–591.
<https://doi.org/10.5964/jspp.7543>

de-Graft Aikins, A., Unwin, N., Agyemang, C., Allotey, P., Campbell, C., & Arhinful, D. (2010). Open Access COMMENTARY BioMed Central Tackling Africa's chronic disease burden: from the local to the global. *Globalization and Health*, 6, 5.
<http://www.globalizationandhealth.com/content/6/1/5>

de Graft Aikins, A., Anum, A., Agyemang, C., Addo, J., & Ogedegbe, O. (2012). Lay representations of chronic diseases in Ghana: implications for primary prevention. *Ghana Medical Journal*, 46(2 Suppl), 59–68.

Doise, W. (1980). Levels of explanation in the European Journal of Social Psychology.

European Journal of Social Psychology, 10(3), 213–231.

<https://doi.org/10.1002/ejsp.2420100302>

Doise, W. (1982). Report on the European Association of Experimental Social Psychology.

European Journal of Social Psychology, 12(1), 105–111.

<https://doi.org/10.1002/ejsp.2420120108>

Doise, W., & Valentim, J. P. (2015). Levels of Analysis in Social Psychology. In *International*

Encyclopedia of the Social & Behavioral Sciences: Second Edition (Second Edi, Vol. 13,

Issue 1980). Elsevier. <https://doi.org/10.1016/B978-0-08-097086-8.24032-4>

Dube, L., Rendall-Mkosi, K., Van den Broucke, S., Bergh, A. M., & Mafutha, N. G. (2017).

Self-Management Support Needs of Patients with Chronic Diseases in a South African

Township: A Qualitative Study. *Journal of Community Health Nursing*, 34(1), 21–31.

<https://doi.org/10.1080/07370016.2017.1260983>

Duda, R. B., Jumah, N. A., Hill, A. G., Seffah, J., & Biritwum, R. (2007). Assessment of the

ideal body image of women in Accra, Ghana. *Tropical Doctor*, 37(4), 241–244.

<https://doi.org/10.1258/004947507782332883>

Ettarh, R., Vijver, S. Van De, Oti, S., Van de Vijver, S., & Kyobutungi, C. (2014). Overweight,

Obesity, and Perception of Body Image Among Slum Residents in Nairobi, Kenya, 2008-

2009. *Preventing Chronic Disease*, 11(4), E212. <http://dx.doi.org/10.5888/pcd11.130198>

Faircloth, C., Boylstein, C., Rittman, M., & Young, M. E. (2004). Disrupted Bodies:

Experiencing the Newly Limited Body in Stroke. *Symbolic Interaction*, 27(1), 71–87.

<https://doi.org/10.1525/si.2004.27.1.71>

Fetters, M. D., & Rubinstein, E. B. (2019). The 3 Cs of content, context, and concepts: A

- practical approach to recording unstructured field observations. *Annals of Family Medicine*, 17(6), 554–560. <https://doi.org/10.1370/afm.2453>
- Filej, B., Žvanut, B., & Kaučič, B. M. (2018). The connection between chronic diseases and self-image and self-esteem. *Journal of Health Sciences*, 8(1), 54–61. <https://doi.org/10.17532/jhsci.2018.483>
- Foster, G. D., Wadden, T. A., Makris, A. P., Davidson, D., Sanderson, R. S., Allison, D. B., & Kessler, A. (2003). Primary care physicians' attitudes about obesity and its treatment. *Obesity Research*, 11(10), 1168–1177. <https://doi.org/10.1038/oby.2003.161>
- Frempong, G. A. (2017). *THE INFLUENCE OF BODY SIZE ESTIMATION ON WEIGHT MANAGEMENT BEHAVIOURS IN ACCRA, GHANA*. 10362227.
- Fusch, P., Fusch, G. E., & Ness, L. R. (2018). Denzin's Paradigm Shift: Revisiting Triangulation in Qualitative Research. *Journal of Social Change*, 10(1), 19–32. <https://doi.org/10.5590/JOSC.2018.10.1.02>
- Gains, F. (2011). Elite ethnographies: Potential, pitfalls and prospects for getting “up close and personal.” *Public Administration*, 89(1), 156–166. <https://doi.org/10.1111/j.1467-9299.2011.01912.x>
- Gallagher, S. (2001a). *Dimensions of Embodiment: Body Image and Body Schema in Medical Contexts*. 147–175. https://doi.org/10.1007/978-94-010-0536-4_8
- Gallagher, S. (2001b). *Dimensions of Embodiment: Body Image and Body Schema in Medical Contexts*. June, 147–175. https://doi.org/10.1007/978-94-010-0536-4_8
- Gallefoss, F., & Bakke, P. S. (2000). Impact of patient education and self-management on morbidity in asthmatics and patients with chronic obstructive pulmonary disease. *Respiratory Medicine*, 94(3), 279–287. <https://doi.org/10.1053/rmed.1999.0749>

- Gattario, K. H., Frisén, A., Teall, T. L., & Piran, N. (2020). Embodiment: Cultural and gender differences and associations with life satisfaction. *Body Image*, 35, 1–10.
<https://doi.org/10.1016/j.bodyim.2020.07.005>
- Global Health. (2019). *Burden of non-communicable diseases in sub-Saharan Africa, 1990–2017: results from the Global Burden of Disease Study 2017*.
[https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(19\)30374-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30374-2/fulltext)
- Gonzaga, M. A. (2013). Listening to the voices: An exploratory study of the experiences of women diagnosed and living with breast cancer in Uganda. *Pan African Medical Journal*, 16, 1–5. <https://doi.org/10.11604/pamj.2013.16.60.2431>
- Gouda, H. N., Charlson, F., Sorsdahl, K., Ahmadzade, S., Ferrari, A. J., Erskine, H., Leung, J., Santamauro, D., Lund, C., Aminde, L. N., Mayosi, B. M., Kengne, A. P., Harris, M., Achoki, T., Wiysonge, C. S., Stein, D. J., & Whiteford, H. (2019). Burden of non-communicable diseases in sub-Saharan Africa, 1990–2017: results from the Global Burden of Disease Study 2017. *The Lancet Global Health*, 7(10), e1375–e1387.
[https://doi.org/10.1016/S2214-109X\(19\)30374-2](https://doi.org/10.1016/S2214-109X(19)30374-2)
- Grabe, S., Ward, L. M., & Hyde, J. S. (2008). The Role of the Media in Body Image Concerns Among Women: A Meta-Analysis of Experimental and Correlational Studies. *Psychological Bulletin*, 134(3), 460–476. <https://doi.org/10.1037/0033-2909.134.3.460>
- Gray, K., Knobe, J., Sheskin, M., Bloom, P., & Barrett, L. F. (2011). More than a body: Mind perception and the nature of objectification. *Journal of Personality and Social Psychology*, 101(6), 1207–1220. <https://doi.org/10.1037/a0025883>
- Griffiths, S., Murray, S. B., Bentley, C., Gratwick-Sarll, K., Harrison, C., & Mond, J. M. (2017). Sex Differences in Quality of Life Impairment Associated With Body Dissatisfaction in

Adolescents. *Journal of Adolescent Health*, 61(1), 77–82.

<https://doi.org/10.1016/j.jadohealth.2017.01.016>

Grogan, S. (2006). Body image and health: Contemporary perspectives. *Journal of Health Psychology*, 11(4), 523–530. <https://doi.org/10.1177/1359105306065013>

Grogan, S. (2021a). Reducing body dissatisfaction and promoting positive body image. In *Body Image* (pp. 217–239). Routledge. <https://doi.org/10.4324/9781003100041-7>

Grogan, S. (2021b). *Understanding Body Dissatisfaction in Men, Women and Children* (4th Editio). Routledge. <https://doi.org/https://doi.org/10.4324/9781003100041>

Gyasi, R. M., & Phillips, D. R. (2020). Risk of psychological distress among community-dwelling older adults experiencing spousal loss in Ghana. *Gerontologist*, 60(3), 416–427. <https://doi.org/10.1093/geront/gnz052>

Hahn, E. A., Cella, D., Bode, R. K., & Hanrahan, R. T. (2010). Measuring social well-being in people with chronic illness. *Social Indicators Research*, 96(3), 381–401. <https://doi.org/10.1007/s11205-009-9484-z>

Hammersley, M. (2006). Ethnography: problems and prospects. *Ethnography and Education*, 1(1), 3–14. <https://doi.org/10.1080/17457820500512697>

Hammersley, M. (2018). What is ethnography? Can it survive? Should it? *Ethnography and Education*, 13(1), 1–17. <https://doi.org/10.1080/17457823.2017.1298458>

Heath, S., Charles, V., Crow, G., & Wiles, R. (2007). Informed consent, gatekeepers and go-betweens: Negotiating consent in child- and youth-orientated institutions. *British Educational Research Journal*, 33(3), 403–417. <https://doi.org/10.1080/01411920701243651>

Holland, G., & Tiggemann, M. (2016). A systematic review of the impact of the use of social

- networking sites on body image and disordered eating outcomes. *Body Image*, 17, 100–110.
<https://doi.org/10.1016/j.bodyim.2016.02.008>
- Holmes, A. M., & Deb, P. (2003). The effect of chronic illness on the psychological health of family members. *Journal of Mental Health Policy and Economics*, 6(1), 13–22.
- Hoppe, S. (2010). Visibility and invisibility in chronic illness. *Medische Antropologie*, 22(2), 361–373.
- Hunter-Adams, J. (2019). Perceptions of weight in relation to health, hunger, and belonging among women in periurban South Africa. *Health Care for Women International*, 40(4), 347–364. <https://doi.org/10.1080/07399332.2018.1549044>
- Hwu, Y. J. (2020). The impact of chronic illness on patients. *Rehabilitation Nursing*, 45(4), 180–184. <https://doi.org/10.1097/RNJ.0000000000000271>
- Ibanez-Gonzalez, D. L., Mendenhall, E., & Norris, S. A. (2014). A mixed methods exploration of patterns of healthcare utilization of urban women with non-communicable disease in South Africa. *BMC Health Services Research*, 14(1), 1–9. <https://doi.org/10.1186/s12913-014-0528-y>
- Iddrisu, M., Aziato, L., & Dedey, F. (2020). Psychological and physical effects of breast cancer diagnosis and treatment on young Ghanaian women: A qualitative study. *BMC Psychiatry*, 20(1), 1–9. <https://doi.org/10.1186/s12888-020-02760-4>
- Isambert, F. A., & Moscovici, S. (1961). La psychanalyse, son image, son public. *Revue Française de Sociologie*, 2(4), 328. <https://doi.org/10.2307/3319763>
- Issah, I., Roberts, S., Kritz, J., Bruwua, S. A., Commeh, M. A., & Fobil, J. N. (2024). *population : need for behavioural interventions with programme*. 686–688.
- Janzon, E., Namusaazi, S., & Bolmsjö, I. (2015). Increasing Obesity in Ugandan Women due to

- Transition from Rural to Urban Living Conditions? a Qualitative Study on Traditional Body Image, Changed Lifestyles and Unawareness of Risk for Heart Disease. *Journal of Research in Obesity*, 2015, 1–13. <https://doi.org/10.5171/2015.213083>
- Joachim, G., & Acorn, S. (2000). Stigma of visible and invisible chronic conditions. *Journal of Advanced Nursing*, 32(1), 243–248. <https://doi.org/10.1046/j.1365-2648.2000.01466.x>
- Johnson, E. R., Affuso, O., Levitan, E. B., Carson, T. L., & Baskin, M. L. (2019). Body image and dissatisfaction among rural Deep South African American women in a weight loss intervention. *Journal of Health Psychology*, 24(9), 1167–1177. <https://doi.org/10.1177/1359105317694489>
- Jokinen, P., Lappalainen, M., Meriläinen, P., & Pelkonen, M. (2002). Ethical issues in ethnographic nursing research with children and elderly people. *Scandinavian Journal of Caring Sciences*, 16(2), 165–170. <https://doi.org/10.1046/j.1471-6712.2002.00076.x>
- Jovchelovitch, S. (2007). *LSE Research Online Book summary*. <http://eprints.lse.ac.uk>
- Jung, G. H., & Chin, Y. R. (2015). The Effects of an Integrated Health Care Program on the Physical, Psychosocial, and Spiritual Health of People with Mental Disorder in Community. *Journal of Korean Academy of Community Health Nursing*, 26(2), 69. <https://doi.org/10.12799/jkachn.2015.26.2.69>
- Katz, S. (1963). Studies of Illness in the Aged. *JAMA*, 185(12), 914. <https://doi.org/10.1001/jama.1963.03060120024016>
- Kim, G. M., Lim, J. Y., Kim, E. J., & Park, S. M. (2019). Resilience of patients with chronic diseases: A systematic review. *Health and Social Care in the Community*, 27(4), 797–807. <https://doi.org/10.1111/hsc.12620>
- Kirmayer, L. J., & Gómez-Carrillo, A. (2019). Agency, embodiment and enactment in

psychosomatic theory and practice. *Medical Humanities*, 45(2), 169–182.

<https://doi.org/10.1136/medhum-2018-011618>

Kling, J., Kwakkenbos, L., Diedrichs, P. C., Rumsey, N., Frisen, A., Brandao, M. P., Silva, A.

G., Dooley, B., Rodgers, R. F., & Fitzgerald, A. (2019). Systematic review of body image measures. *Body Image*, 30, 170–211.

Knobf, M. T. (2007). Psychosocial Responses in Breast Cancer Survivors. *Seminars in Oncology*

Nursing, 23(1), 71–83. <https://doi.org/10.1016/j.soncn.2006.11.009>

Kocan, S., & Gursay, A. (2016). Body Image of Women with Breast Cancer After Mastectomy:

A Qualitative Research. *Journal of Breast Health*, 12(4), 145–150.

<https://doi.org/10.5152/tjbh.2016.2913>

Kpobi, L., Read, U. M., Selormey, R. K., & Colucci, E. (2024). ‘We are all working toward one

goal. We want people to become well’: A visual exploration of what promotes successful collaboration between community mental health workers and healers in Ghana.

Transcultural Psychiatry, 61(1), 30–46. <https://doi.org/10.1177/13634615231197998>

Kretchy, I. A., Boima, V., Agyabeng, K., Koduah, A., & Appiah, B. (2020). Psycho-behavioural

factors associated with medication adherence among male outpatients with hypertension in a Ghanaian hospital. *PLoS ONE*, 15(1), 1–15. <https://doi.org/10.1371/journal.pone.0227874>

Kugbey, N., Oppong Asante, K., & Meyer-Weitz, A. (2020). Illness perception and coping

among women living with breast cancer in Ghana: An exploratory qualitative study. *BMJ*

Open, 10(7), 1–7. <https://doi.org/10.1136/bmjopen-2019-033019>

Laar, A. K., Adler, A. J., Kotoh, A. M., Legido-Quigley, H., Lange, I. L., Perel, P., & Lamptey,

P. (2019). Health system challenges to hypertension and related non-communicable diseases prevention and treatment: Perspectives from Ghanaian stakeholders. *BMC Health Services*

- Research*, 19(1), 1–13. <https://doi.org/10.1186/s12913-019-4571-6>
- Lee, I. M., Shiroma, E. J., Lobelo, F., Puska, P., Blair, S. N., Katzmarzyk, P. T., Alkandari, J. R., Andersen, L. B., Bauman, A. E., Brownson, R. C., Bull, F. C., Craig, C. L., Ekelund, U., Goenka, S., Guthold, R., Hallal, P. C., Haskell, W. L., Heath, G. W., Inoue, S., ... Wells, J. C. (2012). Effect of physical inactivity on major non-communicable diseases worldwide: An analysis of burden of disease and life expectancy. *The Lancet*, 380(9838), 219–229. [https://doi.org/10.1016/S0140-6736\(12\)61031-9](https://doi.org/10.1016/S0140-6736(12)61031-9)
- Liburd, L. C., Anderson, L. A., Edgar, T., & Jack, L. (1999). Body Size and Body Shape: Perceptions of Black Women With Diabetes. *The Diabetes Educator*, 25(3), 382–388. <https://doi.org/10.1177/014572179902500309>
- Linden, M., Linden, U., Goretzko, D., & Gensichen, J. (2022). Prevalence and pattern of acute and chronic multimorbidity across all body systems and age groups in primary health care. *Scientific Reports*, 12(1), 1–8. <https://doi.org/10.1038/s41598-021-04256-x>
- Link, B. G., & Phelan, J. C. (2001). Annual Reviews. *Analytical Chemistry*, 20(8), 689. <https://doi.org/10.1021/ac60020a001>
- Litzelman, K. (2019). Caregiver Well-being and the Quality of Cancer Care. *Seminars in Oncology Nursing*, 35(4), 348–353. <https://doi.org/10.1016/j.soncn.2019.06.006>
- Litzelman, K., Kent, E. E., & Rowland, J. H. (2018). Interrelationships Between Health Behaviors and Coping Strategies Among Informal Caregivers of Cancer Survivors. *Health Education and Behavior*, 45(1), 90–100. <https://doi.org/10.1177/1090198117705164>
- Liu, Z., Heffernan, C., & Tan, J. (2020). Caregiver burden: A concept analysis. *International Journal of Nursing Sciences*, 7(4), 438–445.
- Loizeau, V., & Annequin, D. (2021). Chronic illness and body image construction, the aesthetic

- concern of the adolescent. *Soins; La Revue de Reference Infirmiere*, 66(859), 55–57.
- Maimaitiming, M., Kakunze, A., Feng, Y., Wang, M., Li, N., Shi, J., Huang, K., Jin, Y., & Zheng, Z. J. (2023). Contribution of cardiovascular disease to the burden of non-communicable diseases in Africa: an analysis of data from Global Burden of Disease database, 1990–2019. *Cardiology Plus*, 8(3), 184–190.
<https://doi.org/10.1097/CP9.0000000000000057>
- Mainwaring, J. M., Walker, L. M., Robinson, J. W., Wassersug, R. J., & Wibowo, E. (2021). The Psychosocial Consequences of Prostate Cancer Treatments on Body Image, Sexuality, and Relationships. *Frontiers in Psychology*, 12(October), 1–5.
<https://doi.org/10.3389/fpsyg.2021.765315>
- Marinda, P., Chibwe, N., Tambo, E., Lulanga, S., & Khayeka-Wandabwa, C. (2017). Challenges and opportunities of optimal breastfeeding in the context of HIV option B+ guidelines. *BMC Public Health*, 17(1), 1–13. <https://doi.org/10.1186/s12889-017-4457-7>
- Markey, C. H., Dunaev, J. L., & August, K. J. (2020). Body image experiences in the context of chronic pain: An examination of associations among perceptions of pain, body dissatisfaction, and positive body image. *Body Image*, 32, 103–110.
<https://doi.org/10.1016/j.bodyim.2019.11.005>
- Martire, L. M., & Helgeson, V. S. (2017). *Close relationships and the management of chronic illness: Association and interventions*. 1–14.
<https://doi.org/https://dx.doi.org/10.1037/amp0000066>
- Martire, L. M., Hemphill, R. C., Zhaoyang, R., Stephens, M. A. P., Franks, M. M., & Stanford, A. M. (2018). Daily marital tension and symptom severity in older adults with diabetes or osteoarthritis. *Annals of Behavioral Medicine*, 52(10), 842–853.

<https://doi.org/10.1093/abm/kax062>

Martire, L. M., & Schulz, R. (2007). Involving family in psychosocial interventions for chronic illness. *Current Directions in Psychological Science*, 16(2), 90–94.

<https://doi.org/10.1111/j.1467-8721.2007.00482.x>

McCabe, M. P., & Ricciardelli, L. A. (2003). Sociocultural influences on body image and body changes among adolescent boys and girls. *Journal of Social Psychology*, 143(1), 5–26.

<https://doi.org/10.1080/00224540309598428>

McInnes, S., Halcomb, E., Ashley, C., Kean, A., Moxham, L., & Patterson, C. (2022). An integrative review of primary health care nurses' mental health knowledge gaps and learning needs. *Collegian*, 29(4), 540–548. <https://doi.org/10.1016/j.colegn.2021.12.005>

McIntosh, M. J., & Morse, J. M. (2015). Situating and constructing diversity in semi-structured interviews. *Global Qualitative Nursing Research*, 2.

<https://doi.org/10.1177/2333393615597674>

Mendenhall, E., Kohrt, B. A., Norris, S. A., Ndeti, D., & Prabhakaran, D. (2017). Non-communicable disease syndemics: poverty, depression, and diabetes among low-income populations. *The Lancet*, 389(10072), 951–963. [https://doi.org/10.1016/S0140-6736\(17\)30402-6](https://doi.org/10.1016/S0140-6736(17)30402-6)

Metta, E., Bailey, A., Kessy, F., Geubbels, E., Hutter, I., & Haisma, H. (2015). “In a situation of rescuing life”: Meanings given to diabetes symptoms and care-seeking practices among adults in Southeastern Tanzania: A qualitative inquiry. *BMC Public Health*, 15(1), 1–11.

<https://doi.org/10.1186/s12889-015-1504-0>

Mogre, V., Gaa, P. K., Nagumsi, R., & Abukari, S. (2013). Overweight , Obesity and Thinness and Associated Factors Among School- Aged Children (5-14 Years) in Tamale ,.

European Scientific Journal, 9(20), 160–175.

Mohamed Boushab, B., Fall-Malick, F.-Z., Ould Cheikh Melainine, M. L., & Basco, L. K.

(2017). Forms of Stigma and Discrimination in the Daily Lives of HIV-Positive Individuals in Mauritania. *The Open AIDS Journal*, 11(1), 12–17.

<https://doi.org/10.2174/1874613601711010012>

Morgan, D. D., Tieman, J. J., Allingham, S. F., Ekström, M. P., Connolly, A., & Currow, D. C.

(2019). The trajectory of functional decline over the last 4 months of life in a palliative care population: A prospective, consecutive cohort study. *Palliative Medicine*, 33(6), 693–703.

<https://doi.org/10.1177/0269216319839024>

Morrison, D., Agur, K., Mercer, S., Eiras, A., González-Montalvo, J. I., & Gruffydd-Jones, K.

(2016). Managing multimorbidity in primary care in patients with chronic respiratory conditions. *Npj Primary Care Respiratory Medicine*, 26(May).

<https://doi.org/10.1038/npjpcrm.2016.43>

Moscovici, S. (1960). Les mineurs jugent la nationalisation. *Sociologie Du Travail*, 2(3), 216–229. <https://doi.org/10.3406/sotra.1960.1023>

Moscovici, S. (1982). The Coming Era of Representations. In *Cognitive Analysis of Social Behavior* (pp. 115–150). Springer Netherlands. https://doi.org/10.1007/978-94-009-7612-2_4

Moscovici, S. (1984a). Le Ressentiment. *Le Genre Humain*, N° 11(2), 179–206.

<https://doi.org/10.3917/lgh.011.0179>

Moscovici, S. (1984b). Preface. In *The Social Development of the Intellect* (p. vii). Elsevier.

<https://doi.org/10.1016/B978-0-08-030215-7.50005-6>

Moscovici, S. (1988). Notes towards a description of Social Representations. *European Journal*

- of Social Psychology*, 18(3), 211–250. <https://doi.org/10.1002/ejsp.2420180303>
- Murray, M. (2000). Levels of narrative analysis in health psychology. *Journal of Health Psychology*, 5(3), 337–347. <https://doi.org/10.1177/135910530000500305>
- Ne Joffe, H. (2003). Risk: From perception to social representation. *British Journal of Social Psychology*, 42, 55–73. www.bps.org.uk
- Nyaaba, G. N., Stronks, K., De-Graft Aikins, A., Kengne, A. P., & Agyemang, C. (2017). Tracing Africa's progress towards implementing the Non-Communicable Diseases Global action plan 2013-2020: a synthesis of WHO country profile reports. *BMC Public Health*, 17(1), 1–13. <https://doi.org/10.1186/s12889-017-4199-6>
- Nyaaba, G. N., Stronks, K., Masana, L., Larrea- Killinger, C., & Agyemang, C. (2020). Implementing a national non-communicable disease policy in sub-Saharan Africa: Experiences of key stakeholders in Ghana. *Health Policy OPEN*, 1, 100009. <https://doi.org/10.1016/j.hpopen.2020.100009>
- Ofei-Dodoo, S., Rogers, N. L., Morgan, A. L., Amini, S. B., Takeshima, N., & Rogers, M. E. (2018). The Impact of an Active Lifestyle on the Functional Fitness Level of Older Women. *Journal of Applied Gerontology*, 37(6), 687–705. <https://doi.org/10.1177/0733464816641390>
- Ofori-Asenso, R., Agyeman, A. A., Laar, A., & Boateng, D. (2016). Overweight and obesity epidemic in Ghana - A systematic review and meta-analysis. *BMC Public Health*, 16(1). <https://doi.org/10.1186/s12889-016-3901-4>
- Okop, K. J., Levitt, N., & Puoane, T. (2019). Weight underestimation and body size dissatisfaction among black African adults with obesity: Implications for health promotion. *African Journal of Primary Health Care and Family Medicine*, 11(1), 1–8.

<https://doi.org/10.4102/phcfm.v11i1.2022>

Okop, K. J., Mukumbang, F. C., Mathole, T., Levitt, N., & Puoane, T. (2016). Perceptions of body size, obesity threat and the willingness to lose weight among black South African adults: A qualitative study. *BMC Public Health*, 16(1), 1–13.

<https://doi.org/10.1186/s12889-016-3028-7>

Okoro, E. O., Oyejola, B. A., Etebu, E. N., Sholagberu, H., Kolo, P. M., Chijioke, A., & Adebisi, S. A. (2014). Body size preference among Yoruba in three Nigerian communities. *Eating and Weight Disorders*, 19(1), 77–88. <https://doi.org/10.1007/s40519-013-0060-9>

Oliver, E. J., & Flint, S. W. (2014). A new approach to the regulation of body-image discrepancies: Examining associations between self-talk and personality. *Psychology Serving Humanity: Proceedings of the 30th International Congress of Psychology: Volume 2: Western Psychology*, 277–286. <https://doi.org/10.4324/9781315777184>

Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in qualitative research. *Journal of Nursing Scholarship*, 33(1), 93–96. <https://doi.org/10.1111/j.1547-5069.2001.00093.x>

Otieno, P., Asiki, G., Aheto, J. M. K., Wilunda, C., Sanya, R. E., Wami, W., Mwanga, D., & Agyemang, C. (2023). Cardiometabolic Multimorbidity Associated with Moderate and Severe Disabilities: Results from the Study on Global AGEing and Adult Health (SAGE) Wave 2 in Ghana and South Africa. *Global Heart*, 18(1). <https://doi.org/10.5334/gh.1188>

Owusu, M. F., Adu, J., Gyamfi, S., Martin-Yeboah, E., & Dorte, B. A. (2024). Tackling the non-communicable disease epidemic: a framework for policy action in low- and middle-income countries. *Pan African Medical Journal*, 47, 1–10.

<https://doi.org/10.11604/pamj.2024.47.82.41089>

Patton, T. O. (2006). Hey Girl, Am I More than My Hair?: African American Women and Their

Struggles with Beauty, Body Image, and Hair. *NWSA Journal*, 18(2), 24–51.

<https://doi.org/10.1353/nwsa.2006.0037>

Pinquart, M. (2013). Body image of children and adolescents with chronic illness: A meta-analytic comparison with healthy peers. *Body Image*, 10(2), 141–148.

<https://doi.org/10.1016/j.bodyim.2012.10.008>

Pinquart, M., & Sörensen, S. (2011). Spouses, Adult Children, and Children-in-Law as Caregivers of Older Adults: A Meta-Analytic Comparison. *Psychology and Aging*, 26(1), 1–14. <https://doi.org/10.1037/a0021863>

Piran, N. (2016). Embodied possibilities and disruptions: The emergence of the Experience of Embodiment construct from qualitative studies with girls and women. *Body Image*, 18, 43–60. <https://doi.org/10.1016/j.bodyim.2016.04.007>

Piran, N. (2018). Journeys of embodiment at the intersection of body and culture: The developmental theory of embodiment. *Journeys of Embodiment at the Intersection of Body and Culture: The Developmental Theory of Embodiment*, 34(4), 117–120.

<https://doi.org/10.1016/C2015-0-04666-4>

Poku, B. A., Caress, A. L., & Kirk, S. (2020). “Body as a Machine”: How Adolescents With Sickle Cell Disease Construct Their Fatigue Experiences. *Qualitative Health Research*, 30(9), 1431–1444. <https://doi.org/10.1177/1049732320916464>

Popoola, Y., Adu-idowu, V., Adesola, R. O., & Ogundiran, S. (2022). *Knowledge and Perception of Patients towards the Roles and Service Rendered by Health Information Professionals in Healthcare Institutions*. 9(1000), 1–9. <https://doi.org/10.35248/2573-4598.23.9.208>

Poth, C. N., & Shannon-Baker, P. (2022). State of the Methods: Leveraging Design Possibilities

- of Qualitatively Oriented Mixed Methods Research. *International Journal of Qualitative Methods*, 21, 1–11. <https://doi.org/10.1177/16094069221115302>
- Pradeilles, R., Holdsworth, M., Olaitan, O., Irache, A., Osei-Kwasi, H. A., Ngandu, C. B., & Cohen, E. (2022). Body size preferences for women and adolescent girls living in Africa: a mixed-methods systematic review. *Public Health Nutrition*, 25(3), 738–759. <https://doi.org/10.1017/S1368980021000768>
- Pulvers, K., Bachand, J., Nollen, N., Guo, H., & Ahluwalia, J. S. (2013). BMI-based norms for a culturally relevant body image scale among African Americans. *Eating Behaviors*, 14(4), 437–440. <https://doi.org/10.1016/j.eatbeh.2013.07.005>
- Pulvers, K. M., Lee, R. E., Kaur, H., Mayo, M. S., Fitzgibbon, M. L., Jeffries, S. K., Butler, J., Hou, Q., & Ahluwalia, J. S. (2004). Development of a culturally relevant body image instrument among urban African Americans. *Obesity Research*, 12(10), 1641–1651. <https://doi.org/10.1038/oby.2004.204>
- Puoane, T., Tsolekile, L., & Steyn, N. (2010). Perceptions about body image and sizes among black African girls living in Cape Town. *Ethnicity and Disease*, 20(1), 29–34.
- Quaidoo, E. Y., Ohemeng, A., & Amankwah-Poku, M. (2018). Weight perceptions, weight management practices, and nutritional status of emerging adults living in the Accra Metropolis. *BMC Nutrition*, 4(1), 1–9. <https://doi.org/10.1186/s40795-018-0265-4>
- Ra, J. S., & Cho, Y. H. (2017). Depression Moderates the Relationship between Body Image and Health-Related Quality of Life in Adolescent Girls. *Journal of Child and Family Studies*, 26(7), 1799–1807. <https://doi.org/10.1007/s10826-017-0720-x>
- Ramukumba, T. S., Wright, S. C. D., & Hoffman, W. A. (2013). a Situational Analysis of Obesity Conducted. *Africa Journal of Nursing and Midwifery*, 15(2), 115–130.

- Rateau, P., Moliner, P., Abric, J.-C., & Moliner, P. (2012). Social Representation Theory. In *Handbook of Theories of Social Psychology* (Issue July 2016, pp. 477–497). SAGE Publications Ltd. <https://doi.org/10.4135/9781446249222.n50>
- Redjem, R., Kharraja, S., Xie, X., & Marcon, E. (2011). Coordinated multi-criteria scheduling of caregivers in home health care services. *IEEE International Conference on Automation Science and Engineering*, 519–524. <https://doi.org/10.1109/CASE.2011.6042527>
- Ribeiro, L. B., Maurício Pieper, C., Andrade Frederico, G., Antar Gamba, M., & da Silva Rosa, A. (2021). The relationship between women with diabetes and their body: the risk of diabulimia. *Anna Nery School Journal of Nursing / Escola Anna Nery Revista de Enfermagem*, 25(4), 1–8. <https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=149825312&lang=pt-pt&site=ehost-live>
- Rosa, A. S. De, & Mannarini, T. (2020). The “Invisible Other”: Social Representations of COVID-19 Pandemic in Media and Institutional Discourse. *Papers on Social Representations*, 29(2), 5.1-5.35.
- Rumsey, N., & Harcourt, D. (2004). Body image and disfigurement: Issues and interventions. *Body Image*, 1(1), 83–97. [https://doi.org/10.1016/S1740-1445\(03\)00005-6](https://doi.org/10.1016/S1740-1445(03)00005-6)
- Sahu, A., Sagar, R., Sarkar, S., & Sagar, S. (2016). Psychological effects of amputation: A review of studies from India. *Industrial Psychiatry Journal*, 25(1), 4. <https://doi.org/10.4103/0972-6748.196041>
- Salifu, Y., Almack, K., & Caswell, G. (2021). ‘My wife is my doctor at home’: A qualitative study exploring the challenges of home-based palliative care in a resource-poor setting. *Palliative Medicine*, 35(1), 97–108. <https://doi.org/10.1177/0269216320951107>

- Samraj, K., Radha, S., Nandhagopal, K., Rajalakshmi, S., & Arunachalam, K. (2020). National workshop on Scope of Integrative Medical Treatment in Clinical practice (SIMTI-2020): A brief report. *National Journal of Physiology, Pharmacy and Pharmacology*, 10(0), 1. <https://doi.org/10.5455/njppp.2020.10.04082202021042020>
- Sanuade, O. (2018). Understanding the cultural meanings of stroke in the Ghanaian setting: A qualitative study exploring the perspectives of local community residents [version 2; referees: 2 approved]. *Wellcome Open Research*, 3(0), 1–23. <https://doi.org/10.12688/wellcomeopenres.14674.2>
- Sanuade, O. A., Kushitor, M. K., Awuah, R. B., Asante, P. Y., Agyemang, C., & De-Graft Aikins, A. (2021). Lay knowledge of cardiovascular disease and risk factors in three communities in Accra, Ghana: A cross-sectional survey. *BMJ Open*, 11(12), 13–17. <https://doi.org/10.1136/bmjopen-2021-049451>
- Schulman-Green, D., Martin, F., Alonzo, A., Grey, M., McCorkle, R., Redeker, N. S., Reynolds, N., & Whittemore, R. (2012). Processes of self-management in chronic illness. *Journal of Nursing Scholarship*, 44(2), 136–144. <https://doi.org/10.1111/j.1547-5069.2012.01444.x>.Processes
- Seidu, S., Owusu-agyeman, A. K., Ibrahim, M., & Kyiu, C. (2024). Ghana Journal of Nursing and Midwifery (GJNMID) The role of AI in Improving the Management of Chronic Diseases in Developing Countries Ghana Journal of Nursing and Midwifery (GJNMID). *Ghana Journal of Nursing and Midwifery*, 3602(October), 1–15.
- Singer, M. A., Hopman, W. M., & Mackenzie, T. A. (1999). *Physical Functioning and Mental Health in Patients with Chronic Medical Conditions* Author (s): Michael A . Singer , Wilma M . Hopman and Thomas A . MacKenzie Published by : Springer Stable URL :

<https://www.jstor.org/stable/4037996> REFERENCES Linked ref. 8(8), 687–691.

Singh, P. K., Singh, L., Dubey, R., Singh, S., & Mehrotra, R. (2019). Socioeconomic determinants of chronic health diseases among older Indian adults: A nationally representative cross-sectional multilevel study. *BMJ Open*, 9(9), 1–12.

<https://doi.org/10.1136/bmjopen-2018-028426>

Skinner, D., & Mfecane, S. (2004). Stigma, discrimination and the implications for people living with HIV/AIDS in South Africa. *Sahara J*, 1(3), 157–164.

<https://doi.org/10.1080/17290376.2004.9724838>

Stenzel, L. M., Saha, L. J., & Guareschi, P. (2006). To be fat or thin? Social representations of the body among adolescent female students in Brazil. *International Education Journal*, 7(5), 611–631.

Sündermann, O., Flink, I., & Linton, S. J. (2020). My body is not working right: a cognitive behavioral model of body image and chronic pain. *Pain*, 161(6), 1136–1139.

<https://doi.org/10.1097/j.pain.0000000000001822>

Swami, V., & Chamorro-Premuzic, T. (2008). Factor structure of the Body Appreciation Scale among Malaysian women. *Body Image*, 5(4), 409–413.

<https://doi.org/10.1016/j.bodyim.2008.04.005>

Swan, H. (2016). A Qualitative Examination of Stigma Among Formerly Incarcerated Adults Living With HIV. *SAGE Open*, 6(1), 1–9. <https://doi.org/10.1177/2158244016629524>

Tateyama, Y., Musumari, P. M., Techasrivichien, T., Pilar Suguimoto, S., Zulu, R., Dube, C., Feldman, M. D., Ono-Kihara, M., & Kihara, M. (2019). Dietary habits, body image, and health service access related to cardiovascular diseases in rural Zambia: A qualitative study. *PLoS ONE*, 14(2), 1–15. <https://doi.org/10.1371/journal.pone.0212739>

- Tiggemann, M., Martins, Y., & Churchett, L. (2008). Beyond muscles: Unexplored parts of men's body image. *Journal of Health Psychology, 13*(8), 1163–1172.
<https://doi.org/10.1177/1359105308095971>
- Tiggemann, M., & Slater, A. (2014). NetTweens: The Internet and Body Image Concerns in Preteenage Girls. *Journal of Early Adolescence, 34*(5), 606–620.
<https://doi.org/10.1177/0272431613501083>
- Titchkosky, T. (2001). Coming out disability: The politics of understanding. *Journal of the American Chemical Society, 123*(10), 2176–2181. <https://cursa.ihmc.us/rid=1R440PDZR-13G3T80-2W50/4.Pautas-para-evaluar-Estilos-de-Aprendizajes.pdf>
- Tsaplina, M. (2020). Bodies speaking: Embodiment, illness and the poetic materiality of puppetry/object practice. *Journal of Applied Arts and Health, 11*(1), 85–102.
https://doi.org/10.1386/jaah_00020_1
- Tuoyire, D. A., Kumi-Kyereme, A., Doku, D. T., & Amo-Adjei, J. (2018). Perceived ideal body size of Ghanaian women: “Not too skinny, but not too fat .” *Women & Health, 58*(5), 583–597. <https://doi.org/10.1080/03630242.2017.1321607>
- Tylka, T. L., & Wood-Barcalow, N. L. (2015). What is and what is not positive body image? Conceptual foundations and construct definition. *Body Image, 14*, 118–129.
<https://doi.org/10.1016/j.bodyim.2015.04.001>
- UN-HABITAT. (2009). *Participatory Slum Upgrading and Prevention Programme Narrative Report 2009*. 1–37.
- Van Houtum, L., Rijken, M., & Groenewegen, P. (2015). Do everyday problems of people with chronic illness interfere with their disease management? Chronic Disease epidemiology. *BMC Public Health, 15*(1), 1–9. <https://doi.org/10.1186/s12889-015-2303-3>

- van Lankveld, J. J. D. M., Fler, J., Schroevers, M. J., Sanderman, R., den Ouden, B. L., & Dekker, J. (2018). Recruitment problems in psychosocial oncology research. *Psycho-Oncology*, 27(9), 2296–2298. <https://doi.org/10.1002/pon.4792>
- Van Wilder, L., Pype, P., Mertens, F., Rammant, E., Clays, E., Devleeschauwer, B., Boeckxstaens, P., & De Smedt, D. (2021). Living with a chronic disease: insights from patients with a low socioeconomic status. *BMC Family Practice*, 22(1), 1–11. <https://doi.org/10.1186/s12875-021-01578-7>
- Vartanian, L. R. (2012). Self-discrepancy theory and body image. In *Encyclopedia of Body Image and Human Appearance* (Vol. 2). Elsevier Inc. <https://doi.org/10.1016/B978-0-12-384925-0.00112-7>
- Verbist, I. L., & Condon, L. (2021). Disordered eating behaviours, body image and social networking in a type 1 diabetes population. *Journal of Health Psychology*, 26(11), 1791–1802. <https://doi.org/10.1177/1359105319888262>
- Vineis, P., Stringhini, S., & Porta, M. (2014). The environmental roots of non-communicable diseases (NCDs) and the epigenetic impacts of globalization. *Environmental Research*, 133(2014), 424–430. <https://doi.org/10.1016/j.envres.2014.02.002>
- Vingerhoets, A. J. J. M., & Bylsma, L. M. (2016). The Riddle of Human Emotional Crying: A Challenge for Emotion Researchers. *Emotion Review*, 8(3), 207–217. <https://doi.org/10.1177/1754073915586226>
- Wagner, W. (2020). Social Representation Theory: An Historical Outline. In *Oxford Research Encyclopedia of Psychology* (Issue July 2020). <https://doi.org/10.1093/acrefore/9780190236557.013.606>
- Wagner, W., & Hayes, N. (2005). *Everyday Discourse and Common Sense*. Macmillan

- Education UK. <https://doi.org/10.1007/978-1-137-07263-4>
- Walls, K. L., Boulic, M., & Boddy, J. W. D. (2016). The built environment—a missing “cause of the causes” of non-communicable diseases. *International Journal of Environmental Research and Public Health*, 13(10). <https://doi.org/10.3390/ijerph13100956>
- Waltsgott, L., Adediji, A., & Buchcik, J. (2024). Ideal body image and socioeconomic factors: exploring the perceptions of Kenyan women. *BMC Women's Health*, 24(1). <https://doi.org/10.1186/s12905-024-03307-5>
- Watson, L. B., Lewis, J. A., & Moody, A. T. (2019). A sociocultural examination of body image among Black women. *Body Image*, 31, 280–287. <https://doi.org/10.1016/j.bodyim.2019.03.008>
- Wilkerson, W. (2013). *Body as a Plurality of Forces*. 27(3), 297–307.
- Williams, S. (2000). Chronic illness as biographical disruption or biographical disruption as chronic illness? Reflections on a core concept. *Sociology of Health and Illness*, 22(1), 40–67. <https://doi.org/10.1111/1467-9566.00191>
- Williams, T. (2021). Addressing Body Image after Reconstructive Surgery in Adult Patients with Cancer. *Plastic Surgical Nursing*, 41(3), 132–140. <https://doi.org/10.1097/PSN.0000000000000371>
- World Health Organisation. (2023). *Non-communicable diseases*. <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>
- Wrigley-Asante, C., Agyei-Mensah, S., & Obeng, F. A. (2017). It's not all about wealth and beauty: Changing perceptions of fatness among Makola market women of Accra, Ghana. *Singapore Journal of Tropical Geography*, 38(3), 414–428. <https://doi.org/10.1111/sjtg.12200>

- Zare, F., Ameri, H., Madadizadeh, F., & Reza Aghaei, M. (2020). Health-related quality of life and its associated factors in patients with type 2 diabetes mellitus. *SAGE Open Medicine*, 8. <https://doi.org/10.1177/2050312120965314>
- Zhang, K. C. (2013). What I Look Like: College Women, Body Image, and Spirituality. *Journal of Religion and Health*, 52(4), 1240–1252. <https://doi.org/10.1007/s10943-012-9566-0>
- Zhang, Y. B., Pan, X. F., Chen, J., Cao, A., Zhang, Y. G., Xia, L., Wang, J., Li, H., Liu, G., & Pan, A. (2020). Combined lifestyle factors, incident cancer, and cancer mortality: a systematic review and meta-analysis of prospective cohort studies. *British Journal of Cancer*, 122(7), 1085–1093. <https://doi.org/10.1038/s41416-020-0741-x>



APPENDICES

APPENDIX A – DATA COLLECTION TOOL

[1] INTERVIEW GUIDE - INDIVIDUAL PARTICIPANTS WITH CHRONIC CONDITIONS - BODY IMAGE AND EMOBIMENT

Pre-ambule: reviewing the information sheet, signing the consent form, and gathering demographic details (separate sheet to be completed).

Hello, Good morning or afternoon, and thank you for agreeing to participate in this interview and for your time. My name is [Your Name], and I am conducting research on Body image, embodiment and chronic illness as part of my [PhD degree program at the University of Ghana]. I am interested in understanding your personal experience and how you negotiate changes in body image, and embodiment after the diagnosis of a chronic illness.

I want to guarantee that everything you share will be kept confidential, and your participation is voluntary—you are free to withdraw at any time without any negative consequences. I request your consent to record our conversation for the sake of accuracy. The recording will solely be used for research purposes. There are no right or wrong answers. Most interviews last about one hour, and we will make time afterwards to discuss any issues that emerge. Are you happy for us to start and do I have your permission to record the interview?

Section A. Body Image, Embodiment and Chronic Condition

5. I am going to show some cards with pictures/images of body sizes. Look at the cards and select the one that best describes your ideal body size.

- What do you think is the ideal body size or the body type that is most preferred in Ghana?
[When asking this question, there has to be a distinction between personal body image preference and culturally accepted body image]
- Do you think there are different Ghanaian expectations of ideal body size/image for (A) men and (B) women?
- What is your view on the ideal body size expected for (A) younger men and older adult men and (B) younger women and older adult women?

Probe: on aesthetics, appearance, physicality, skin color, etc.

6. Do you think there are different expectations of body image for ethnic groups?

Probe: Asantes, Hausas, Gas, Ewes, Fantis, Dagbanis, etc.

7. What does thinness mean to you, and what are the health implications to thinness?

- What does fatness mean to you, what are the health implications of fatness?

[Let the participant choose a picture of thinness or fatness to explain]

8. What are your feelings about your current size/weight?

Probe: emotions, happy, sad, indifferent, anxious

9. How do you feel when your body deviates from your ideal body image as a man/woman?

10. Which aspect would you like to change about your current body image? What would you do? How would you do it? Why would you do it?

Section B: The impact of chronic conditions on the body image of patients

11. How would you describe your body before you had [state the condition(s) of the participant]?

Probe: would you say you had the ideal body size and image? This is in relation to your body before the (state the condition) Probe: size, shape, skin quality, color, etc.

12. How has your body changed following your diagnosis of [state the condition]?

Probe: Physicality, mobility, aesthetics, appearance, etc.

13. Where did you obtain information about the [state the condition] and its effects or changes to the body? What was that information?

Sources: Self, family, friends, healthcare professionals, and community members.

- After receiving information about the disease and its effect on the body, how did you feel?

Probe: fear, anger, anxiety, depression, sadness, etc.

14. When you were experiencing the changes on your body, what were some of society's concerns that affected your body image?

Probe: concerns related to body reduction, weight gain, amputation, and breast removal, etc.

15. What have you done since your body went through the changes

Explore: biomedical treatment, traditional herbal treatment, spiritual treatment, changes in diet and physical activity

16. How have the changes in your body affected the relationship between you and your partner/family/friends? Explore positive and negative changes.

Probe: any experiences on sexual changes, or sexual challenges and coping strategies.

[Examine how partners/family/friends are supporting each other on issues of disease and body image, emotional/psychological well-being, and economic well-being]

17. What do you think are the causes of [state the condition]?

Probe: spiritual, biomedical, or physical causes for the changes in your body image?

Section C: Socio-cultural perceptions of body image and chronic diseases

18. What beliefs do people in your community and ethnic groups hold about chronic illness and body size/image?
19. Choose a card and explain whether the card represents an individual with a healthy body weight that can lead to a chronic condition.
- unhealthy body weight that can lead to chronic conditions?
20. Within your community how do people relate with those suffering from [state the condition] and its effect on body image?
Probe: stigmatization, discrimination, stereotyping, etc.
21. What is the typical Ghanaian view about being fat? Explore the source of the viewpoint, the meaning of that viewpoint, etc.
22. What cultural barriers prevent people with body image problems and chronic diseases from talking openly about them?

Section D: Maintenance, Disease management and body Image

23. How are you managing the current state of your body and the disease [weight gain, weight loss, affected part of the body] as you manage your condition(s)?
- What efforts are you making to maintain your body image?
(Consider dieting, exercising, herbal medicine, spiritual implications, and concoctions)
- What are your reasons/purpose for embarking on these efforts?
(Probe: what the efforts mean to them)
- What stress do you experience in these efforts?
24. Can you tell me if the medicine(s) that you take for the treatment of [state the condition] has affected your body image in any way?
- It could be positive or negative. What are the specific drugs?
 - what effect do they have on your body?

25. Are there any medications you take to maintain your body in addition to the medications for your conditions?

If yes, what are the medications? Why do you take them?

If not, why not?

Section E: Debriefing

Review interviews, explore and clarify concerns, and explain the following sets of interviews.

[2] INTERVIEW GUIDE – FOR ADULT CAREGIVERS

Pre-ambles: reviewing the information sheet and gathering demographic details.

Good [morning/afternoon] and thank you for your time and for agreeing to participate in this interview. My name is [Your Name], and I am conducting research on **Body image, embodiment and chronic illness** as part of my [PhD degree program at the University of Ghana]. I am particularly interested in knowing about your experience as a caregiver and how you feel the illness has influenced your care recipient's body image, self-perception, and overall well-being.

I want to guarantee that everything you share will be kept confidential, and your participation is voluntary—you are free to withdraw at any time without any negative consequences. I request your consent to record our conversation for the sake of accuracy. The recording will solely be used for research purposes. There are no right or wrong answers. Most interviews last about one hour, and we make time afterwards to discuss any issues that emerge. Are you happy for us to start and do I have your permission to record the interview?

Section A: Body image and chronic condition

5. I am going to show some cards with pictures/images of body sizes. Look at the cards and select the one that best describes your ideal body size.

- What do you think is the ideal body size or the body type that is most preferred in Ghana?

[When asking this question, there has to be a distinction between personal body image preference and culturally accepted body image]

- Do you think there are different Ghanaian expectations of the ideal body size/image for (A) men and (B) women?
- What is your view on ideal body size expected for (A) younger men and older adult men and (B) younger women and older adult women?

Probe: on aesthetics, appearance, physicality, skin color, etc.

6. Do you think there are different expectations of body image for ethnic groups? Probe: Asantes, Hausas, Gas, Ewes, Fantis, Dagbanis, etc.

Section B: The impact of chronic conditions on the body image of patients

7. How would you describe the body image of your care recipient before he/she was diagnosed with [state the condition(s) of the care recipient]?

Probe: would you say he/she had the ideal body size and image? Probe: size, shape, skin quality, color, height, etc.

8. How has the body image of your care recipient(s) changed after he/she has been diagnosed with [state the condition]?

Probe: Physicality, mobility, appearance, aesthetics, etc.

9. Where did you obtain the information about the disease and its effects on the body from?

Source: patient, a family member, a friend, a health professional, social networks, or the community at large.

10. How did you react to hearing about your care recipient(s) condition when you first heard about it?

Probe: fear, disappointment, depression, anxiety, sadness?

11. How has the change in the body image of your care recipient(s) affected your personal relationship with him/her? Explore positive and negative changes.

Probe: any experiences on sexual changes, or sexual challenges and coping strategies if the caregiver is the partner.

[Examine how partners/family/friends are supporting each other on issues of disease and body image, emotional/psychological well-being, and economic well-being]

12. What do you think are the causes of [state the condition]?

Probe: spiritual, biomedical, or physical causes for the changes in your body image

Section C: Socio-cultural perceptions of body image and chronic disease

13. What beliefs do people in your community and ethnic groups hold about chronic illness and body size/image?

14. What does thinness mean to you? What are the health implications of thinness?

- What does fatness mean to you? What are the health implications of fatness?

[let the participant choose a picture of thinness or fatness to explain]

15. Choose a card and explain whether the card represents an individual with a healthy body weight that can lead to a chronic condition.

- unhealthy body weight that can lead to chronic conditions

16. Within your community how do people relate with those suffering from chronic conditions and its effect on body image?

Probe: stigmatization, discrimination, stereotyping, etc.

17. What is the typical Ghanaian view about being fat? Explore the source of the viewpoint, the meaning of that viewpoint, etc.

18. What cultural barriers prevent people with body image problems and chronic diseases from talking openly about them?

Section D: Maintenance/Management of body image

1. How does your care recipient manage his/her present body and [state the condition], including weight gain, weight loss, and affected areas of the body?

- What efforts does he/she make to maintain his/her body image?

(Consider dieting, exercising, herbal medicine, spiritual implications, and concoctions)

- Do you know the reasons/purpose for embarking on these efforts?

(Probe: what the efforts mean to them)

- What stress does he/she experience in making these efforts
2. Can you tell me if the medicine(s) that your care recipient(s) takes for the treatment of the [state the condition] has affected his/her body image in any way?
 - It could be positive or negative. What specific drugs
 - What effect do they have on his/her body?
 3. Are there any medications that your care recipient(s) take(s) to maintain his/her body in addition to the medications for their conditions?
If yes, what are the medications? why do they take them?
If not, why not?

Section E: Debriefing

Review the interview, explore and clarify concerns, and explain the following sets of interviews.

[3] INTERVIEW GUIDE – FOR HEALTHCARE PROFESSIONALS

Pre-amble: reviewing the information sheet and gathering demographic details.

Good [morning/afternoon] and thank you for your time and for agreeing to participate in this interview. My name is [Your Name], and I am conducting research on Body image, embodiment and chronic illness as part of my [PhD degree program at the University of Ghana]. I am particularly interested in understanding your professional experience in working with patients who have chronic illnesses, specifically how you perceive the illness affects their body image, self-esteem, and overall well-being.

I want to guarantee that everything you share will be kept confidential, and your participation is voluntary—you are free to withdraw at any time without any negative consequences. I request your consent to record our conversation for the sake of accuracy. The recording will solely be used for research purposes. There are no right or wrong answers. Most interviews last about one hour, and we make time afterwards to discuss any issues that emerge. Are you happy for us to start and do I have your permission to record the interview?

Section A: Body image and chronic condition

5. I am going to show some cards with pictures/images of body sizes. Look at the cards and select the one that best describes your ideal body size.
 - What do you think is the ideal body size or the body type that is most preferred in Ghana?

[When asking this question, there has to be a distinction between personal body image preference and culturally accepted body image]

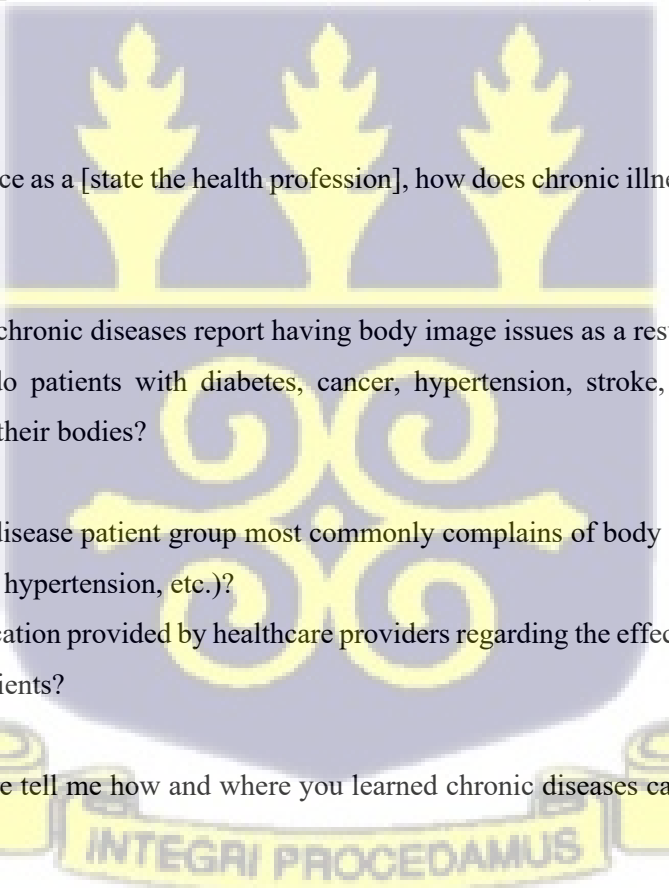
- Do you think there are different Ghanaian expectations of ideal body size/image for (A) men and (B) women?
- What is your view on the ideal body size expected for (A) younger men and older adult men and (B) younger women and older adult women?

Probe: on aesthesis, appearance, physicality, skin color, etc.

6. Do you think there are different expectations of body image for ethnic groups?

Probe: Asantes, Hausas, Gas, Ewes, Fantis, Dagbanis, etc.

Section B: The impact of chronic conditions on the body image of patients

- 
7. In your experience as a [state the health profession], how does chronic illness affect the body image of patients?
8. Do people with chronic diseases report having body image issues as a result of these diseases?
9. In what ways do patients with diabetes, cancer, hypertension, stroke, and overweight/obesity complain about their bodies?
10. Which chronic disease patient group most commonly complains of body image problems (cancer, diabetes, stroke, hypertension, etc.)?
11. Is there any education provided by healthcare providers regarding the effects of disease on the body image of the patients?
12. Could you please tell me how and where you learned chronic diseases can affect body image and embodiment?
- Investigate the source of information (media, family, friends, healthcare providers, community)

Section C: Socio-cultural perceptions of body image and chronic disease

13. What beliefs do people in your community and ethnic groups hold about chronic illness and body size/image?
14. What does thinness mean to you, and what are the health implications of thinness?
 - What does fatness mean to you, what are the health implications of fatness?[let the participant choose a picture of thinness or fatness to explain]
15. Choose a card and explain whether the card represents an individual with a healthy body weight or an unhealthy body weight that can lead to chronic conditions.
26. Choose a card and explain whether the card represents an individual with a healthy body weight that can lead to a chronic condition.
 - unhealthy body weight that can lead to chronic conditions?
16. Within your community, how do people relate with those suffering from chronic conditions and their effect on body image?
Probe: stigmatization, discrimination, stereotyping, etc.
17. What is the typical Ghanaian view about being fat?
Explore the source of the viewpoint, the meaning of that viewpoint, etc.
18. What cultural barriers prevent people with body image problems and chronic diseases from talking openly about them?

Section D: Psychological, emotional, and social challenges

19. What psychological complaints do they experience because of their physical condition?
20. How does the condition affect their bodies and affect their emotional well-being?
21. As a consequence of the chronic condition(s) that affect their body image, and embodiment, what sex-related problems do they experience?
22. In what ways does the disease affect the participants' relationships with friends, family, and members of the community?

Section E: Body image, embodiment management and treatment compliance

23. How do body image and embodiment issues impact treatment compliance among patients with chronic illnesses?
24. How do you think those with chronic disease manage their body image and embodiment? What are some of the things they do?
25. What effect has gender, socioeconomic status, occupational group, community and ethnic group had on individuals' body image and chronic conditions?
26. In what ways can chronic diseases and their impact on body image be made more understandable to patients and members of the community?

Section E: Debriefing

Review the interview, explore, and clarify concerns, and explain the following sets of interviews.

[5] INTERVIEW GUIDE – LAY HEALTHY INDIVIDUALS

Pre-amble: reviewing the information sheet and gathering demographic details.

Good [morning/afternoon] and thank you for your time and for agreeing to participate in this focus group discussion. My name is [Your Name], and I am conducting research on Body image, embodiment and chronic illness as part of my [PhD degree program] at the University of Ghana]. I'm interested in hearing your thoughts and opinions on how chronic illness affects people's body image and perceptions of their body within the community.

I want to guarantee that everything you share will be kept confidential, and your participation is voluntary—you are free to withdraw at any time without any negative consequences. I request your consent to record our conversation for the sake of accuracy. The recording will solely be used for research purposes. There are no right or wrong answers. Most focus group discussions last about one and a half hours, and we make time afterwards to discuss any issues that emerge. Are you happy for us to start and do I have your permission to record the interview?

Section A: Body image and chronic condition

5. I am going to show some cards with pictures/images of body sizes. Look at the cards and select the one that best describes your ideal body size.

- What do you think is the ideal body size or the body type that is most preferred in Ghana?
[When asking this question, there has to be a distinction between personal body image preference and culturally accepted body image]
- Do you think there are different Ghanaian expectations of ideal body size/image for (A) men and (B) women?
- What is your view on the ideal body size expected for (A) younger men and older adult men and (B) younger women and older adult women?

Probe: on aesthetics, appearance, physicality, skin color etc.

6. Do you think there are different expectations of body image for ethnic groups?

Probe: Asantes, Hausas, Gas, Ewes, Fantis, Dagbanis, etc.

7. What does thinness mean to you, and what are the health implications of thinness?

- What does fatness mean to you, what are the health implication to fatness?

[Let the participant choose a picture of thinness or fatness to explain]

8. What are your feelings about your current size/weight?

Probe: emotions, happy, sad, indifferent, anxious

Section B: The impact of chronic conditions on the body image of patients

9. Do chronic diseases affect the body image of those suffering from them? How?

10. Please tell me how and where you learned chronic diseases can affect body image.

- Investigate the source of information (media, family, friends, healthcare providers, community)

11. What do you think are the causes of [state the condition]?

Probe: spiritual, biomedical, or physical causes for the changes in your body image?

Section C: Socio-cultural perceptions of body image and chronic disease

12. What beliefs do people in your community and ethnic groups hold about chronic illness and body size/image?

13. Choose a card and explain whether the card represents an individual with a healthy body weight or an unhealthy body weight that can lead to chronic conditions.

27. Choose a card and explain whether the card represents an individual with a healthy body weight that can lead to chronic condition.

- unhealthy body weight that can lead to chronic conditions?

14. Within your community, how do people relate with those suffering from chronic conditions and experiencing issues regarding body image Probe: stigmatization, discrimination, stereotyping, etc.

15. What is the typical Ghanaian view about being fat? Explore source of viewpoint, meaning of that viewpoint, etc.

16. What cultural barriers prevent people with body image problems and chronic diseases from talking openly about them?

Section D: Management of the body image and chronic disease

17. How do you think those with chronic disease manage their body image? What are some of the things they do?

18. How can patients with chronic diseases maintain a healthy appearance/body image?

Probe: exercise, diets, aesthetics etc.

Section E: Debriefing

Review discussion, explore and clarify concerns, explain the following sets of interviews and negotiate future interviews with the participant.



APPENDIX B – PARTICIPANT PROFILES

Tables for bio-demographic information for participants, Individual with chronic conditions in individual interviews

Pseudonym	Location of study	Gender	Age	Ethnicity	Individual's Condition(s)	Level of Education	Marital Status	Occupation	Religion	Years with condition(s)
ICC-MS-II-1-AKU	James Town	Female	60	Ga	Diabetes, Hypertension	Form 4	Married	Petty trading	Christian	Diabetes- 17 years, BP- 11 years
ICC-MS-II-2-KAFA	James Town	Male	60	Ga	Stroke, Hypertension	Form 4	Divorced	Unemployed	Christian	Stroke- 12 years, BP-12 years
ICC-MS-II-3-PADIKI	James Town	Female	67	Ga	Diabetes, Hypertension, Arthritis	Form 4	Married	Unemployed	Christian	Diabetes- 5 years, Arthritis- 2 years, BP- 15
ICC-MS-II-4-	James Town	Female	68	Ga	Obesity, Hypertension	Form 4	Divorced	Unemployed	Christian	Obesity- 45, BP- 12
ICC-MS-II-5	Ussher Town	Male	38	Ga	Hypertension, Stroke	Basic	Divorced	Unemployed	Christian	Stroke-6 years BP- 6 years
ICC-MS-II-6	Ussher Town	Female	44	Fante	Asthma	JHS	Divorced	Seamstress	Christian	Asthma 44 years
ICC-MS-II-7	James Town	Male	44	Ashanti	Diabetes	JHS	Married	Butcher	Christian	Diabetes 1 year

ICC-MS-II-8	Legon	Female	59	Ewe	Diabetes, Hypertension	N/A	Widowed	Petty Trading	Christian	4 years
ICC-MS-II-9	Legon	Female	63	Fante	Breast Cancer	Tertiary	Married	Retired accountant	Christian	6 years
ICC-MS-II-10	Jamestown	Female	56	Ashanti	Hypertension, Arthritis	Secondary	Married	Petty trading	Christian	7-8 years
ICC-MS-II-11	Ussher Town	Female	29	Fante	Hypertension	Primary	Single	Food vendor	Christian	2 years
ICC-MS-II-12	James Town	Female	63	Akuapim	Hypertension	Primary	Divorced	Cleaner	Christian	15 years
ICC-MS-II-13	James Town	Male	64	Ashanti	Diabetes	Primary	Married	Artisan	Christian	1 year
ICC-MS-II-14	Ussher Town	Female	65	Fante	Stroke	JHS	Married	Petty Trading	Christian	4 years
ICC-MS-II-15	Legon	Female	35	Ewe	Breast Cancer	tertiary	Married	Administrato r	Christian	2 years
ICC-MS-II-16	Legon	Male	69	Mamprusi	Stroke, Hypertension, Diabetes	Basic	Divorced	Retired Security personnel	Tradition alist	Stroke -4, Diabetes – 5, BP - 5
ICC-MS-II-17	Legon	Female	59	Ewe	Hypertension, Diabetes	Tertiary	Married	Petty Trading	Christian	5 years

ICC-MS-II-18	Legon	Female	22	Fante	Sickle cell disease	Tertiary	Single	National service personnel	Christian	Whole life
ICC-MS-II-19	Legon	Male	25	Ashanti	Sickle cell disease	Tertiary	Single	Student	Christian	Whole life
ICC-MS-II-20	Legon	Male	41	Ga	Asthma	Tertiary	Married	Student	Christian	Whole life
ICC-MS-II-21	Legon	Male	37	Ga-Adangbe	Sickle cell disease	JHS	Married	Fashion designer	Christian	Whole life
ICC-MS-II-22	Legon	Male	43	Ga	Sickle cell disease	JHS	Co-habiting	Electrician	Christian	43 years whole life
ICC-MS-II-23	Jamestown	Male	44	Ga	Sickle cell disease	JHS	Co-habiting	Shoe repairer	Christian	44 years whole life

Individuals with chronic conditions in dyadic interviews

Pseudonym	Location of study	Gender	Age	Ethnicity	Individuals Condition(s)	Level of Education	Marital Status	Occupation	Religion	Years with condition(s)
ICC-DI-1a	Jamestown	Female	74	Fanti	Hypertension	Form 4	Widowed	Unemployed	Christian	7 years
ICC-DI-1b	Jamestown	Female	70	Akwapim	Stroke, Hypertension	N/A	Widowed	Unemployed	Christian	4 years

ICC-DI-2a	Ussher Town	Female	39	Ga	Hypertension	JHS	Married	Petty Trading	Christian	2 years
ICC-DI-2b	Ussher Town	Female	27	Krobo	Diabetes	SHS	Single	Petty Trading	Christian	14 years
ICC-DI-3a	Jamestown	Female	75	Fante	Hypertension	Basic	Married	Petty Trading	Christian	2 years
ICC-DI-3b	Jamestown	Female	30	Ga	Asthma	JHS	Single	Petty Trading	Christian	30 years
ICC-DI-4a	Jamestown	Female	47	Ga	Diabetes	JHS	Divorced	Petty Trading	Christian	2 years
ICC-DI-4b	Jamestown	Female	60	Ashanti	Hypertension	Basic	Widowed	Seamstress	Christian	2 years

Individual interviews with Caregivers of chronic conditions

Pseudonym	Location of study	Gender	Age	Ethnicity	Conditions cared for	Level of education	Marital Status	Occupation	Religion	Years of providing care
CG-II-1	Jamestown	Female	30	Ga	Diabetes, Hypertension	SHS	Co-habiting	Petty Trading	Christian	5 years
CG-II-2	Ussher Town	Female	43	Ga	Stroke, Diabetes, Hypertension	JHS	Married	Petty Trading	Christian	4 years

CG-II-3	Ussher Town	Female	40	Ga	Stroke	JHS	Divorced	Bus conductor	Christian	1 year
CG-II-4	Ussher Town	Female	59	Ga	Asthma, stroke, hypertension	Secondary	Divorced	Petty Trading	Christian	6 years
CG-II-5	Legon	Male	40	Ashanti	Breast Cancer	Tertiary	Married	Accountant	Christian	8 Months
CG-II-6	Jamestown	Female	64	Ewe	Prostate cancer, hypertension, stroke, diabetes	Primary	Married	Petty trading	Christian	5 years
CG-II-7	Legon	Female	47	Ewe	Sickle cell disease	JHS	Widowed	Petty trading	Christian	8 years

Dyadic interviews for caregivers of chronic conditions

Pseudonym	Study Location	Gender	Age	Ethnicity	Conditions cared for	Level of education	Marital Status	Occupation	Religion	Years of providing care
CG-DI-1a	Legon	Male	28	Buli	Diabetes, Hypertension	SHS	Single	Unemployed	Christian	4 years

CG-DI-1b	Legon	Female	30	Buli	Diabetes, Hypertension	JHS	Married	Petty Trading	Christian	4 years
CG-DI-2a	Jamestown	Female	61	Kwahu	Diabetes, Hypertension	Secondary	Divorced	Petty Trading	Christian	2 years
CG-DI-2b	Jamestown	Female	23	Ga	Diabetes, Hypertension	Secondary	Married	Petty Trading	Christian	2 Years
CG-DI-3a	Legon	Female	51	Ashanti	Diabetes, Hypertension	Primary	Married	Unemploy ed	Christian	10 years
CG-DI-3b	Legon	Male	28	Ashanti	Diabetes, Hypertension	Tertiary	Single	NSS	Christian	3 years
CG-DI-4a	Jamestown	Male	20	Ga	Stroke	SHS	Single	Student	Christian	5 years
CG-DI-4b	Jamestown	Female	42	Akyem	Stroke	Primary	Co- habiting	Cleaner	Christian	3 years

Healthcare providers

Pseudonym	Study Location	Gender	Age	Ethnicity	Conditions treated	Level of education	Marital Status	Occupation	Religion	Years of working in community
-----------	-------------------	--------	-----	-----------	-----------------------	-----------------------	-------------------	------------	----------	-------------------------------------

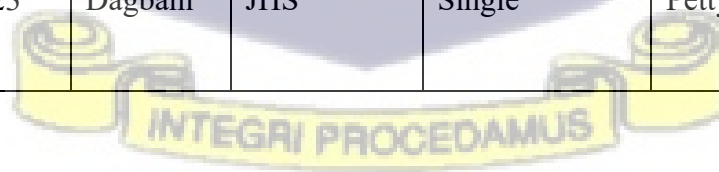
HCP-1	Ussher Polyclinic	Female	26	Fante	Diabetes, Hypertension, stroke, Asthma,	Diploma	Single	Nurse	Christian	1 year
HCP-2	Ussher Polyclinic	Female	28	Ashanti	Diabetes, Hypertension, stroke, Asthma,	Diploma	Single	Nurse	Christian	8 months
HCP-3	Seaview Clinic	Male	59	Krobo	Diabetes, Hypertension, stroke, Asthma, Sickle cell disease, etc.	Tertiary	Married	Clinical Pharmacist	Christian	22 years
HCP-4	Ussher Polyclinic	Male	34	Ashanti	Diabetes, Hypertension, stroke, HIV Aids etc.	Tertiary	Married	E N T Specialist	Christian	14 years
HCP-5	Legon	Female	37	Ashanti	Breast Cancer	Tertiary	Single	Clinical Psychologist	Christian	4 years
HCP-6	Palladium	Male	37	Ga	Diabetes, Hypertension, stroke, etc.	Tertiary	Single	Dietician	Christian	4 years
HCP-7	Legon	Female	28	Ashanti	Diabetes, Hypertension,	Tertiary	Single	Pharmacist	Christian	2 years

					stroke, Cancers, Sickle Cell, Asthma, HIV Aids etc.					
HCP-8	Ussher town	Female	31- 40	Ashanti	Diabetes, Hypertension, Stroke	Diploma	Married	Nurse	Christian	-

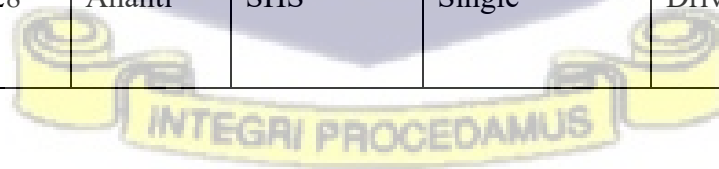
Individual information on Focus Group Discussants.

Pseudonym	Study location	Gender	Age	Ethnicity	Level of education	Marital Status	Occupation	Religion
FGD-1-F-L-Mama Azuma	Legon	Female	36	Brusa	N/A	Married	Petty trading	Christian
FGD-2-F-L-Awura	Legon	Female	43	Ewe	Vocational	Married	Seamstress	Christian
FGD-3-F-L-Abena	Legon	Female	34	Ewe	Tertiary	Married	Businesswoman	Christian
FGD-4-F-L-Rebecca	Legon	Female	35	Akwapim	JHS	Co-habiting	Hairdresser	Christian
FGD-5-F-L-Hellen	Legon	Female	41	Guan	Tertiary	Separated	H/R	Christian

FGD-6-F-L-Ama	Legon	Female	28	Ashanti	Tertiary	Single	Student	Christian
FGD-7-F-L-Fosua	Legon	Female	38	Fante	JHS	Married	Petty Trading	Christian
FGD-8-F-L-Akos	Legon	Female	40	Akwapim	JHS	Married	Petty Trading	Christian
FGD-9-F-L-Rama	Legon	Female	38	Mamprusi	N/A	Married	Petty Trading	Muslim
FGD-10-F-GM-Akwele	Ga-Mashie	Male	20	Ga	SHS	Single	Unemployed	Christian
FGD-11-F-GM-Esaana Asa	Ga-Mashie	Male	26	Ashanti	SHS	Co-habiting	Welder	Muslim
FGD-12-F-GM-Ama GM	Ga-Mashie	Male	27	Ewe	JHS	Co-habiting	Unemployed	Christian
FGD-13-F-GM-Cynthia	Ga-Mashie	Male	21	Ga	JHS	Single	Boxer	Christian
FGD-14-F-Afterwork	Ga-Mashie	Male	22	Ga	JHS	Co-habiting	Footballer	Christian
FGD-15-F-GM-Tsofa	Ga-Mashie	Male	23	Dagbani	JHS	Single	Petty trading	Christian



FGD-16-F-GM-Zipoo	Ga-Mashie	Male	24	Ga	SHS	Single	Petty trading	Christian
FGD-17-M-GM-Nuumo	Ga-Mashie	Male	20	Ga	JHS	Single	Footballer	Christian
FGD-18-M-GM-Castero	Ga-Mashie	Female	62	Ga	Basic	Married	Petty trading	Christian
FGD-19-M-GM-Jah	Ga-Mashie	Female	50	Ga	Basic	Married	Caterer	Christian
FGD-20-M-GM-Bob	Ga-Mashie	Female	52	Ga	Primary	Divorced	Petty trading	Christian
FGD-21-M-GM- Odeshay	Ga-Mashie	Female	55	Ga	Form 4	Divorced	Petty trading	Christian
FGD-22-M-GM- Painful	Ga-Mashie	Female	61	Ga	Form 4	Widowed	Petty trading	Christian
FGD-23-M-GM- Mango Land	Ga-Mashie	Female	50	Ga	JHS	Married	Petty trading	Christian
FGD-24-M-GM-Money	Ga-Mashie	Female	47	Ga	SHS	Single	Petty trading	Christian
FGD-25-M-L-Akwesi	Legon	Male	28	Ahanti	SHS	Single	Driver	Christian



FGD-26-M-L-Benjilo	Legon	Male	45	Kwahu	Tertiary	Married	Administrator	Christian
FGD-27-M-L-Nana	Legon	Male	22	Ewe	JHS	Single	Electrician	Christian
FGD-28-M-L-Agya Manu	Legon	Male	70	Ashanti	JHS	Married	Petty trading	Christian
FGD-29-M-L-TT	Legon	Male	35	Krobo	Form 4	Single	Cleaner	Christian
FGD-30-M-L-Charles	Legon	Male	68	Ga	Form 4	Married	Retiree	Christian
FGD-31-M-L-BY	Legon	Male	60	Ashanti	Form 4	Married	Driver	Christian
FGD-32-M-L-Remember	Legon	Male	48	Wa	JHS	Married	Gardener	Muslim
FGD-33-M-L-Fred	Legon	Male	52	Ga	Tertiary	Married	Pastor	Christian



APPENDIX C – CODING FRAMEWORK
CODING FRAMEWORK FOR BODY IMAGE, EMBODIMENT STUDY
CHAPTER FOUR
SOCIAL REPRESENTATIONS OF BODY IMAGE

Ideal body						
Organizing/Main Themes	Basic themes	Codes	ICC	GC	HCP	LIIs
Representations of ideal body	- Aesthetics: attraction	Fine body,	4	3		
		curvaceous,	4		3	8
		fit dressing,	4		2	
		pleasing and attractive,	5			2
		Nice body image,	5	7		12
	- Functionality; mobility	Walk, sit, stand	4	3		10
	- Size	Normal or average size,	7	3	3	6
		not overweight or not too small,	4			
		Previous body size	3	3	3	1
	- Healthiness	Unsusceptible to diseases	3	2	5	4
		Active				11
	- Muscularity and attractiveness	Muscular body	3		2	3
	-	Attract opposite sex				2
	- Occupational suitability	Professional appearance	3			2
	- Ideal Body size Cards	Underweight- A-B	1	4	1	2
		Normal weight- B-C	15	5	6	19

		Overweight -E-F	10	3		9
		Obese – G-H-I	2			
Gendered and age nuances	- <i>Young women:</i> beauty and attractiveness	Aesthetics	3	3	4	6
		Attractive to me or sexy	3			3
		Drug enhancers,	3			2
		normal or Average body size	5	2	1	
		Physically active or smart		4		8
		Healthy		2		6
		Men preference for women			2	
	- <i>Ideal body size</i>	Underweight- A-B	4	2	5	5
		: Normal weight- B-C	10	5	2	12
		: Overweight -E-F	12	2		2
		Obese – G-H-I	1			
	- <i>Older women:</i> smallish and healthy	Ageing and physical change	5	3	5	4
		Health concern (healthy/unhealthy)	4	5	2	3
		Social interactions,				

		mobility/lifestyle	4		2	1
	-	Underweight- A-B	3	3	1	
		Normal weight- B-C	1	3	3	4
		Overweight -E-F	6	2		9
		Obese – G-H-I	5		2	
	- Young men: fit and attractive	Attractive (smart)	9	2	1	
		Muscular/ strong	8	3	6	3
		health concern (Active),				10
		attraction to women,	3			
		(Clothing appearance	3		1	
		Average				3
	- Occupation impact	Job preference	1			
	- Ideal body size cards	Underweight- A-B	5	4	1	1
		Normal weight- B-C	14	5	5	13
		Overweight -E-F	2	1	1	2
	- Older men: active and strong	Health and body size (Active)	5	3	3	6
		Overweight and health risk	2			
		dependency	2			
		Lifestyle	3		1	

	- Ageing issues	Ageing	12	5	2	4
	- Heredity	Heredity	1			
	- Ideal body size cards	Underweight- A-B	3			2
		Normal weight- B-C (	5	8	4	6
		Overweight -E-F	7		1	6
		Obese – G-H-I	1		2	1
	- Ghanaian women: Attractiveness and social appearance	Beauty and appearance	6	3	1	6
		men's preference for women's BI	1	2	1	
		Curvaceous	5		2	3
		Average/normal		3		
	- Healthy and functioning body	Active and functioning body, physical dependent,				2
		preference for big bodies			2	5
	- Cultural belief	Big is beautiful,	1		1	
	- Ideal body size cards	Underweight- A-B	2	1		
		Normal weight- B-C	6	3	2	6
		Overweight -E-F	4		3	5
		Obese – G-H-I	3	1	2	9
	- Ghanaian men: Attractiveness and social preference	Beauty and appearance (nice)	3	3	1	4
		normal or average body size	3			4

		women preference for men's BS	4			2
		preference for slim body size	3			2
		Muscularity	2	1	2	
	- Health considerations	Health reasons	5	2		3
	- Cultural belief	Big body associated with wealth	1			3
	- Ideal body size Cards	Underweight- A-B	1			
		: Normal weight- B-C	12	4	3	7
		: Overweight -E-F	2	1	1	8
		Obese – G-H-I	2			
Ethnic representations of ideal body	- Akan: Balanced body size and complexion	Average size,	11	3	4	
		Dark skin	6	2	3	6
		average height	7	2		
		short		2		7
		slim		1		2
		tall		2	1	
	- Ga: Preference for lager body	Big bodies or fat bodies,	13	4	6	16
		Darker skin,	4	3		
		Bleach,	3	4	3	

		use drug enhancers	4			
	- Ewe: Diverse body size and complexion	Big body,	5	2	3	3
		Light-skin,	4		5	3
		Average height	2	3	2	
		tall		2		
	- Northerners: height, muscular and lean body	Tall,	6	3	3	
		Muscular,	2	2	2	
		(Fair-dark skin,	5		2	
		Average body size	4		2	
		Slim body	4	1		
Representations of fatness and thinness	- Meaning of Fatness	Bad fat	3		6	2
		big body size	4			
		fatty food as cause of fatness	8			
		concealed illness	3			
		Inability to perform physical activities	5			
		fatness as risk factor for disease	12	8		
		genetics	5	5		
		fatness as hard-work	1			

		silhouettes body size	10	11		
		childbirth		3		
		beautiful				4
	- <i>Implication of fatness</i> - <i>Positive</i> - <i>Negative</i>	Good health	3			4
		Caregiver burden	5	1		
		physically inactive	8	3	1	
		prone to diseases	17	9	4	9
		difficult to get partners			1	
	- <i>Meaning of Thinness</i>	natural	4	7		4
		smallish body	13	2	4	
		underweight silhouettes	11	4	2	
		healthy and active	5			8
		cause by illness	2			1
		sign of illness or prone to disease	6	3		
		unhealthy body size			3	
	- <i>Implication of thinness</i> - <i>Positive</i>	Thin as healthy	6	10	6	
		illness masking	3			2

	- <i>Negative</i>	Unhealthy/prone to disease	7	5		12
		Lack of respect	1			
		Nutritional deficiency stereotype	1	2		
Cultural perception of fatness in Ghana	- Perception of fatness	Fatness as beauty	10	2		
		fatness as wealth or prosperity	5	2	3	
		fatness as unhealthy	4	3	2	
	- <i>Stigmatisation</i>	Stereotype	3		2	
		Discrimination healthy		1	1	
Sources of information on fatness	- Sources of knowledge	Community,				1
		Television,				
		Hospital				2
		personal observation				1



Sources of knowledge on ideal body

Organizing/Main Themes	Basic themes	Codes	ICC	CG	HCP	LIs
Scientific/Medical (Hospitals) knowledge	- Hospital, healthcare professionals - Educational institutions	- Hospital, doctors, nurses - School, books, CPDs, workshops	21	9	3 8	3
Embodied/Personal Experience	Lived experience	Affected, personal	9		6	
Common sense knowledge	Observation	saw people with chronic conditions	6	5	3	19
Religious knowledge	Religious spaces	Church HCP education -church		2		3
Social knowledge	Social networks; Family, friends, community members	Siblings, parents, wife, mother	8	2		12
Media knowledge	- Traditional media - Digital/social media	- TV, radio, newspapers - websites, online articles	6 4	4 1	3	5
Cultural knowledge	- cultural norms - cultural practices	History or cultural sayings	1			2

Functions of representations of ideal body –

Organizing/Main Themes	Basic themes	Codes
Psychological functions	- functioning: acceptance of diagnosis: - disruption; denial of diagnosis	- resilience, positive outlook, take control, professing long life - overthinking, sleeplessness,
Treatment and management strategies	- coping strategies - adaptive strategies: Compliance with advice - Disregard for treatment measures	- spiritual, controlling emotions and avoidance coping

Seeking social support	- Family support	People to keep company
------------------------	------------------	------------------------

CHAPTER FIVE

REPRESENTATIONS OF BODY IMAGE IN ICC

Body image and chronic illness experience

Organizing/Main Themes	Basic themes	Codes	ICC	CG
Pre-diagnosis	- Satisfied with body size	- Plumb/big body size, - Normal body /fine body, - perception of self as slim body	13 7 2	4 6
	- Beautiful skin color	Nice skin color	4	5
	- Dress to fit body	fashion	3	
	- functionality	- physically active, fatigue	5 3	4
Post-diagnosis	- bodily changes	- Darkening skin, - hair loss, - amputation, - breast removal, - eye color, weight fluctuations		1
	- Negative/ Dissatisfied with body image	- Dissatisfied with body image - Impacted skin color - affected choice of clothes - slowed physical development, - loss weight	12 4 3 1 10	3 4 6
		deforming the physicality of the body	5	4

	-	Embarrassment and shame Uncertainty	5 7	3
	Embarrassment and shame	Embarrassed	5	1
	- Positive body change / satisfied with body size	- Satisfied with current body weight, Satisfied with complexion	11 3	1
Discrepancies: Negative-	Emotional disruption	Grief, sadness, shock, fear, anxiety, disappointment, regret, worry, shame	6	2
	Psychological disruption	Reduced self-esteem	6	2
	Social disruption	Social isolation, stigma	8	3
	Existential crisis	sense of incompleteness	2	
	Functional disruptions		9	5
	Physical disruptions		11	4

Embodiment and chronic illness experience

Organising / Main themes	Basic theme	Codes	ICC	CG
Pre-diagnosis	Active and functioning body	Physically active Socially active		4 1
Post-diagnosis	Able to perform daily activities	Functioning body	3	



	Declining in functional use of the body	Unable to perform daily activities	13	5
		Partially immobile,	7	7
		restricted activities,	7	
		unable to perform previous activities,	9	
		fatigue,	3	
		breathing difficulty	1	
		Unable to speak	1	2
		Experiencing numbness	3	2
		Unable to sleep	3	2
	Physical barriers to sexual activities	Experience changes in sexual activities,	7	1
		low sexual desires,	2	
		reproductive dysfunction	4	
	Physical distress	Experiencing pain	6	4
	Psychological impact/disruptions	Low self-esteem,	2	
		misperception	1	
Psychosocial impact on embedment	Impact on social activities	Gender role,	2	
		loss of interest in social activities	5	4
	Occupational disruptions	Physical incapacity to work,	6	2
		career change,	3	
		job security	1	

	Economic impact	Financial difficulty	6	4
	Educational impact	Affect schooling and learning	3	

Disease impact on relationship with significant others

Organizing/Main Themes	Basic themes	Codes	ICC	CG	OB	LI
Social engagement	- Social support	- Emotional support, - spousal support, - financial support, - prayers from family, friends and church, - support from friends,	6 6 11 3 4 4	12 4 3 3 4	2 2 3 1	3 4 5
	- Lack of support	- Lack of social and emotional support,	3 4	2	3	8 4
	- Stigmatisation	- Stigma and misconception	4 1	2		14
	- Impact on relationship	- Divorce, - Emotional burden,	3 5	5	2	

		- Difficulty sharing illness with family - Physical burden of caregiving	1	6	2	
		- Neglect - Depression and anxious			2	
	- Impacted social life	Affected social activities	4	6	2	-
Supportive in sexual relationship	- Sexual adjustment	Understanding partners	4	3		-
Stigmatisation	- Psychosocial impact and stigma	- Misconceptions, - Stereotype and stigmatisation,	9	2	1	5
		Gossip	6		3	3
			5			3
	-					-
Disease impact on participants from community members (CG)	- Reaction to changes on the body image	Care	2		3	-
	-	Caregiver burden			3	-
	-	Stigmatization			3	
	-	Supernatural belief			2	-



HLI knowledge on disease effect on the body

Organising theme	Basic theme	HLI	Codes
Disease impact on the body	Affected body	10	Deterioration
		6	Body alteration
		6	Immobile/limited in mobility
		5	Physical effects (amputated, sores, reduce weight)
		2	Impede body functioning

Causal attributions to changing body

Organizing/Main Themes	Basic themes	ICC	CG	HCP	HLCM	Codes
	- Causes to bodily changes	7	8	2	10	- Lifestyle,
		4			2	- Genetics,
		4	4			- Biological/medical,
		8	2	1	2	- spiritual
					2	- Curse
				4	3	- Stereotype/stigmatisation
					6	- False attribution
	- Perceptions of disease and	2			5	- Cancer,

	physical manifestation	4 3 2 2 1			5 1 6 1 1	- Diabetes - Sickle cell disease - stroke - Hypertension - asthma - obesity
Diagnosis impact on patients	Psychological impact	3 3 5 3 1 1 3 3 4 2 1	2 4 1 3 3 2 3 3 3 3 2			- Scared - Unhappy - Worried - Disturbed - Shocked - Sad - Negative feeling - Denial state - Frightened -comply to advise Economic interpretation of illness

Organising theme HCP	Basic theme	HCP	Codes
Knowledge of impact of disease on body image and embodiment	Physical impact	4	Weight fluctuation (gain weight, loss weight)
		3	Hair loss
		2	Change in skin color
		3	Disfigurement
		5	Change in appearance
		3	Impotent
		5	Sexual challenges
		2	Los of speech
		3	Disability
		2	Deformity
	Psychological impact	1	Feeling discomfort
		1	Fear of difficulty in finding a partner
		1	Over conscious/avoidance
		1	Social withdrawal

		ICC	CG	HLCM	
Barriers to disclosing diagnosis	Knowledge barrier	4	4	6	Lack of knowledge
	Psychological	8		4	Shame and embarrassment,

		1	4		shyness
		4	2	6	Stigmatisation
			3		Social withdrawal
			2		Individual difference
	Social	7	3	3	Gossiping,
		2		1	stereotype
	Financial		2	4	Financial challenge
	Spiritual		2	4	Supernatural/ spiritual connotation

CHAPTER SIX BODY IMAGE MANAGEMENT AND CHRONIC ILLNESS

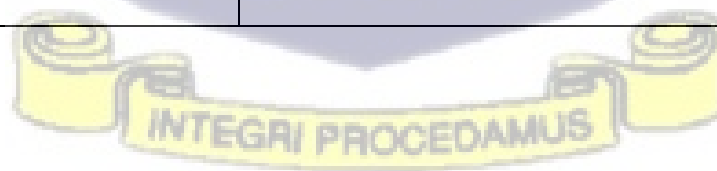
Body Image management:

Organizing/Main Themes	Basic themes	Codes	ICC	CG	HCP	LIs
Holistic management	Coping strategy	Comply with instruction,	6	2	3	5
		Avoidance and prevention,	3	1		
		spiritual coping,	6	3		4
		coping with illness,	5			
		fewer physical activities	2			
	Dietary management and hydration	Dietary management	21	8	3	25
		food Supplement ,	4	2		
		drinking of water	4	1		

	Physical Care and activity management	- Physical activity (EXERCISE) weight management, Hot water therapy, Avoiding injury Change of lifestyle	10 4 4 3 8	7 1	3	8 5 7
	- Aspiration for perfect body	Desire for perfect eyes	2			
		Change whole body, desire to fix specific body parts, Desire to gain weight, maintain current size, Reduce weight	8 6 4 3 7			
	- Restore physical health	Reduce pain intensity	6			

Chronic illness management:

Organizing/Main Themes	Basic themes	Codes	ICC	CG	HCP	LI
------------------------	--------------	-------	-----	----	-----	----



	Orthodox medicine	Medical treatment Medications, Ventolin inhaler, Insulin injection, painkillers	19	8		6
	Herbal medicine	Herbal medicine	6	4		3
	Medical Pluralism	Orthodox and herbal	5	4		
Physical management practices	Aesthetic practice	Controlling emotions,	3			
		Camouflage of physical effects (wear sunshades, big dresses, breast pad),	4	3	3	
		Wigs	4			
		Wear wig slippers of swell,	1	2	3	
	Psychological strategies	Not over-thinking, control anger	5			
	Rest	Enough rest	5			4
	Massage	Massage therapy,	3	1		
		Wheelchair	2	2		
		Walking stick	3	2		1

Sources of treatment and management of conditions

Organizing/Main Themes	Basic themes	Codes	ICC	CG	HCP
Orthodox treatment	- Hospital, pharmacy, drug stores	Hospital, doctors medicine, pharmacy	11	5	4

	-				
herbal	- Herbal medicine	Herbal medicine	4	4	2
	Communal	friends, family, neighbours	5	2	2
	Religious	Spiritual, prayers, shrine	7	3	4
	Media	TV, Radio	8	2	4
		Social media, online	3	1	2
		education	1	1	

Organising theme	Basic themes	Codes	ICC	CG	HCP
Challenges with management treatment	Treatment effects	Positive effect	9	5	
		Negative effect	11	4	1
	Barriers to effective management and treatment	Financial constraints	7	4	2
		Side effect of drugs (reduces sexual drive)	3		4
		Afraid of orthodox treatment	1		1
		Frustration with available food and dietary guideline,	3		
		Challenges with schedule time	2		

CHAPTER SEVEN IMPROVING CARE

Care Needs

Organizing/Main Themes	Basic themes	ICC	CG	HCP	Codes
	- Financial	6	-	-	- Financial challenges

	- Dependency	1	5	-	- Personal hygiene needs support (clean urine, room etc)
	- Physical need	6	2		Mobility assistive help (Visit to hospital, surgeries, medication adherence)
		8	3		Providing food, medication management help
		3			Dressing assistance need
	Spiritual support	4			Prayers, pastors visit, non-caring church members
	Healthcare providers	4			Lack of proper education on body alteration,
	Psychological and emotional need	7	1		
	Social care needs	4			Family support, friends support community support

Care Experiences

Organizing/Main Themes	Basic themes	ICC	CG	Codes
	Plurality of treatment sources	11	3	Hospital, talking to medical Doctors, buy from pharmacy
			5 4 1	Herbal medicine, traditional medicine, shrine consultation
	Orthodox and herbal	4	5	Herbal, traditional, shrine, orthodox
	Caregiver dynamics		7	Emotional support, overburdened, dependency, psychological support
Management of the body	Body alteration	4		Change body image
	Appearance impact	4 2		Visible effect Invisible effect
	Psychological impact	4		Emotional distress, anxious, frustration, Fear, uncertainty about the future, existential reflection

Improving Care

Organizing/Main Themes	Basic themes	ICC	CG	HCP	Codes
Care improvement	Accessibility of treatment	11	5	4	Financial challenges
	Quality care	4	-		Lack of resources, good care, uncaring HCPs
	Cultural sensitivity of care	4	-		Blend both herbal and orthodox medicine, respect herbal medicine
	-	-	-		-
Education on management	- Health Education	3		5	Education on Chronic Diseases awareness,
		2		2	Education on effects on the body
		4			No education on disease impact on the body
		1		1	Education on drug adherence
	Guidance on appearance	3	2	2	Guidance on aesthetic appearance
Improving healthcare system	Support system	3		1	Policy for proper care,
		2		1	Funding support,
				2	Less expensive care
		1		1	Include Psychologist in care management of the body'
		1			Provide assistive devices

