



## Research Article

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# Lived Experiences of Diabetics with the Health Care System in the Rural Areas

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## Abstract

Descriptive Phenomenology was used to explore the lived experiences of diabetes patients with the health care system in the rural areas of the Eastern Region. Thirty-one diabetes patients were conveniently interviewed using semi-structured interview guide. Analysis of the interview data was done in line with Interpretative Phenomenological Analysis (IPA) approach. The two main themes generated were accessibility to health care facilities, and encounter with health care providers. Each of these themes had sub-themes. Patients narrated the difficulties experienced with transportation when accessing health care. The poor road networks and long distances compromised their clinic attendance. Patients also go through long queues at the various clinics which they perceive it to be time consuming, and complained about the different doctors they meet every clinic day. In terms of their encounter with health care professionals, most patients commended the positive attitudes of the health care professionals, but few also bemoaned the inadequate time for consultation. Based on the experiences shared by patients, it was recommended that health centres, clinics, and Community Health Planning and Services (CHPS) compounds in these rural areas be well resourced to reduce the burden on the diabetes clinics in towns and cities, and to also reduce the stress patients go through on clinic days.

## Introduction

Diabetes has become a global public health threat because of its prevalence in both developed and developing countries in the world [1]. According to International Diabetes Federation (IDF) report of 2016 [2], 450 million people are living with diabetes in the world and approximately 5.1 million people die

from the disease every year. Globally, it is estimated that 146 million diabetic people were living in rural areas in 2017 and these figures were projected to increase to 279 million by 2045 [3]. This global trend has similar implications on Africa. For example, in 2013, almost half of the number of people living with diabetes in Africa died of the condition [4]. In Ghana, diabetes is the cause of prolonged ill health as this has been identified in over four million of the Ghanaian population [1,5]. It is alarming to note that the prevalence of diabetes mellitus in some parts of Ghana is even higher than the world average of 2.8%. Aikins and Ofori-Atta posited that diabetes threatens 50% of Ghanaians [6]. In 2019, approximately 281 adults between the ages of 20-79 years were reported with diabetes in every 1000 individuals in Ghana. One thousand two hundred and nine (1,209) Type 1 diabetes cases were found in children and adolescents between 0-19 years [7]. In the said year, approximately 5,397 diabetes related deaths were recorded in the Ghanaian adult population, and the national prevalence and age adjusted comparative prevalence of adults' diabetics were 1.8% and 2.5% respectively [7].

Access to health facilities is important as it improves the living standards of the entire populace. Therefore, despite a person's socio-economic status and geographical location, it is important that access to health care becomes imperative. The situation has not been anything better among Ghanaians, especially those living in the rural areas. The rural communities are often disadvantaged since most of the health facilities and hospitals are concentrated in the urban areas. The Government of Ghana has not relented on its effort to increase the quality of health care for the rural populace. However, this objective of reaching the rural people with close-to-client service has not materialized [8]. One of the strategies which were adopted to enhance access to health among the rural people has been the Village Health Workers (VHW) system which was established in the 1980s, but this has not necessarily been achieved. The VHW initiative was faced with some barriers that prevented its success [9], and these challenges included training, resources, organization, supervision and monitoring which eventually led to the collapse of the entire initiative [10]. Despite the Government's effort to achieve Health for All, many Ghanaians (70%) still travel from long distances (8km) to the nearest health facility to access health care [8] and this has eventually increased the mortality rate [10]. According to Nyong'oro et al., the Ministry of Health has targeted access to health care delivery as its main focus and has therefore introduced some other policies and strategies to achieve main goal [9]. Some of these policies include Community-based Health Planning and Services

(CHPS) which was introduced in 1999, National Health Insurance Scheme (NHIS) introduced in 2004, and Health Sector ICT Policy and Strategy introduced in 2004. With all efforts, Ghana has not been able to achieve the Millennium Development Goals which are health related (Goals 4 and 5) [11]. A modest achievement has been made in the area of non-communicable diseases; however, MOH noted that sufficient information on the actual size of burden of non-communicable disease (NCD) was difficult to access [12].

According to van den Boom, Nsowah-Nuamah and Overbosch, Ghana with a population of 23.5 million had only 1,439 health care facilities and this remained a problem [13]. Research conducted by van den Boom et al. noted that healthcare facilities or centres were not proportionally distributed across the country, thus preventing most of the rural dwellers from accessing proper health care [13]. Most Ghanaians do not live close to a health care facility where medical consultants could be reached; however, half of the populace lives about 5km to hospital facilities [13]. Even though others live 5km away from health care centres, they cannot access health care because of transportation problems. About 25% of the people studied by van den Boom et al. lived more than 15km from where health care could be accessed [13]. Sulemana and Dinye also examined access to health care among rural dwellers and the result showed that 70% of the participants had at least once in their lifetime accessed hospitals, clinics and health centres located in the district capitals [10]. The findings of the study also revealed that accessing these health facilities was not encouraging to participants due to ineffective transportation systems and long distances. This situation has increased the mortality rate among rural dwellers, and the cost of health care associated with transportation challenges. Tricycles and boats were often the expensive and dangerous means by which individuals visited hospital in case of emergencies when the person's condition was severe and threatening. Finally, Sulemana and Dinye concluded that access to health services in the rural areas was limited due to few health workers, inadequate health facilities and equipment, poor transportation system, high illiteracy rate, low-income levels, and poor communication services [10]. Similar transportation challenges have been reported by Carolan et al. [14], Kagee, Le Roux and Dick [15], and Metta et al. [16].

In order for patients to accommodate the problem with accessing health care and improve health outcomes, issues bordering on inequalities must be addressed. Africa Health Workforce Observatory emphasized that there was unfair distribution of health facilities and human resources both within and among regions [17]. This was also confirmed by National Health Insurance Authority [NHIA] [18] and the Ghana Statistical Service [19] that rural dwellers and the poor were less likely to access health facilities (like National Health Insurance Scheme [NHIS] cards) than the rich households and people in the urban centres. Findings from Drislane, Akpalu and Wegdam [20] indicated that it was difficult for rural areas to receive medical training because of lack of health personnel and health care facilities [20]. Thus, there is an urgent need for health personnel (physicians) in the rural areas; however, their working conditions are not attractive enough to lure and retain the physicians in the rural areas. The main focus of health care is the promotion of health and well-being of people, its major aim being ensuring the provision of adequate, efficient and equitable ac-

cess to preventive and curative health care as suggested by the Alma-Ata Declaration [21]. The Alma-Ata Declaration states that primary health care is the key to the achievement of the goal of Health for All. Patient-centred health care is a person-oriented approach which intends to meet the needs, preferences and expectations of individuals. Donabedian [22] conceptualized health care as a system, but also noted that the relationship between quality and system was difficult for people to understand [23]. According to him, the success of a system is dependent on the individual's ethical perception. Therefore, Donabedian [22] proposed that love is the ultimate secret to quality. Thus, health care professionals need to love the patient, love the profession and have love for God.

Researches from advanced countries have reported that patient-centred health care improves quality of care processes, user's self-management, satisfaction, and reduces the general cost of health care due to emergencies and hospitalization [21,24,25]. Patient-centred health care that provides patients with diabetes-related information increases patients' feelings of autonomy and self-confidence, and reduces cost and complications [26]. Respondents in Tabong et al. [27] study expressed satisfaction at the care given to them by the health care professionals. They reported a positive experience with the health system, and opined that the health care providers treated them well. In a study by Dube, van den Broucke, Dhoore, Kalweit and Housiaux [28] to review the current state of policies and implementation of Diabetes Self-Management Education (DSME) in South Africa, it was recognised that doctors, nurses and dieticians usually provided diabetes self-management education. Similar findings about health providers' care have been confirmed by Bayındır Çevik, Özcan and Satman [29]. Other studies have cited some negative experiences of patients with regards to time spent (usually within five minutes) [30], communication [31,32], attention and respect (disrespect and abuse) [31-35]. O'Brien, van Rooyen and Ricks [36] conducted a qualitative, descriptive, exploratory and contextual study at Nelson Mandela Bay in South Africa, to explore self-management experiences of diabetes patients. As part of patients' view on how professional nurses assisted them to achieve self-management, they reported that the nurses were at times insensitive to the manner and time in which diabetes information was presented. Thus, education of patients was done at the convenience of the nurses but not when the patient was ready. In other instances, health care professionals failed to establish relatedness with their patients and this affected time spent, communication skills, ability to explain information, counselling, emotional support and reassurance, and this usually occurred at the time of diagnosis [31]. Some service providers exhibited rude and impatient behaviour, and eventual separation from patients.

The disappointment of and misbehaviour from health care providers have also been reported by patients in Booyesen and Schlemmer [33], Yasmin et al. [32] and Zimmermann et al. [35]. Studies have reported on the time spent and delays that occurred at the health facilities which could also compromise quality of health care [14,37,38]. Carolan et al. [14] explored the concerns and experiences of individuals in low socio-economic settings and one of the concerns raised by patients was the time they had to wait in order to meet the doctor for consultation due to long queues. These delays and waiting time as reported by Mwangome et al. [38] might have caused the

collapse of some patients because they could only eat after they had tested for fasting blood sugar and met the doctor. Consistently meeting a particular health provider is key factor in the quality of care as this helps with establishment of rapport and relatedness with patients thereby improving doctor-patient relationship. For example, in Sweden, diabetes patients were taken care of at the primary health care centres with a physician specialized in family medicine, and a diabetes nurse [39]. According to Pikkemaat et al. [39], diabetes patients who did not have any complications visited the facilities twice every year to meet the physician and nurse on scheduled basis. Any additional visits by the patients could occur only when there were complications due to changes in medication. Patients were only referred to another specialist outside the facility only when their complications could not be managed at the primary health care centre.

The population distribution pattern in the Eastern Region shows that 34.6% of the region's population lives in urban settlements while a greater percentage (65.4%) lives in rural communities [40]. There has been an increase in diabetes case in the region from 31,887 in 2014 to 36,857 in 2015 [41]. These figures were reduced to 22,001 in 2016. However, there was an increase (23,689) again in 2017 [42]. Rural people experience different illness profile compared to their counter parts in the urban areas [43], and the beliefs, experiences, and cumulative health outcomes of rural people have received minimum attention in research as an aspect of chronic disease experience [44]. It is important to gain knowledge and information on the experiences of diabetes patients in rural areas. This will help develop quality patient care and interventions in order to reduce the prevalence of diabetes and its associated complications. Therefore, since majority of the people in Eastern region lives in the rural areas, the situation has called for urgent concerns to investigate the lived experiences of diabetes patients, especially the greater percentage who has limited access to health care in the rural areas of the region.

## Materials and Methods

### Research Design

The study adopted the Descriptive Phenomenological approach which is interested in the subjective meaning people give to events in their lives rather than just representing or recording objective events [45]. Phenomenology is concerned with how participants make meaning of their personal and social worlds, and then the researcher attempts to interpret and understand the situation [46]. Phenomenology is not interested in generalizing findings but rather seeks an in-depth description from individual cases and experiences. The approach was more suitable for this research since the aim was to understand from the perspective of participants, their experiences in accessing health care in rural areas.

### Participants

The population was made up of diabetic patients who lived in the rural areas, and visited the diabetes clinic in the urban areas for regular clinical schedules since clinics in the rural areas do not have diabetes units to specifically attend to diabetes cases. In all, 31 participants were conveniently sampled for the study. The convenience sampling approach was used because patients happened to be situated at the hospital at the time of the data collection, they were readily available, and willing to

participate. Patients were continuously sampled until the point of saturation where no issues arose from the interviews.

### Recruitment of Participants

To be selected for the study, participants had to meet the following criteria, that is, be a diabetic patient diagnosed not less than six months at the time of research. Again, participants should be living in rural areas. In addition, they had to come from a rural area located in the Eastern Region. A person diagnosed with any type of diabetes (Type 1, Type 2 and Gestational Diabetes) was accepted into the study. Furthermore, participants should be able to articulate their views and communicate well in a local language (Twi). Finally, patients selected were those who were willing to participate in the study. Patients who were diagnosed for less than six months and those who have been diagnosed with some other conditions were excluded from the study. Again, the study excluded patients who were not from the rural areas in the Eastern Region. The hospital administrations were contacted about the purpose of the study. Verbal consent was requested from the patients after they were briefed about the purpose of the study by the nurses in charge of the various clinics. Those who agreed to participate were interviewed in a private room at the hospital.

### Demography of Participants

Out of the 31 participants selected, five of them were diagnosed with Type 1 diabetes, and the remaining 26 were known Type 2 diabetics. Six of the patients were males and the rest females, and they were aged between 33 and 89 years. Thirteen were married, five single, eight widowed, two separated and three divorced. In terms of occupation, 28 were farmers and the remaining three being traders.

### Data Collection Procedure

Semi-structured interview guide was used to investigate participants' perceptions, thoughts, feelings, and experiences of accessing health care. The interview guide enabled the engagement of participants in a dialogue whereby initial questions were modified in the light of the participants' responses, and the investigator was able to probe interesting and important areas which arose therefrom [46]. Interviews were conducted at the hospital premises (in private rooms in each facility), and they were audio taped and later transcribed. Interviews lasted between 45 minutes and an hour. Interviews were conducted in the local language (Twi) and later transcribed into English for easy analysis. The face-to-face interview helped the interviewer to establish rapport, trust and intimacy with each participant.

### Data Processing and Analysis

The interview data collected were transcribed to text format. Analysis was done in accordance with principles and guidelines of interpretative phenomenological analysis outlined by Smith, Jarman and Osborn [47]. In doing interpretative phenomenological analysis, it is important to withhold all previous knowledge, experiences and ideas about the phenomena (experiences) under investigation [48] [46]. In this study, the texts produced from the interviews were read several times, and notes that reflected the initial thoughts and observations of the participants were taken down. This enabled familiarization with the texts in order to gain an understanding of participants' experiences. During the second stage of analysis, themes were formed from the texts using the notes that had already been made. This was done separately for each interview transcript. The next stage was to introduce structure and derive meaning. At this point, themes were grouped into clusters to introduce



a structure into the analysis and themes that shared a common link; ideas were grouped into one cluster. Finally, there was a production of summary table of themes with titles, relevant quotations and line numbers from the original texts. Analysis was done for subsequent transcript using the same principles and stages stated above. Themes from each participant's transcript were captured in order to identify common themes and new ones. The themes identified from the various transcripts were finally integrated for a final list of Master Themes and their constituent themes. The final master theme was discussed to ensure that all the experiences of the participants had been captured by all the superordinate themes.

### Trustworthiness

In order to ensure the trustworthiness of this study, the peer review and debriefing, member checking, and external audit were used. Using the peer review and debriefing, a peer debriefer was made to critically examine the study and ask questions to ensure that the accounts emanate from the experiences shared by participants. In using member checking, participants were contacted to review the transcript materials to ensure that it captured what transpired during the interview. Again, each participant was engaged in a discussion on the final themes generated. An external auditor who was not familiar with the study reviewed the entire research in order to provide an objective assessment of the research process and its conclusion.

### Results

The study sought to understand patients' experiences with the health care system, especially patients' access to health care, drugs, and their encounter with doctors and nurses at the hospital. The interest lay in how patients accessed health care from the rural areas, and how they were treated by doctors and nurses at the hospital, and whether patients were satisfied with the health care system. It is believed effective communication and attitude from health professionals will significantly influence patients' commitment towards treatment adherence. Therefore, patients were asked to give a narration of what they went through at the diabetes clinic. They were asked to describe the advice and help they received from the doctors and nurses when they were diagnosed, and if the advice was helpful. Finally, patients were required to share their experiences on how easy or difficult they accessed health care. The generated themes are shown in Table 1 below.

Themes	Number of Participants
<b>1. Accessibility to Health Care Facilities</b>	
• Transportation challenge (Long distance and poor road)	9
• Long queue (Time consuming)	7
• Meeting different doctors	6
• Waking up early	5
• Difficulty meeting appointments	4
<b>2. Encounter with Health Care Providers</b>	
• Positive attitude of health workers	27
• Inadequate consultation time (lack of patience, inability to ask questions)	4

Table 1: The Experiences of Rural Diabetics with Health Care

### System

Source: Interview Data, 2020

### Accessibility to Health Care Facilities

Accessibility is considered as the existence of transport between people and service. In this instance, access had to do with the movement of patients from their homes to hospital and back. Patients had problem commuting to hospital because it was difficult getting a vehicle and, in some cases, the vehicle did not get full on time for the driver to start the journey. Poor road network contributed to transportation problem because some patients lived in areas with bad roads thus making it difficult for them to report at hospital in time. In this case, patients resorted to the services of motor bike riders (okada) to assist them get to the main road on time in order to get a vehicle early enough.

*I pick a motor bike to the road side, before I pick a car ... (said Participant 9).*

Participant 12 also shared her experience as follows:

*Coming from my village to the main road is far, so when I wake up at dawn, I am afraid. But if I delay too much, I will not get to the main road early; I may find it difficult getting a car. So, I must come early.*

Again, the distances between patients' villages and the hospital are far. Some picked as many as four vehicles before they got to hospital. Participant 28 had this to say: I really suffer to get here...

Long distances, coupled with transportation difficulties prompted patients to wake up early. Some indicated that they woke up very early at dawn in order to get to the road side on time to get a vehicle.

Today for instance, I woke at 4am to prepare the children for school and by the time I finished it would be 5am. I left home at 5:30am and got to the roadside by 6am. Not long after, I had a car. (Participant 12)

From the narration given by patients, it could be seen that accessing health care was a challenge since patients had to go through transportation difficulties because of poor road networks. The rural communities are also far from the cities and this sometimes compromises patients' willingness to attend clinics. These challenges are characteristics of rural areas, and often prevent patients from accessing certain amenities in the urban centres. Due to this, many patients depended on motor bikes as their means of transportation. Those who did not have their own motor bikes had to depend on public transports which also delayed patients' appointment schedules. The transport services in rural areas are not reliable, safe and trusted, and sometimes cannot deliver to the expectations of the people. Again, the poor nature of the roads makes it hazardous for commuters. This makes the ability to reach basic and crucial services in urban centres more difficult. All these tend to impact negatively on patients' accessibility of health care (diabetes clinics) in the cities. Despite all these, patients defied all odds to get to the hospital on time. So, by 6am, they would be at the hospital. Patients were of the view that if they did not go through this transportation ordeal to get to the hospital on time, they would face another challenge with long queues at the hospital.

Patients noted that they met long queues at the hospital because many of them reported on particular clinic days. Diabetes clinics were scheduled for particular days in most hospitals visited. On a particular scheduled day, patients with their numerous complaints visited the clinic for medications which would serve them till the next visit. On such visits, patients would be

frustrated by tedious travelling and hectic consultation. This was so because those coming from far places would have to set off as early as 4am to get to hospital on time. The situation was worse when the consultation day was not a market day during which vehicles would be available for travelling. Despite the stress from travelling, they had to join long queues and wait for hours before their blood samples were taken for blood sugar tests, and wait for the results before going to see the doctor. This test had to be done before the patient could eat; by the time patients met the doctor, they were already frustrated. This delayed their eating time since they had to go through a series of laboratory tests before they could take their medicine and eat. So, if they did not come in early, they would not be attended to on time which meant they would leave the hospital late. This is the narration of Participant 12:

We suffer, especially when going to do the lab we will be in a queue and will be pushing and jostling so by the time you leave the hospital, you are already tired. So, you see, we really suffer. Again, collecting drugs from the main pharmacy is a problem for us. They should bring our medicines to the clinic so that immediately we finish seeing the doctor, we take the medicine. But we will suffer and wait for a long time at the clinic and when we are done, we have to go through that same challenge at the pharmacy. You see, so by the time we are done from the hospital, it will be about 6pm or 7pm.

To Participant 12, there were long queues at every department of the hospital and to her; there must be decentralization of services. Diabetic patients must be treated, and all their drugs given at the diabetes clinic. That is, patients are not to go for their drugs at the main hospital pharmacy as this consumes a lot of time. Participant 31 concluded that the entire process of coming for regular check-up was time-consuming.

Another challenge indicated by the patients was meeting different doctors on clinic days. This shows that patients were not familiar with their care-givers and had no personal relationship with them. A patient indicated that she wished she was attended to by one particular doctor, but this was always not the case since it was a matter of chance to meet this doctor. Additionally, she did not have the choice to determine which particular doctor she wanted to meet:

There are some of the doctors who are very nice, so anytime I come I want to go to them but it's not feasible. So, you can't go to them and they wouldn't mind you if you request to go to them. Whoever they take you to, you accept him like that. (Participant 11)

This was a source of worry for Participant 11. Patients did not know the doctors personally, neither did they have personal contacts to call any time or book an appointment. This may not enhance a doctor-patient relationship which could lead to improvement in patients' health.

### Encounter with Health Care Providers

Another theme that emerged from the interview transcripts was the encounter patients had with health care professionals. This specifically explored the attitude of the health professionals towards patients when they (the latter) visited the hospital for their regular check-ups. Most diabetics were happy with how the doctors and nurses treated patients, interactions with patients, time spent with them, care given by these professionals, their patience with patients and their ability to explain issues concerning diabetes. Most of the patients interviewed indicated that the attitude of the health care professionals was

positive in relation to explaining issues concerning medication, diet, management of the disease and general lifestyle which included exercising and reducing strenuous work. Patients were educated on when to eat, the type of food to eat and avoidance of certain foods that could complicate the disease or increase sugar levels. The doctors and nurses also advised patients on medications. Some patients indicated that the doctors had patience to explain issues about the disease. Generally, most of the patients shared the view that they were satisfied with the health care providers' attitude. Participant 7 shared her opinion as follows:

When we come, they have the patience to attend to us. They are able to explain to us how to take our medicine and eat well because sometimes our sugar levels will be high... We shouldn't be eating one type of food all the time; we have to balance our diet.

From Participant 7's account, it could be deduced that the doctors and nurses explained issues about diabetes and the misconceptions people had about the disease. However, few patients indicated that the attitude of the health professionals was negative. This was how Participant 12 explained the attitude of the health workers:

No, no; they don't have patience for me to ask questions just as you have asked me, no. They are in a hurry to finish with me and attend to somebody else so they don't have the time to questions. The moment I enter the consulting room, they just check my lab results and prescribe the medicines I am to take, then I leave. They just ask about my condition and where I feel pains; that is all. They will not ask me anything else.

From the narration given by Participant 12, it seems the doctors did not have patience with patients. Patients were rushed through simply because the doctors had to attend to many clients on a particular clinic day and within time. Again, she shared her frustration of not given opportunity to ask questions.

### Discussions

Two main themes emerged: accessibility to health care facilities and encounter with health care providers. Accessibility to health care facilities had sub themes like transportation difficulties (poor road network), time consuming (long queues), and meeting different doctors on clinic days. The problem with transportation in the current study corroborates the same difficulties and challenges cited in Metta et al. [16], Sulemana and Dinye [10], Lu et al. [49], Kagee et al. [15], and van den Boom et al. [13] which identified the challenges experienced by rural dwellers to include waking up at dawn, long distances, poor transportation, long waiting for and on vehicles, using motor bikes and in the worst instances, abandoning the journey altogether. Carolan et al. [14] highlighted lack of transportation as one of the logistical challenges that limited patients' access to health care. This was in line with other studies conducted among patients in Africa, especially those in the rural areas, who reported that commuting between their villages and health care centres was extremely difficult [15,16,30]. Financial burden coupled with transportation challenges made it difficult sometimes for patients to keep to regular clinical appointments [35,38]. This meant that diabetes had a significant health and economic challenges for patients and families [50].

Patients complained of long queues and delays at the hospital. They recounted the ordeal and frustrations they had to endure at the hospital; according to Mwangome et al. [38], patients could be at risk of collapsing for lack of food in the system. Some pa-

tients in Carolan et al.'s study [14] also complained of the long waiting appointments they experienced when they visited the hospital. Patients opined that they had to wait in long queues for two to three hours before they met the doctor. Similar sentiments were shared by respondents in Hjelm and Mufunda's study [37] that they delayed in seeing the doctors or collecting drugs from the pharmacy. Zimmermann et al. [35] conducted a scoping review of studies on Type 2 diabetics' experiences in Africa and found out that sampled participants described how they experienced long delays at the hospital.

Another related challenge of accessibility to health care that literature failed to mention was the situation where patients met different doctors any time they went for their appointment. Patients in the current study reported that they met different doctors any time they visited the clinic for their regular schedule. This is in sharp contrast with the report by Pikkemaat et al. [39] that in Sweden diabetes patients are treated by a General Physician who is a specialist in family medicine and diabetes specialist nurse at the Primary Health Care Centre (PHCC). Pikkemaat et al. noted that patients visited the PHCC twice every year to meet the general physician and the nurse. Patients are only referred to other specialists only when there are complications that cannot be managed at the PHCC. This was not the case for patients in this study who were from the rural areas. Perhaps to the doctors, it is a normal practice and just a continuation of care. Going through the patient's folder enabled the doctors to understand the patient's condition and continue with the care. However, to the patients, it is a new world of experience and it raises an issue about consistency of care. Patients believed that meeting different doctors actually does not enhance patient-doctor communication. Again, the hospital could have done better by explaining to patients why doctors are constantly being changed, but these explanations are often not given and this might eventually create doubts about the quality of care provided. It is idle for health care professionals to provide patients with information on what is to be done at every stage of the care process. According to Donabedian [22], the contribution of health care must include but not limited to addressing issues concerning patient's satisfaction and preferences in health. Donabedian emphasized that improving quality of care is not only limited to systems thinking, rather love is the secret to quality. Thus, the health care provider must love the patients, love the profession and love God. With love, the health care provider can work backwards to monitor and improve the system.

In view of the patients' encounter with health care providers, Almino et al. [51] posited that a good and healthy relationship between physician and patient is said to enhance the control of diabetes. According to Guanais et al. [21], health care provider's communication and time spent with patients is associated with better trust in health care systems. In their narration, patients commended the doctors for their patience and professionalism. Patients were given information on dieting and medication. Dube et al. [28] and Bayindir et al. [29] indicated that the information provided by health professionals on diabetes centred on the meaning of the disease, its complications (effects), and management strategies (often physical activities and healthy diet). However, in the current study, the information provided to patients centred more on management strategies. Patients' satisfaction with attitudes of doctors and nurses was also echoed by respondents in the study of Tabong et al. [27] that they were treated very well when they visited the hospital for treatment, and were satisfied with the total care

[33]. Should health care professionals continue to educate and provide patients with information on their disease, it would increase patients' confidence and autonomy [26].

Although most patients admitted anytime they visited the hospital they were educated on how to manage diabetes, a few felt the doctors and nurses did not do enough to provide comprehensive education and care. Patients were given general information when they went for consultation and the time doctors and nurses spent with them was inadequate. Likewise, some patients in Yasmin et al. [32] complained strongly about the lack of attention and inadequate consultation time provided by physicians. They never had the opportunity to ask questions or be well examined as doctors were always in a rush during consultations and this was evident in the experiences of Participant 12. This revelation is in line with the findings of Zimmermann et al. [35] who described how participants felt when they were not given the necessary support by the health care professionals. Again, Murphy et al. [31] pointed out that health care providers failed to establish rapport with their patients because they did not have enough time for patients; their communication skills were poor and they failed to provide counselling at the time of diagnosis. In this situation, patients became anxious and frustrated about the quality of care.

Participants studied by Adeniyi et al. [30] expressed disappointment at the hurried attitude of doctors during consultations. Respondents remarked that though doctors counselled them, the counselling was not practical because patients felt they were not rich enough to afford the management strategies (healthy eating) suggested by the doctors. This was consistent with Booyesen and Schlemmer's [33] study which found out that few participants reported that nurses were sometimes harsh, and embarrassed patients in the presence of others. Nurses were insensitive to the manner and time in which information about the disease was given [36]. This could be explained by the large number of patients attending clinic on the same day, compelling doctors and nurses to attend to a large number of patients. Aside that, clinics were normally scheduled for a particular day in the week, at times just once or twice in a week and this really stressed up the doctors and nurses since clients from far and near all visited the hospital on that scheduled day or days. According to O'Brien et al. [36], the large attendance on a clinic day made it impossible for the health care professionals (doctors and nurses) to attend to all clients. This probably explains why clinical counselling was ineffective in the study area. Competent care and positive experiences which are attributes of good quality care can significantly impact the patients' health, their confidence and trust in the health system [34]. This could eventually affect the patients' decisions regarding where and when to seek health care.

Considering the challenges diabetic patients go through in accessing health, it is important that health centres, clinics, and Community Health Planning and Services (CHPS) compounds in these rural communities are upgraded and well-resourced to cater for the needs of diabetes patients. Instead of patients going to towns for clinics, they can be directed to the CHPS compounds. This would reduce the stress patients go through on clinic days. These clinic days at the hospitals could be decentralized to the community levels, precisely CHPS compounds, where specialist doctors and nurses would visit to take care of patients. This again will reduce the build-ups and congestions that occur on clinic days at the hospitals in towns and cities. This would eventually reduce the pressure on health care



professionals and increase the time patients spend with doctors when they go for their regular check-ups. The proposition of bringing health professionals to the community level would reduce or completely eliminate most of the challenges experienced by patients. Even though majority of the patients reported they were satisfied with the attitudes of doctors and nurses, and information given to them, few patients had their reservation about the professional conduct of the health care providers. These mixed reactions about the attitudes of doctors and nurses need to be addressed by future research. Health facilities must step up their effort to respond appropriately to the needs of patients.

## Conclusion

Access to health care facilities was challenging for patients from the rural areas and complained of doctors whenever they visited the clinic. Transportation difficulties and poor road network often impeded patients' access to health care in the urban areas. The difficulty of accessing health care could lead to non-attendance or skipping hospital visits. Meeting different doctors on each visit without adequate explanation would cause mistrust in the care process and affects patients' general satisfaction with the general health care system. This eventually, increases patients' use of traditional medicines and prayer camps.

## Recommendations

In order to improve access to health care by patients from the rural areas, it is important that the MOH and GHS review policies regarding health centres, clinics, and community health planning and services (CHPS) compounds in these rural communities so that these centres can be upgraded and well-resourced to meet the demands of diabetes patients. Instead of patients going to towns for clinics, they can be directed to these centres to reduce the stress they go through on clinic days. Once these centres are well-equipped, clinic days at the hospitals could be decentralized to community levels, precisely to CHPS compounds where specialist doctors and nurses would visit to take care of patients. This calls for increase in recruitment and training of doctors and nurses to take up such roles to support the already burdened health system. This policy will reduce the build-ups and congestions that occur on clinic days at the hospitals in towns and cities. The pressure on health care professionals would be reduced and the time doctors spend with patients during consultation would increase. Additionally, there must be a team of doctors assigned to provide care for patients to have a continuous relationship and trust with health care providers. Patients would also have the belief that if a member of the team of doctors is absent, the others will continue to attend to the patient in providing proper care. This will reduce the complaints made by patients about meeting different doctors on clinic days.

## Consent

Informed consent was obtained from each eligible participant after they had been provided with detailed information about the study. Participants had the right to withdraw from the study at any time without suffering any negative consequences. Names of the respondents were not included in the study report. In order to conceal the identity of the participants, pseudonyms were used to represent the names of participants throughout the study. All information gathered from study participants was treated confidentially and anonymously. No physical risk

was involved in this study since interviews were carried out at the hospitals premise. However, participants were made aware of some minimal emotional risk since they will be required to provide detailed accounts of their experiences that may be unpleasing.

## Ethical Approval

The University of Cape Coast Ethical Review Board gave ethical approval for the conduct of the study. This was to ensure and safe guard participants' rights. Approval was also obtained from the various local hospitals from where the participants were selected.

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