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**SOCIAL ROLES OF FAMILY MEMBERS AND
EFFECTIVENESS OF DIABETES MANAGEMENT OF
PATIENTS SEEKING CARE AT ST. MARY'S MISSION
HOSPITAL, NAIROBI**



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SOCIAL ROLES OF FAMILY MEMBERS AND EFFECTIVENESS OF DIABETES MANAGEMENT OF PATIENTS SEEKING CARE AT ST. MARY'S MISSION HOSPITAL, NAIROBI

Zipporah Wawira Njiru

School of Arts Social Sciences, Catholic University of Eastern Africa
P.O Box 62157 Bogani E Rd, Nairobi, Kenya

Corresponding email: wawirazipporah@gmail.com

Prof. Dr.B.A. Mulemi

School of Arts Social Sciences, Catholic University of Eastern Africa
P.O Box 62157 Bogani E Rd, Nairobi, Kenya

Dr.S. Ngacha Njeri

School of Arts Social Sciences, Catholic University of Eastern Africa
P.O Box 62157 Bogani E Rd, Nairobi, Kenya

Abstract

Purpose: Diabetes is one of the non-communicable diseases (NCDs) of great global public health and development concern. This NCD has adverse effects on the social well-being of patients, their households, and the whole society. The overall objective of this study was to determine the relationship between social roles of family members and effectiveness of diabetes management of patients seeking care at St. Mary's Mission Hospital, Nairobi.

Methodology: This study drew on descriptive study design, involving quantitative and qualitative methods, particularly closed and open questions. The sample size was 269 respondents included in the study through purposive and convenient sampling. These sampling techniques were preferred in this research since data was gathered from the respondents during their visit to the hospital. The researcher collected data through interviewer-administered questionnaires containing both open and closed questions. Qualitative data was grouped, coded, and categorized, picking on cross-cutting issues, then compiled, analysed, and interpreted accordingly. Quantitative data was coded then entered into Statistical Package for Social Sciences (SPSS) version 22 for windows. SPSS was used to run frequency distributions and cross-tabulations for analysis and interpretation, and Microsoft Excel was used for graphical presentation.

Findings: The study established that diabetes management is costly and not affordable to many patients. Hence, it affects the social well-being of the patients and their families.

Unique Contribution to Theory and Practice: The study recommends free or affordable and available medication for diabetes patients, and continuous awareness programs for patients, family members and the community across all Counties to address the effects of diabetes management on the patients, families, and the Nation. This would contribute to the social well-being of the patients and their families and the Nation's economic development.

Key Words: *Social Roles, Diabetes Management, and Family Members*

Introduction

NCDs threaten to reverse substantial health gains achieved in recent decades, and the challenge would impair sustainable development for Low-Middle-Income Countries (LMICs) (Galambos & Sturchio, 2014). Massive national income percentage is channelled towards mitigating the impacts of diseases like diabetes, which are long-term, yet their prevalence is continuing to increase across the nations. The 2030 Agenda for Sustainable Development recognizes NCDs like diabetes as significant obstacles to sustainable development (WHO, 2021). Patients and households incur catastrophic expenditure in diabetes management, which affects their income, impeding them from engaging in development activities. Diabetes also affects the work-life balance of patients and family members as they spend many hours in hospitals, which could be used for development activities. Some diabetes patients have resigned from work due to the demands for diabetes management, which affects family income and the children's education, leading to school dropouts. This, in turn, affects the overall revenue of the Country.

Around 422 million persons have diabetes globally. This accounts for about 8.5% of the general international's population, yet the prevalence of the disease has been unexpectedly increasing in LMICs (Ayah et al., 2013). Diabetes is a crucial motive of lack of eyesight, kidney malfunction, coronary heart attacks, stroke, and accelerated lower limb amputation (Ayah et al., 2013). Diabetes induced 1.5 million deaths in 2012, and a number of those deaths (43%) happened below 70 years and WHO predicts that diabetes might be the 7th predominant motive to loss of life in 2030 (Ayah et al., 2013). Because of diabetes complications, patients and families spend vast amounts of money, which could be used for development activities for the well-being of the members. Additionally, increased mortality rates resulting from diabetes imply loss of productivity, and income in families and the nation as a whole, affecting the socio-financial growth of families and the nation. The diabetes charge repercussions to society encompass direct charges to patients, their households, and hospitals, and oblique expenses to communities and nations, which may be the productiveness fees, and insubstantial costs, bringing about the unfavorable consequence on quality of life (Islam et al., 2013).

Statement of the Problem

Diabetes affects patients' lives and their households, and its management impacts their social well-being. Lack of proper diabetes management resources and information results in socioeconomic problems worsened by smoking, advanced cholesterol levels, weight problems, increased blood pressure, and scarcity of regular workouts. Diabetes causes additional social well-being difficulties resulting from complications such as persistent wounds, commas, and heart illnesses. These difficulties nearly regularly bring about long periods of hospitalization ensuing in massive hospital payments and loss of working hours, which poses extensive financial and social demanding situations, which can affect the patient's capacity to manage the ailment as well as their social well-being (Muga, & Muhati, 2016). In LMICs, for example, Kenya, numerous patients struggle to obtain primary diabetes care (Shannon et al., 2019). Despite the efforts and the techniques like Kenya Health Policy (2014-2030) and Kenya National Diabetes Strategy (2010-2015), through the Ministry of Health and the Ministry of Public Health and Sanitation, to make sure effective control of diabetes, more than 8,700 diabetes-associated demises were recorded in Kenya in 2015 (Shannon et al. 2019). Nearly all the deaths occurred in patients below 60 years. Diabetes patients in Kenya in recent times have encountered many obstacles to care that would consist of distance to the hospital, insufficient knowledge, drug treatments unaffordability, unavailability of diagnostic and monitoring tools, and inefficient nearby hospital structure capability.

Following the promulgation of the Kenyan constitution in 2010, the health system is expected to offer essential primary health care services through decentralized mechanisms. The National Ministry of Health has coverage and regulatory roles, and the 47 county health structures have provider provision roles for more efficient health care delivery (Oyando et al., 2019). Despite these provisions, the barriers mentioned above to health care services lead to poor diabetes management among the patients. These account for increased diabetes complications and frequent hospitalizations that affect socioeconomic development. These affect the social well-being of patients and their relatives who have to incur catastrophic health care expenses and make several sacrifices to provide whatever services their patients require. Diabetes cases are on the increase in Kenya, and patients are suffering from the illness at an earlier age than those in evolved worldwide nations. Kenya's public health care is organized into six tiers. Each of these is predicted to provide preventive, promotive, curative, and rehabilitative services, as noted in the Kenya Essential Package for Health, which incorporates interventions and services aimed at diabetes control (Oyando et al., 2019). Kenyans are at a threat of acquiring complications because they go to hospitals when the ailment has progressed (McFerran, 2008 as noted in Muga & Muhati 2016: 142). However, consistent with the Ministry of Public Health of Kenya (as said in EL-busaidy et al 2014: 1), above 50% of health centres hospitalizations and 55% of health facilities demises in Kenya are from NCDs and diabetes is one of the main. This has led to an increased social burden, particularly in low-income households. Some patients have progressed to adverse diabetes complications like kidney failure, loss of eyesight, and amputation of body parts. This reduces productivity in affected families with adverse outcomes at the social and economic improvement of the nation.

This study is concerned with how diabetes and its management affect patients' overall social well-being and their households as an essential dimension of livelihood resilience and development. The effects on the income status and stigma associated with diabetes lead to poor adherence to diabetes management strategies. This, in turn, leads to complications that hinder the patients' ability to manage their condition. In Kenya, initiatives to design effective diabetes management strategies to prevent the patients from progressing to adverse complications are still insufficient. Little is documented on how social roles, relationships, the responsiveness of the health system and financial care support would enhance diabetes management and prevent the rate at which the disease threatens to destabilize the overall social well-being of the patients and their families in Kenya.

Research Objective

To explain the relationship between the social roles of family members and the effectiveness of diabetes management among the patients

Theoretical Review

Structural Violence Theory

The idea of structural violence first emerged within the 1960s to provide an explanation for disparities in health and development between rich nations and impoverished submit-colonial states (Hirchfeld, 2017). The idea of structural violence developed out of Dependency Theory and defined poverty and ailment within the developing international because the manufactured from exploitation with the aid of colonial or neo-colonial powers. This theoretical framework can display dynamics of societal practices and structural forces that operate across a couple of dimensions of peoples' lives in approaches that may not right away appear associated with health (Page-Reeves & Janet et al., 2013:33). The term "Structural Violence" as implemented

in health and healthcare studies is attributed to Farmer drawing at the work of Latin American liberation theologians and Johan Galtung (1969; 1990). The liberation theologians espoused an ethical vital for the Church in Latin America to move beyond responding to the desires of the poor people to actively undermine and challenge the social and economic inequality and promote social justice (Page-Reeves & Janet et al., 2013).

This structural violence theory is appropriate to this study about diabetes management and the social well-being of the patients in the sense that the social, economic, political, and religious structures contribute to the reduction of societal disparities, for example, health disparities hence ensuring societal well-being. However, in some nations like Kenya, some Counties are more structurally developed, for instance, in health care facilities than other Counties. With structural inequity, the poor and marginalized experience violence due to lack of accessibility to timely health care facilities, which contributes to late diagnosis of chronic diseases such as diabetes at advanced stages when the complications are irreversible. This leads to a social weight to the relatives and the community, affecting their overall well-being. This is in line with the argument in the authors of a review of the Southeast Asia situation as cited in Galambos & Sturchio (2014: 7) that NCDs affect millions of lives and often the lives of those who have the least and besides, the inequality in risk factors and disease impact between groups of lower socioeconomic status and those of higher socioeconomic status appears to be a global phenomenon (Galambos & Sturchio, 2014).

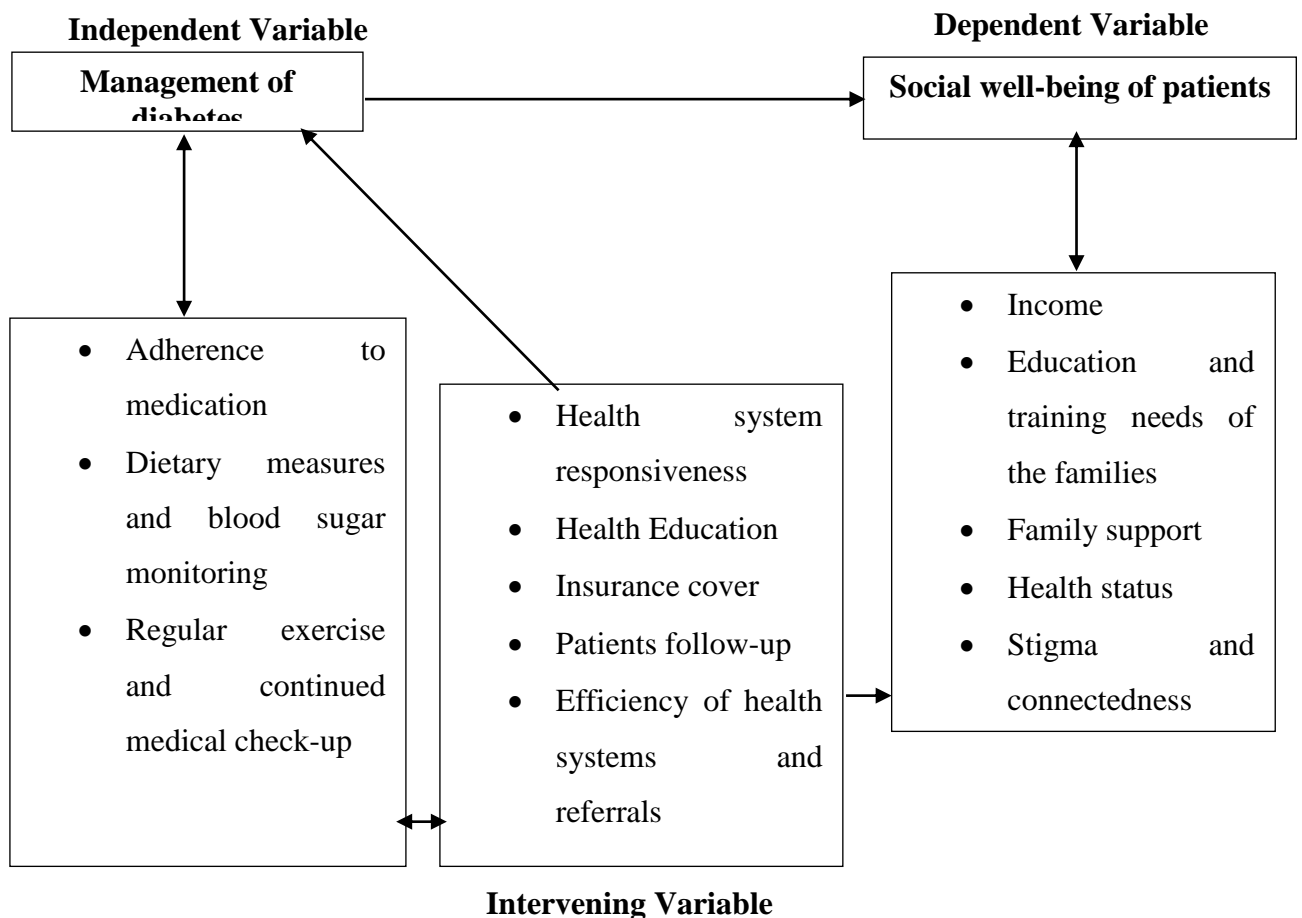
Social roles of family members in diabetes patient care

People with diabetes live within their families and larger social surroundings, which affect their diabetes care (Pamungkas, Chamroonsawasdi, & Vatanasomboon, 2017). According to Rad et al. (2013), demographic factors like accelerated age lower self-care. Moreover, socioeconomic elements like less education, low monetary level, and social factors like vulnerable individuals and family relationships notably hinder diabetes self-control (Rad et al., 2013). In the research by Vijan on 446 urban and rural patients (as stated in Rad et al., 2013: 2), one of the barriers suggested by patients concerning observing dietary suggestions was lack of own family and social support. In that studies, people who received more support from their families without problems determined and adhered to diets. Rosland (2009) argues that family and friends affect patients' self-control because meals, exercises, and stress management occur in social settings. This is because relatives determine which food to buy or keep in their homes, what meals to cook, what sports are wholesome for the family's timetable, and how health is positioned among family priorities.

Social assistance is needed for health conduct change regarding diabetes self-care. According to Ahmed & Yeasmeen (2016), diabetes self-care can enhance glycaemic management and prevent the development of related demanding situations, hospitalization, and mortality. Family individuals can actively assist and take care of persons with diabetes. They can offer many help styles, which embody accompanying the patients to appointments or assisting injecting insulin, and social and emotional help resources in supporting patients with their ailment (Baig et al., 2015). According to an investigation by DiMatteo, as referenced in Miller & DiMatteo (2013), Social help is needed for health behaviour amendment regarding diabetes self-care. It promotes adherence by encouraging optimism and self-esteem, which can buffer the stress of being ill and reduce the affected individual melancholy (Miller & DiMatteo, 2013). Diabetes self-care can improve glycaemic control and prevent the improvement of related challenges, hospitalization, and mortality (Ahmed & Yeasmeen, 2016). There is a clear indication from this literature that family members play crucial roles in helping the patients manage diabetes. However, some patients may feel like their family members are too demanding to adhere to diabetes management. This could make the patient lose their self-

motivation to manage their condition. Hence, they could follow the guidelines from their family members without inner motivation. This could affect their overall well-being and sense of belonging among their family members.

Conceptual Framework
Figure 1 Conceptual Framework



Research Methodology

This study used mixed methods descriptive research design, which involved quantitative and qualitative methods. The research population was diabetes 900 patients aged 18 years and above who seeking treatment in St. Mary’s Mission Hospital, Nairobi, from October 2021. The study used purposive and convenience sampling techniques. The sample size of 269 respondents was derived using Fisher’s (1998) formulation and Mugenda & Mugenda (2003). Data was collected through interviewer-administered questionnaires containing both open and closed questions. Qualitative data was manually grouped, coded, and categorized, picking on cross-cutting issues according to the frequency of responses per question, then compiled, analyzed, and interpreted accordingly. Quantitative information was coded then keyed into Statistical Package for Social Sciences (SPSS) version 22 for windows. SPSS was used to run frequency distributions and cross-tabulations for analysis and interpretation. Microsoft Excel was used for graphical presentation.

Results

Respondents’ Demographic Characteristics

The demographic characteristics of the study included the data on respondents ‘gender, age, marital status, county of origin, level of education, sources of income, and the duration of experience with diabetes management.

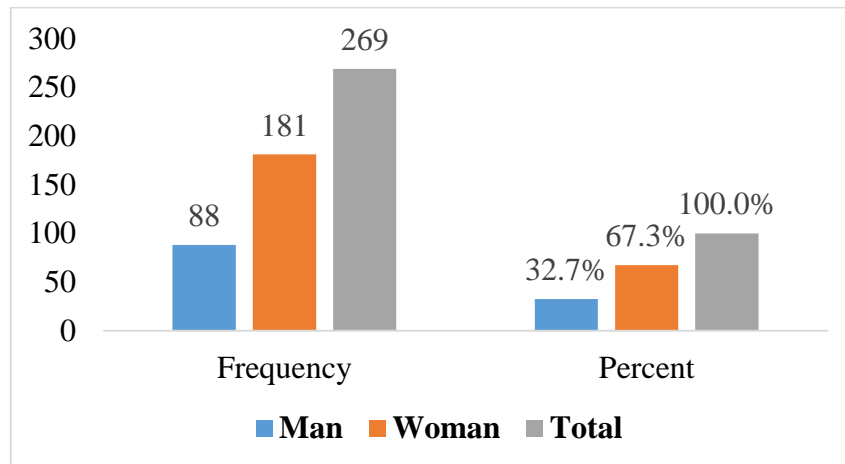


Figure 2: Summary of respondents by gender

The majority of the respondents (67.3 %, 181 n=269) were women, and 32.7 were men. These findings could imply that more women than men arrive for hospital care at the facility.

Respondents’ Age

The study participants’ age is shown in figure 3 below:

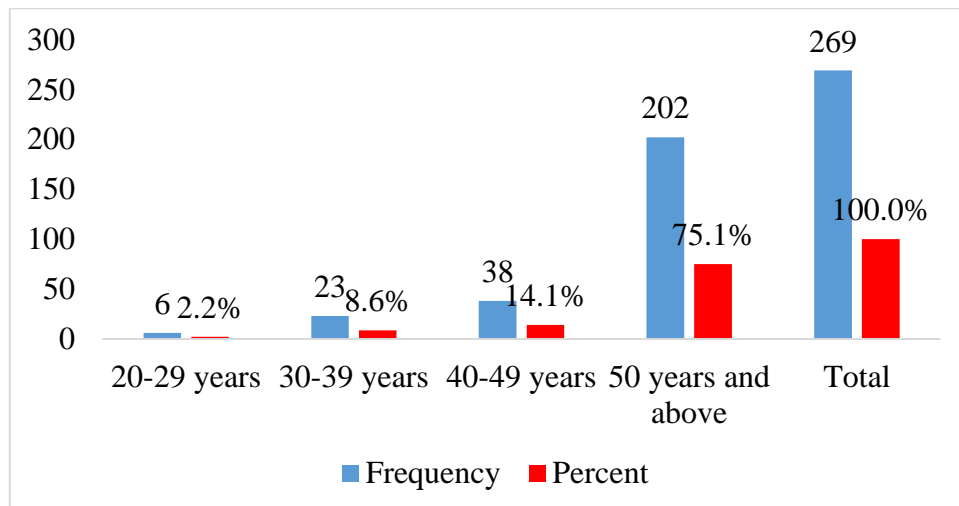


Figure 3: Summary respondents ’age

The majority (75.1%, 202 n=269) of the respondents were 50 years of age and above. 14.1% (38) were aged between 40-49 years, 8.6 % (23) were aged between 30-39 years, and 2.2% (6) were aged between 20-29 years. In this study, the young people with diabetes confirmed that diabetes cuts across all ages. Most of those patients aged 50 years and above were retired and had to depend on pension or family members for their diabetes management support, such as medication and diet. The retired citizens are not able to participate in the socio-economic development of their families and the society, which agrees with the argument by Medici,

Hennis & Alleyne (2016) that LMICs like Kenya face a more remarkable boom in NCDs like diabetes burden due to hastily growing and aging populations and these sicknesses drive inequity, make contributions to poorer financial outcomes for individuals, communities, and societies.

Table 1: Respondents' County of origin

	Frequency	Percent
Mombasa	1	.4
Garissa	5	1.9
Wajir	2	.7
Mandera	6	2.2
Marsabit	2	.7
Isiolo	2	.7
Meru	8	3.0
Tharaka-Nithi	1	.4
Kitui	11	4.1
Machakos	20	7.4
Makueni	20	7.4
Nyandarua	5	1.9
Nyeri	11	4.1
Kirinyaga	2	.7
Murang'a	34	12.6
Kiambu	34	12.6
Turkana	2	.7
Nandi	1	.4
Laikipia	2	.7
Nakuru	6	2.2
Narok	2	.7
Kajiado	29	10.8
Kakamega	3	1.1
Vihiga	3	1.1
Busia	2	.7
Siaya	4	1.5
Kisumu	6	2.2
Homabay	2	.7
Migori	1	.4
Kisii	7	2.6
Nyamira	4	1.5
Nairobi City	24	8.9
Uganda (Nairobi)	2	.7
Ethiopia (Nairobi)	1	.4
South Sudan (Kajiado)	1	.4
India (Nairobi)	1	.4

Somalia (Nairobi)	2	.7
Total	269	100.0

The majority of the respondents were from Murang’a County and Kiambu County, with 34 (12.6%) respondents each representing the highest number of respondents combined (68) with a percentage of (25.2%). The respondents from other countries resided in the counties indicated in the brackets on the table above. These findings suggest that St. Mary’s Mission Hospital, Nairobi serves patients from different counties in Kenya, giving some insight into diabetes management in the Kenyan health system. The hospital also serves patients from other countries who reside in Nairobi and Kajiado counties to access the hospital for their treatment. These patients expressed that the St. Mary’s Mission Hospital offers quality care for diabetes patients compared to their countries of origin. The findings also indicate that the hospital is more easily accessed from some counties than others.

Respondents’ Marital status

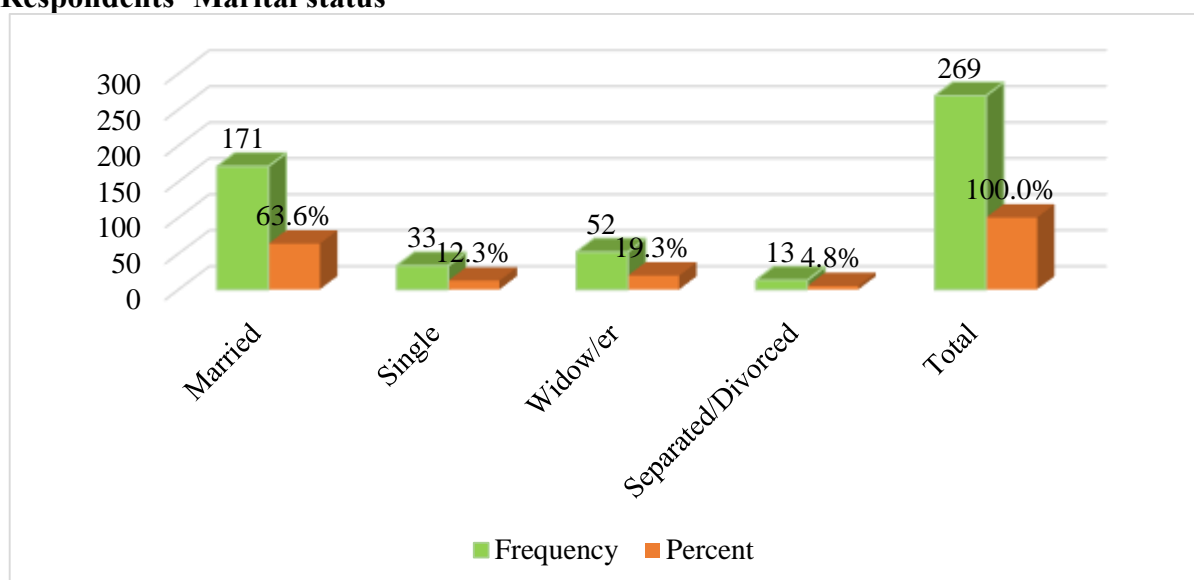


Figure 4: Summary of respondents’ marital status

Majority of the respondents (63.6%, 171 n=269) were married, 12.3% (33) respondents were single, 19.3% (52) respondents were Window/er, and 4.8% (13) respondents were Separated/Divorced. Some of the married people aged 50 years and above were retired and depended on their family members for financial support on diabetes management, and others depended on pension. The majority of these respondents cannot enjoy their pension by going on vacation because the whole amount is spent on diabetes medication and diet, which are very expensive, reducing their quality of life. As a result of these expenses, people walking on the streets, especially diabetes patients, appear angry. This agrees with the argument by Nash (2014) that study has shown that low temper and melancholy are very common among diabetic patients. The findings show a possibility that married couples encourage their spouses to go to the hospital for effective diabetes management compared to people of another marital status. Hence, marriage could be a basis for proper diabetes management contributing to the social well-being of patients and their families.

Study participants' Level of education

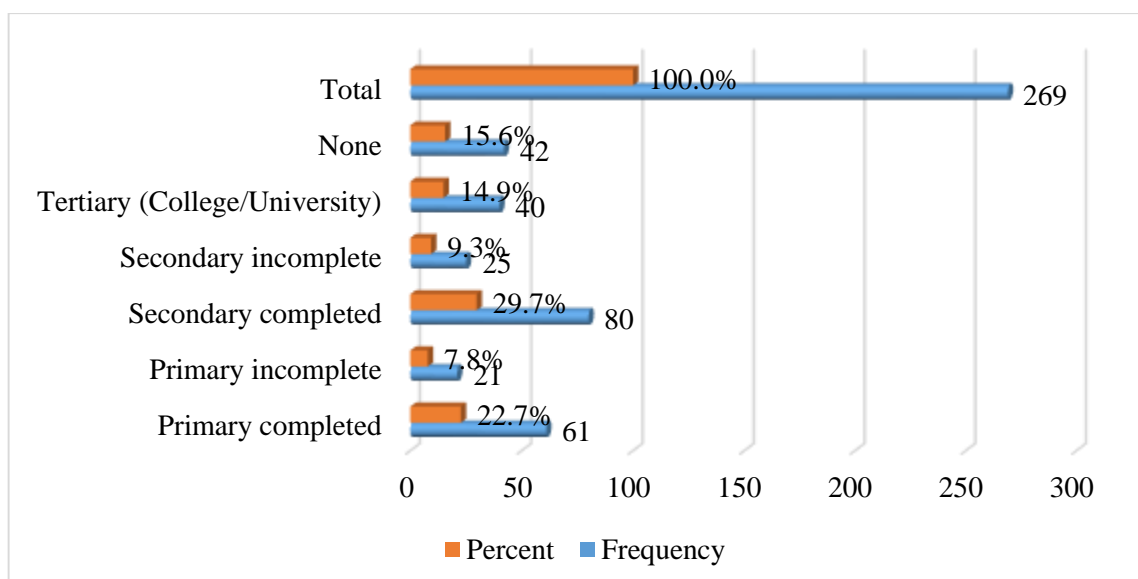


Figure 5: Education level of the respondents

The majority of the respondents (29.7%, 80 n=269) had completed secondary level accounting for the highest number of the respondents. However, these respondents had not progressed to the tertiary level of education. The findings show a difference in the prevalence of diabetes in terms of education level. With these differences, there is a likelihood that, as per the argument by Paula et al. (2008), people with higher education levels have a tendency to be healthier and live longer. A low education level as per the findings could indicate poor adherence to diabetes management strategies due to limited knowledge about diabetes complications and their effects on social well-being. Furthermore, according to Alwan (as cited in Khan & Khan, 2017: 2), without knowing about the diagnosis of a disease, one cannot manage an infection effectively.

Main sources of regular income

	Frequency	Percent
None	107	39.8
Self-employed	133	49.4
Salaried	23	8.6
Missionary	1	.4
Casual	5	1.9
Total	269	100.0

Table 2: Respondents source of Regular income

The majority of the respondents, 133 (49.4%), were self-employed in selling clothes, shopkeepers, farming, and selling vegetables. 107 (39.8%) respondents had no source of regular income. They said they had stopped working due to the demands for diabetes management and related health care. Others had retired and were on a pension while staying at home and depended on their family members and well-wishers for support. This confirms the argument by Dwyer & Mitchell (1999 as referenced in Bloom et al., 2013: 4) that sickness

burden can impact economic increase through numerous methods, such as early retirement, and horrible expectancies regarding employment (McGarry, 2004 as stated in Bloom, et al., 2013: 4), and decreased productiveness (LopezCasasnovas, Rivera, & Currais, 2005 as cited in Bloom et al., 2013: 4). These elements may also make a contribution to decreasing exertions supply and growing the ratio of dependents to personnel (Bloom et al., 2013). Some patients who depended on family members for diabetes management requirements faced significant challenges. If the family members, who had their responsibilities, did not have the financial capacity to support their sick member, the patient stayed without medication and ate the wrong diet, which put them at risk of developing diabetes complications. As observed by Ciechanowski et al. (2001 cited in Waari, 2019:1), complications of diabetes result from poor adherence to best care practices, which affect the affected person's quality of life. This, in turn, increase death, disease, and the financial price of the illness to society.

	Frequency	Percent
One year	13	4.8
2-3 years	21	7.8
3-4 years	17	6.3
4-5 years	13	4.8
Five years and above	176	65.4
Less than one year	9	3.3
Newly diagnosed	20	7.4
Total	269	100.0

Table 3: The respondents' duration of diabetes management

As indicated in Table 3 above, most respondents had been managing diabetes for two years and above despite their inadequate income. The majority of the respondents (176) had managed diabetes for five years and above, accounting for the majority of the respondents. These findings portray that majority of the respondents had personal experiences for a substantive duration of how diabetes management has affected their social well-being over the years they have lived with it and the financial burden of diabetes management on them and their families. The following section presents the study findings and the discussion.

The majority of the respondents (195, 72.5% n=269) said that the most significant responsibilities of the relatives in diabetes management of the patients are financial support and diet. Some of the study participants said that the relatives do not have any duties in the diabetes management of the patients. Other respondents said they were unsure if relatives should take any roles and responsibilities to support the patients apart from joining them in prayers as they managed diabetes. Some respondents shared how their family members are very keen on what they are supposed to eat though the patient sometimes hides and eats whatever they are not supposed to eat. This enhanced their adherence to diabetes management. The findings indicated that the primary expected responsibilities and roles of relatives of the diabetes patients were to provide financial support and facilitation for proper diet. These are crucial for the appropriate management of diabetes hence contributing to the social well-being of the patients and their relatives. Some respondents (176, 65.4% n=269) said that their family members participated in their diabetes management by giving them financial support to buy medicines and go to the hospital for clinics, proper diet, and accompanying them to the hospital. Some respondents said that their family members give them moral support. A particular respondent said, *"They have helped provide financial support."*

Several respondents (19 % of the n=269) said that their family members did not participate in their diabetes management task. They attributed the lack of support to their relatives' financial constraints, lack of jobs, other family responsibilities, such as paying school fees for their children. Hence, the patients are not able to observe diabetes management requirements. This is consistent with the argument in Miller & Dimatteo (2013) that non-adherence to disease management strategies can occur for many reasons. These include economic constraints related to treatment, medication facet results, difficulty in dealing with complex remedy regimens, inadequate affected person health literacy, shortage of social support, and sizeable health risks within the care of many chronic illnesses. Family members, relatives, and friends are essential for diabetes management. Family members determine which meals to shop for or maintain across the house, what food to make, what sports activities are healthy for the household's timetable, and how health is placed among distinct circle of relatives' priorities. Rosland (2009) argues that family and friends affect patients' self-management because daily food consumption, physical activity, and stress control occur within social surroundings. A respondent shared said, *"my sister thinks I am pretending to be sick to eat a special diet. Therefore, she cooks food that I am not supposed to eat as a diabetes patient."*

Family members' roles and responsibilities in diabetic Patient care

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pretending to be sick to eat a special diet. Therefore, she cooks food that I am not supposed to eat as a diabetes patient.”

Barriers to the Effective Kin Support for Diabetes management and Patient care

The issues that affect the role of relatives in helping the patients manage diabetes were categorized as; lack of jobs, financial constraints, anxiety and fear, and family quarrels. A respondent said, *“due to the increased cost of diabetes medication, I feel like not going to the hospital and waiting for whatever will happen to me.”* Another respondent shared, *“due to lack of money, I had to skip some days without medication.”* Other respondents said that the key issues that affected the role of relatives in helping the patients manage diabetes were old age. Old relatives typically lack sources of financial income and would not support their ailing family members. Other respondents shared the barriers to adequate kin support were; deaths of breadwinners, other family responsibilities like paying school fees for the children, busy schedules, lack of time, and lack of refrigerators to store insulin.

Some respondents cited family decision-making dynamics as being among the factors that affected diabetes management. Some of the family decisions that affect diabetes management include: members deciding not to be engaged in the diabetes management of the patients and concentrating on other family responsibilities such that they ignore the diabetic patient’s needs, not taking the patient to the hospital due to religion whereby the patients and family members believe that they can pray for the patient, deciding to prepare food that is not suitable for the patient or would tempt the patient to eat, choosing to use herbal medicines instead of the medicines given in the hospital. A respondent said, *“family members should not cook food like roasted meat which is tempting to patients, yet they are not supposed to eat.”* Adequate kin support is key to diabetes management and patient care. Therefore, as Bennich et al. (2017) argue, disruptive family behaviours, including quarrelling about nutrition, exercising, or medicines, are obstacles to the affected person’s effective self-management of the disease. Figure 6 below presents stigma and its effects on diabetes management, patient care, and support.

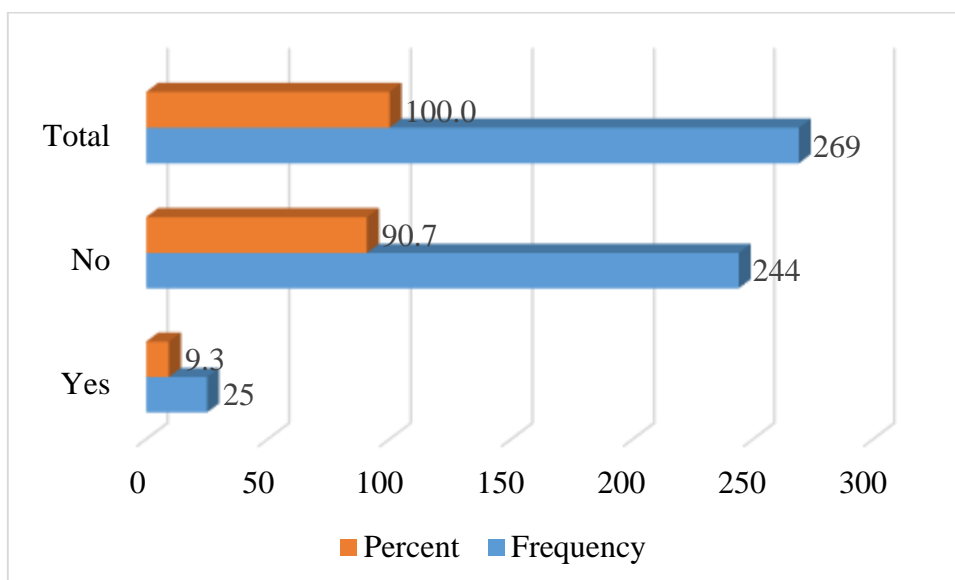


Figure 6: Stigma and its effects on Diabetes Management, Patient Care, and Support

The majority of the respondents, 244 (90.7%), said they had not experienced stigma from relatives and other people as diabetes patients. However, 25 (9.3%) respondents had experienced stigma. They said they felt like a burden to their relatives and other people. These

findings imply a gap in the knowledge about diabetes and the potential of the disease to be associated with the stigma that would affect patients' care and wellbeing. The respondents who had experienced stigma observed that they felt terrible, hopeless, isolated, outcasts, and lonely. A respondent said, *"when one goes for social gatherings, people say openly that diabetic patients should not be considered while cooking because their disease is not to be cured."* This makes the patients feel like outcasts and want to stay alone. Another respondent said, *"people have nicknamed my family as a family of sugars."* This makes the patient feel bad and wants to be isolated from the society. Other sentiments that the patients associated with perceived stigma included; feeling like a burdened family, fear of visiting social places due to diabetes management requirements, such as (eating small portions of food many times a day, eating a different type of food, and using the washroom frequently). Some respondents described the experience of stigma related living with diabetes as isolation from the community. They said that when they joined social gatherings, some people openly announced that those preparing food to remember "people of diabetes". Such comments were perceived as stigmatising as they unnecessarily made them keep remembering that the disease would not be cured. A respondent said, "due to diabetes management requirements, I do not go to family gatherings. As aforementioned, some respondents considered their diabetes status is a family secret to avoid stigma. Some diabetes patients have self-stigma within their families whereby they hide their medicines from people at home by locking those medicines in the cupboard. As Stangl et al. (2019) put it, stigma is an obstacle for health-seeking behaviour, involvement in care, and faithfulness to remedy in many illnesses like diabetes.

Summary

Effects of diabetes management on the social well-being of patients and their families

Diabetes management affects the social well-being of the patients to a large extent. According to the findings, diabetes management requirements such as diet and medication are very expensive. Patients and family members spend a lot of money seeking treatment for diabetes, a long-term disease. This spending of money is worsened by diabetes complications and the mandatory diagnostic tests for diabetes patients. Some families have ended up selling their assets. This massive spending of money has reduced some families into poverty. They cannot cater to other family needs, such as children's education. Some respondents shared that their family members are always anxious, thinking that the patient will die soon. This agrees with Rintala, Paavilainen, Kurki (2013) that besides fear, the family members and friends are often anxious, especially if the patient is hospitalized and experiencing sugar levels fluctuation. Other family members and relatives quarrel and disagree on how to support their sick member, especially financially. This causes stress to the patient, and sometimes they have to stay without medication and proper diet. This brings a lack of peace between the patients and their families, affecting their well-being. The section below highlights how social roles contribute to the effectiveness of diabetes management.

Social roles and effectiveness of diabetes management

Family members, relatives, and friends are essential in the management of diabetes. The findings indicated that the primary expected responsibilities and roles of relatives of the diabetes patients are to provide financial support and facilitation for proper diet. These are important for the appropriate management of diabetes, hence contributing to the patients' social well-being and their relatives. The family members also have a role of accompanying the patients to the hospital for clinics. This helps the family members understand how to help the patients manage diabetes effectively. According to the findings, moral support from

relatives plays a crucial role in diabetes management among patients. The study established that family decision-making dynamics such as diet affects diabetes management among the patients. Some family members cannot participate in diabetes management of the patients due to financial constraints, lack of jobs, other family responsibilities, such as paying school fees for their children, old age, and death of breadwinners. Hence the patients are not able to observe diabetes management requirements. Rosland (2009) argues that family and friends have an effect on patients' self-control due to the fact daily eating, bodily activity, and stress control take place within social settings. Family members determine which meals to buy or store in the house, what food to make, what sports are healthy for the household's timetable, and the way health is positioned many of the circle of relatives' priorities. The section below presents the implications of diabetes management for family income and livelihood.

Diabetes patient care and consequences for their family and Kinship relationships

The findings indicated that diabetes management leads to disagreements and quarrels between the family members, especially on who to provide financial support for medication, diet, and hospital clinics. This is due to the high cost of the medication and diet, which drains the income of the patients and families. As per the findings, diabetes affects the libido of patients; hence, they cannot fulfil their conjugal rights, which leads to separation and divorce among some couples, especially if there is a lack of understanding between them. The findings also indicated that patients feel uncomfortable eating different kinds of foods with the rest of the family members, which are very expensive. Some family members think that the patient is pretending to be sick, which is why they are eating a special diet. Those family members who understand the patients are very supportive and accompany them to the hospital for clinics. This makes the patient feel accepted, hence, lessening their burden of diabetes management and contributing to their social well-being. The patients feel uncomfortable among the relatives and friends who may despise them or present foods in social gatherings that are unfavourable. This puts the patients at temptations of eating the wrong food, which spikes their sugar levels and places them at threat of developing diabetes complications. According to the findings, some patients feel like a burden to their family members. Some depend on their family members for monetary support for their disease management requirements. The findings indicated that some patients fear being rejected by their family members. Therefore, they hide their medicines in locked cupboards and ensure that no family member knows they have diabetes. This could put them at risk of developing coma in low sugar levels, and the family members do not know about the condition. The section below presents the implications of health care system responsiveness on diabetes management.

Conclusion

Diabetes is a collective issue that cuts across and affects the patients and their family members and the health structures. Diabetes management affects the lives of patients and their households and impacts their social well-being. This is due to the catastrophic expenses associated with it as per the findings. Hence in agreement with Islam et al. (2013), diabetes imposes a big weight on health structures and societies. The rate implications of diabetes to society are multi-fold: direct prices to humans with diabetes, their families, and the health care sectors, indirect expenses to society and authorities, which might be the productiveness costs; and intangible fees, cause detrimental effects on quality of life (Islam et al., 2013).

Study Recommendations

The study recommends that the family members/relatives/community provide moral support, encouragement, financial support, and accept the patient without thinking they are pretending. They should also avoid tempting the patient with what they are not supposed to do, like

preparing meals that the patient is not supposed to eat. They should create a conducive environment for the patients to manage diabetes without stress or hide their medication due to stigma. The family members/relatives should accompany the patient to the hospital for clinics to learn how to help the patient manage diabetes effectively. The eateries in the community to consider diet for diabetes patients.

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