Health-Seeking Behavior of Diabetic and Hypertensive Patients in Rural Communities of Ghana

Michael Amponsah Kodom
mkodom@vvu.edu.gh
Valley View University, Accra, Ghana

Abstract

Background: This study examined the health-seeking behaviors of patients with diabetes and hypertension in rural communities in Ghana. In Ghana, most studies on diabetes and hypertension are clinically oriented. However, medical-sociological truism suggests that attitudes towards health and illnesses, such as hypertension and diabetes, have a social-cultural perspective.

Method: This study adopted a qualitative approach where twenty (20) participants who were either diabetic, hypertensive, or both were interviewed.

Results: One of the study's significant findings was that diabetics/hypertensives use only orthodox hospitals to treat their conditions. Another finding was that the problems and challenges diabetics and hypertensives face include financial difficulties, social isolation, and stigmatization.

Conclusion: Recommendations were made based on these findings. For instance, the registered traditional medicine practitioners should collaborate with the Ghana Health Service to intensify education on the importance of using certified traditional medicines in the treatment and management of diabetes and hypertension and provide customer-age-factor services at the various health facilities for persons with chronic diseases such as diabetics and hypertension.

Keywords: Diabetics, hypertensives, rural communities, health-seeking behavior, Ghana

Introduction

According to the World Health Organization (WHO, 2016), diabetes mellitus and hypertension have emerged as major medical and public health issues worldwide. Both conditions are essential risk factors for coronary artery disease, heart failure, and cerebrovascular disease. The prevalence of diabetes in adults worldwide was estimated to be 4.0% in 1995 and is predicted to rise to 5.4% by 2025 (WHO, 2016). "In Africa, non-communicable diseases are estimated to become the commonest cause of death by 2030" (Musau, 2017, para. 12). Africa has been identified as the region with the fastest increase in various non-communicable diseases. According to Dalal et al.(2011), the number of persons living with diabetes aged 20-79 years in Africa is projected to increase by 98% from 12.1 million in 2010 to 23.9 million

by 2030, compared with a global average of 54% increase over the same period.

Several studies conducted in Ghana on chronic diseases have alluded to the rising trend of diabetes and hypertension, which are major risk factors for most chronic diseases (MOH, 2014). Ghana Health Policy acknowledged that while Ghana's disease profile is characterized by high levels of parasitic and infectious diseases, there is a rising incidence of chronic non-communicable diseases, including hypertension and diabetes (MOH, 2014; Aikins, 2010). According to the National Diabetes Association of Ghana (NDAG, 2019), the prevalence of diabetes mellitus and hypertension has been on the rise. They are among the leading non-communicable diseases of public health concern in Ghana.

Several people knowingly and unknowingly live with these conditions and their attendant complications (NDAG, 2019). The comorbidity of diabetes and hypertension has had a heavy toll on the lives of Ghanaians. They are referred to as 'silent killers' in the medical context. Most studies about chronic diseases such as diabetes and hypertension in Ghana are clinically oriented (Aikins, 2016). However, medical-sociological truism suggests attitudes towards health and illnesses are socio-culturally determined. In other words, the working and living conditions of a person, the definition and labeling of a health condition, and the appropriate therapeutic processes are all determined by society (Kodom et al., 2022).

One's knowledge and understanding of any disease influences one's decisions regarding managing such conditions (Kodom et al., 2022). Therefore, knowledge of the patterns that influence health and medical services use for people with diabetes and hypertension should be analyzed. To understand the health-seeking behavior of people living with diabetes and hypertension in some rural communities in Ghana, the following research questions were considered:

1. What are the participants' risk factors for diabetes and hypertension?
2. What are the participants' health-seeking behaviors?
3. What challenges do participants encounter during the health-seeking process?
4. Do the participants have a family support system?

Many studies on diabetes and hypertension in Ghana have focused on urban centers rather than rural communities (Addo et al., 2006; Nyarko et al., 2014). This current study was carried out in rural communities because economically, the rural populace is the agricultural productive force shouldering the socioeconomic development and advancement of the country. Therefore, such a study is undertaken in rural communities so that any health intervention policies regarding diabetes and hypertension will consider the rural populace. The study was carried out in the Shai-Osudoku District of the Greater

Accra Region. The Shai Osudoku District was selected because it is a peri-urban district comprised of typical farming communities.

Literature Review

The reviewed literature focuses on studies associated with the global prevalence of diabetes and hypertension in Africa and Ghana. It also focused on the literature associated with the socio-cultural and health-seeking behavior of diabetic and hypertensive patients. According to the American Diabetes Association (2003), the combination of hypertension and type 2 diabetes is particularly lethal and can significantly raise one's risk of heart attack or stroke. In addition, the same report indicated that having type 2 diabetes and high blood pressure also increases the chances of developing other diabetes-related diseases, such as kidney disease, and may cause blindness. There is also significant evidence to show that chronic hypertension can speed the onset of aging-related cognitive problems, such as Alzheimer's disease and dementia (WHO, 2016). Diabetes, according to American Diabetes Association (ADA, 2003), increases the risk of coronary events two-fold in men and four-fold in women. This increase is partly due to the frequency of associated cardiovascular risk factors such as hypertension, dyslipidemia, and clotting abnormalities.

Several studies have reported alternative treatments for diabetes and hypertension, such as traditional and herbal medicines (Annan et al., 2014; Chinenye and Ogbera, 2013). For instance, Chinenye and Ogbera (2013) reported that many Nigerians often 'supplement' the care they receive in clinics and hospitals with treatment from traditional healers. Again, some health workers, such as nurses, even recommend certain traditional healers for patients suffering from diabetes and hypertension for further treatment. The community's ideas and attitudes toward health and illness affect how they utilize health services. This is because these ideas and attitudes provide ideological bases for the healthcare system (Omotosho, 2010; WHO, 2013). Omotosho (2010) states that in Nigeria, the quest for health easily shades into issues of morality and religion because the latter plays a significant aspect in social life. The rural populace has cosmological notions which ascribe the etiology of diseases and ill health to entities far beyond the realm of the stethoscope. They believe the doctor knows all and can cure all diseases, provided the right conditions are fulfilled. Hence, treatment of diseases classified as "common" or "ordinary" is diffused using either traditional or allopathic medicines, while those classified as "severe" or "extraordinary" usually require traditional attention (Ewhrudjakpor, 2007; Omotosho, 2010).

Overtly challenging patients' health beliefs can result in non-adherence and treatment failure, especially if patients view chronic illnesses such as hypertension or diabetes mellitus as intermittent diseases that require ephemeral treatment (Iyalomhe & Iyalomhe, 2010). A consistent

finding in many studies is that, for some illnesses, people will choose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or government health facilities (Ahmed et al., 2001). Thus, there is growing acknowledgment that healthcare-seeking behaviors and local knowledge must be taken seriously in programs and interventions to promote health in various contexts (Price, 2001).

Factors Contributing to Health Care Seeking

According to Iyalomhe & Iyalomhe (2012), there are two main determinants of healthcare-seeking behavior: the first analyzes barriers to care that lie between the patients and the services, and the second type investigates the process of health care seeking. This involves identifying pathways to the formal healthcare system, often commencing with home care and traditional healers, and extending to the formal system: pathways differing according to the presenting condition. Health-seeking behavior studies generally look at illness behavior and focus on motivating factors of illness perception and health belief (Iyalomhe & Iyalomhe, 2012). Studies that look beyond the individual for social patterns or determinants of decision-making include the sense of local control over circumstances and the influences local groups and communities have on decision-making patterns (MacKian, 2003).

Senah (2004) found that in Ghana, in most cases, when the patient did not know the kind of drug to purchase, he or she consulted the pharmacist or the store attendant, who would then suggest the appropriate medication. In some communities in Ghana, because of the belief that every disease has a spiritual cause, many people consult a fetish priest when they or members of their family are sick before they attempt any other form of treatment (Asenso-Okyere et al., 1998). All these factors have a significant influence on the health-seeking behavior of a patient.

The decision to seek care depends on many factors, including the availability of a healthcare provider within the community, proximity of the provider, reputation of the provider, perceived quality of the services, perceived causes of the disease, cost of treatment, and arrangement for payment (Asenso-Okyere et al. 1998). The cost of orthodox health care is increasingly hindering many healthcare seekers, leading them to seek alternative providers. Senah (2004) reported that drug peddlers and drug store operators who are closer to the people provide healthcare services that may be cheaper than regular healthcare providers because of the non-payment of consultation fees and transport expenses. Asenso-Okyere et al. (1998) found that in rural areas of Ghana, health workers believed that patients attempt initial treatment by buying drugs from drug stores and report to the health center only if the condition becomes worse.

Annan et al. (2014), in their analysis of the health-seeking behavior of patients with tuberculosis and related factors

in the central region of Ghana, found that more than half of the respondents sought treatment elsewhere as their first point of treatment before reporting to the health centers. They also found out that the National Health Insurance Scheme (NHIS) played an important role in the health-seeking behavior of respondents, with 45.9% of tuberculosis patients with NHIS visiting the health facility as the first provider and 49.4% without health insurance going to prayer camps. Their study further revealed that factors such as staff attitude, distance to a treatment center, gender, employment, and educational level of respondents were crucial factors that affect the health-seeking behavior of tuberculosis patients in the central region of Ghana.

Social Support and Healthcare Seeking

According to Rosland et al. (2008), positive social support (from family or friends) plays a vital role in one's ability to make healthier choices. Social support means having access to reliable people when needed (Rosland et al., 2008). Family members are the most significant source of that support. The support of family and friends during a crisis has long been seen to have a positive emotional effect on people. According to a study by Rosland et al. (2008), people tend to experience higher blood pressure and heart rates during stressful times. However, the presence of friends or family members has been shown to reduce these rates among people during difficult periods. In terms of chronic disease, the support of family or friends has been shown to lessen the chance that one will become sick or die from heart disease (Uchino, 2006). Research conducted at Brigham Young University and the University of North Carolina by Gallant et al. (2007) found that people who did not have strong social support were 50% more likely to die from chronic diseases than those with such support. Family and friends are also important for those diagnosed with chronic diseases such as heart disease, high blood pressure, and diabetes (Gallant et al, 2007). Having family support is beneficial in helping patients follow a physician's recommendations. Strong family support will help patients adhere to their medical regimen by reminding them to keep their medical appointments with their doctors, monitor their blood sugar and blood pressure, remind them to take their medicines on time, help them get regular exercise, and eat healthier foods.

Empirical studies have shown positive and significant relationships between social support and treatment adherence among patients with diabetes and hypertension. Social support from the family provides patients with practical help and can buffer the stress of living with illness (Lewandowski & Drotar, 2007). Patients' efforts to maintain and adhere appropriately to diabetes and hypertension management directives often occur in social settings and can alter family and social dynamics (Rintala et al., 2013). According to research by DiMatteo (2004), support from friends and family promotes adherence by encouraging optimism and self-esteem, which can buffer the stress of being ill and reduce patient depression. While social support

can influence the ability to adjust and live with illness, social support has also been linked to adverse health outcomes. Some studies suggest that patients often feel criticized or nagged, sometimes even guilty, when receiving support from family members (Carter-Edwards et al., 2004).

Methodology

Research Design

In this study, a qualitative approach was adopted. Qualitative research methods allow the study population to provide more personal explanations than quantitative methods. It is also believed that qualitative research is an effective way to do culturally sensitive research such as this one (Neuman, 2011). This enabled the participants with diabetes and hypertension to describe their illness experiences and beliefs in depth.

Setting

This study was conducted in the Shai-Osudoku District of the Greater Accra Region of Ghana. From the District Health Directorate, the Diabetic and Hypertensive Association has been formed in the district. The main objective of this association is to assist members in managing their conditions well. The association's total membership at the time of the fieldwork was 97 people, made up of 57 females and 40 males. Of this, 38 had both diabetes and hypertension, 47 had hypertension, and 12 had diabetes only.

Sampling and Data Collection

The study sample consisted of twenty (20) of the Diabetic and Hypertensive Association members (97 people), representing approximately 20% of the participants who volunteered to be interviewed (7 males and 13 females). Since participation was voluntary, no specific formula was used to choose participants, however, this reflected the composition of the association. The minimum age of the participants was 36 years and the maximum was 72 years. The ages of eight out of the twenty participants ranged from 66 to 72 years. These were the people who had both diabetes and hypertension, and the rest had only hypertension. An attempt was made to include at least some members who only had diabetes, but none was ready to be part of the study. In all, 15 were married, two women had been divorced, one woman was a widow, and two men were separated from their wives. On the level of education, four had no formal education, one had basic education, three had secondary level education, three completed vocational/technical school, and nine had up to tertiary level. All the participants were Christians. Most participants (12) were employed in the formal sector, six were farmers, and of the last two, one was into trading and the other was an artisan (electrician). At least each participant had stayed in the district for four years and was Ghanaian by birth.

Face-to-face, semi-structured interviews were conducted. Using a semi-structured format allowed the investigator to focus the interview questions on each participant's knowledge of diabetes and

hypertension. The flexibility of this format also made participants discuss their opinions and perceptions freely. Field notes were documented as observational and personal notes of events around the interviewing processes.

Data Analysis

Content analysis was performed by coding information. Three levels of coding were identified for the analysis: open coding, axial coding, and selective coding. These processes involved scanning the data to look for illustrated themes, generalizable trends, and conclusions. Throughout the coding process, memos of ideas and conceptual schemes helped identify assumptions and emerging themes. The thematic analysis led to the development of themes within and across data categories.

Ethical Considerations and Researcher's Reflexivity

Observing ethical guidelines was core to the success of the study. All participants were assured of confidentiality and that none of their details, such as names and health status, would be disclosed. This was done so that participants answer the questions without fear. The needs of the study had to be balanced against the needs of the participants, noting the particular sick conditions of some of them to eliminate all possible risks inherent in the process. For instance, since some of them were prone to fatigue, stress and discomfort, this informed the scheduling of visits on days and locations most convenient for each of them. Care was also taken to ensure that the interview process did not pose any physical discomfort. It was important to be closely attuned to participants' non-verbal behaviors and paralinguistic cues of physical pain and be prepared to end an interview at the first sign of fatigue or distress.

Results and Discussions

Participant's Risk Factors Associated with Diabetic and Hypertensive

The study sought to determine whether participants were aware of the risks of hypertension or diabetes. The common risk all the participants who had only hypertension mentioned was fear of developing diabetes in the future. They explained that the tendency for one to contract the two conditions was very high, especially if one already had any of them. Some referred to their neighbors and friends who first contracted one of the diseases but later developed the other. One risk that those who have both diabetes and hypertension mentioned was fear of battling with chronic wounds in case there is a cut on any part of their body. Other common risks all participants mentioned were fear that their present conditions could bring them were: kidney problems, stroke, heart attack/heart failure, and side effects of taking constant medications. Some explained that they knew people who had both conditions, and before they died, they were put on dialysis due to kidney problems they developed. These views expressed by the majority of the participants reflect the literature reviewed

(WHO 2016; ADA, 2003) regarding the risks of being diabetic or hypertensive.

Participant's Health Seeking Behaviors

Participants in this study were asked to share their experiences of seeking treatment. All participants responded that they sought medical treatment from the orthodox hospitals. Most of them explained that anytime they experienced symptoms like dizziness, severe headache, and other symptoms related to their conditions, they either visited the hospitals or pharmacies to buy their known drugs for self-medication as prescribed by their doctors. It was revealed that those who had only hypertension practiced self-medication more as per their doctors' instructions than those who had both diabetes and hypertension. However, those with both conditions explained that they mainly reported to their doctors anytime they felt unusual reactions in their body.

Interestingly, the research found that the highly educated participants were among those who preferred self-medication with their doctor's advice. They could, for example, self-test their sugar level using their own glucometer, check blood pressure, and self-inject themselves with insulin. The following excerpts demonstrate the most common explanations:

> *"I have my own machine that I use to check my blood pressure….. Usually, it is my husband who does so for me. I usually check it once every week, but anytime I feel that am not feeling fine, I call my doctor to tell him the results and how I feel. In most cases he (my doctor) tells me what medicine to take. Even though I know most of the hypertensive medicines, I just want to take the instructions from him."*

A retired teacher Contrary to the above explanations, one woman with both conditions said:

> *"My doctor always gives me a date that I should report to him, so I always do that….Whether I am well or not, when the date he has given me is due, I have to go and see him...He is a very good doctor. But he has also told me that, even if the date he gives me is not due, and I feel unusual reactions in my body, I should not wait for the date he has given me…. but I should rather come and see him….. So I always do that".*

Surprisingly, the findings of this study contradict the literature reviewed because none of them mentioned using traditional medicine as an alternative source of seeking treatment. A plausible explanation for this would be that most African societies treat chronic diseases in combination with traditional herbal medicines and biomedicines (Annan et al., 2014; Chinenye and Ogbera, 2013). The most common explanation was that they had been educated during their meetings that relying on traditional medicines could lead them to further complications.

Challenges Participants Encounter During the Health-Seeking Process

This study sought to determine whether the participants encountered any challenges or problems in their quest

for treatment. Aikins (2016), among her findings, stipulated that in Ghana, without health insurance, managing health conditions such as diabetes and hypertension can cost more than what the average individual earns. A rural-urban study of diabetes experiences showed that many poor rural men and women with diabetes often relied on financial support from their immediate and distant family members. Chronic conditions such as hypertension and diabetes, according to the study, appear to be stigmatized. Asenso-Okyere et al. (1998) have also reported on the stigmatization of poor people suffering from severe chronic diseases such as diabetes and hypertension in some communities in rural Ghana where certain community members view them as HIV and AIDS patients. Similarly, WHO (2017) and Ndiaye (2010) also reported that diabetic or hypertensive patients without health insurance could not effectively manage their conditions as those with health insurance.

However, some of the findings from this study are inconsistent with the literature reviewed. Results from this study did not recognize the use of health insurance as an effective management method for diabetes and hypertension at the time of the research. Olasehinde (2018) reported that financial barriers, non-adherence to medication regimen, cultural barriers such as self-medication with local herbs, and lack of privacy during doctors' consultations were related to poor diabetes and hypertension management among Nigerians. Although this study's findings agreed with some of the literature reviewed, none of the study participants reported using local herbs to treat diabetes and hypertension or the lack of privacy at the hospitals.

Beune et al. (2006) also reported that some Ghanaians expressed reservations about sharing their diabetic or hypertensive conditions with community members because it might cause social stigma. Famuyiwa (1985) indicated that, in Nigeria, cases of summary dismissals from jobs are due to the erroneous belief that diabetes is contagious and harassment of diabetic patients by the police for possessing insulin syringes and needles have been found. McGuigan (2010) found that some diabetic and hypertensive patients perceived long-term medication adherence as an addiction rather than chronic disease management. Lack of physical activities due to busy work schedules was also found among the Eritreans and Ethiopians.

Participants were asked to share any problems they encountered in their quest to seek treatment for their condition. Overall, participants described two main problems: financial constraints, the most frequently mentioned, and long queues in the hospital before one could see the doctor. Most of them described the problem they encountered as financial with regard to purchasing prescribed medicines. Even though some said they received financial support from their immediate family members (children), it was still a challenge. Some of them also explained that since they had been put on a special diet, particularly those with both conditions, the high cost of buying

special foodstuffs, especially plantain was highlighted. They further pointed out that during specific periods of the year, it was difficult to get plantain (the main component of their prescribed food) from their various communities. One woman explained her financial problem as:

> *"They say if you use the health insurance card, they will not give you 'good' medicines, so my children buy all my drugs from Accra for me which are very expensive. These days, getting plantain to buy is very difficult…..plantain is the main food I eat. When you get it, it is too costly. I spend all the money the children send me to buy plantain".*

The second main problem was the long queues at the hospital, which sometimes they go to join before they can see a doctor. In Ghana, the elderly are given certain privileges at hospitals to see doctors ahead of the young. Nevertheless, according to their explanations, even the elderly is not spared the long queues because of limited facilities and inadequate numbers of doctors assigned to see the elderly at the hospitals. One man described it as:

> *"My main problem is going to see the doctor. Sometimes if you don't go early in the morning, you will spend the whole day at the hospital because of long queues….. that is my only worry".*

Apart from these two main problems, other challenges also emerged during the interviews. These are the usage of regular medications and restricted lifestyles. This theme was apparent throughout the interview process, beginning with the participants' emotional reactions to the initial diagnosis of diabetes and or hypertension. It was revealed that most participants reacted negatively to the diagnosis due to associating it with lifestyle changes and medical complications, as well as the risk of developing subsequent diabetes (those who have only hypertension). They expressed their challenges in several ways, but the most frequent ones turned out to be taking regular medications and restricted lifestyles.

They described how uncomfortable it was to take medication every day at regular intervals. Those who have both conditions explained that, because of the regular medication and insulin injection, it became difficult and uncomfortable to travel outside the comfort of their homes. It was realized during the interview that, even some of them did not want their relatives and friends to know their health conditions, and this made it difficult for them to visit, particularly those who lived outside their hometowns.

The other challenge that all participants consistently mentioned was their eating habits. A change in diet and meal planning was one of the main themes that emerged, as the foods, they ate affected their health conditions. They (those with both conditions) explained that their meal planning had to change as they had to modify their eating habits and, embrace nutritious food choices, eat smaller portions regularly to avoid further health complications. This was viewed as difficult for the other members of the diabetic/hypertensive family to adjust. It was further compounded when the family

was accustomed to certain foods that diabetics/hypertensives needed to limit in their diet. As if these were not enough, some explained that it was difficult for them to attend social functions such as parties, where all kinds of tempting foods were available. Consistently, they kept referring to how difficult it was to avoid eating certain foods, some of which they liked. The most common thing they all referred to as challenging regarding their eating habits and change in diet included: eating time, especially for those with both conditions; avoiding eating or drinking certain favorite foods or drinks; cannot eat from family members' houses because of the restricted type of foods to eat; immediate family members like grandchildren being unwilling to eat their non-salty foods, among others. According to most of them, all these challenges sometimes made it uncomfortable to travel outside their home, making them feel socially isolated.

Comparing the findings of this study to the literature reviewed, none of the literature reviewed identified long queues at the hospitals and difficulty of eating non-salty foods as diabetics' and hypertensives' challenges, as revealed in this study. However, social isolation, loneliness and difficulty in visiting their family members (children) because of their restricted lifestyles revealed in this study are consistent with the literature reviewed (Beune et al., 2006; Asenso-Okyere et al., 1998).

The study revealed that even though all 20 diabetic/hypertensive patients had a National Health Insurance card, most did not use it when going to the hospital. Anecdotal evidence suggests that they will not be given 'proper' medicines when they use the insurance card to access health services. Therefore, they claim that if one wants 'proper' drugs and good treatment from the hospital, one should not use an insurance card. This finding, however, contradicts the literature reviewed (Yusuf et al., 2017; Aikins, 2016) that diabetic and hypertensive patients who do not have health insurance packages in Nigeria and Ghana face severe challenges in the treatment and management of their health conditions. It is therefore suggested that even if the cost of treatment and management of diabetes and hypertension is more costly than what diabetic and hypertensive patients pay as premiums for the National Health Insurance, special arrangements could be made for them to pay a higher premium. This will let them have confidence in the Scheme so that they will use it to treat and manage their diabetic and hypertensive conditions properly.

Family Support System?

One of the themes that emerged from the study was that the family is the primary source of social support to the participants in their quest for treatment and management of their health conditions. Family members were often involved in the lifestyle changes people made after they were diagnosed with diabetes/hypertension. Almost all participants mentioned that their spouses,

partners, and children were essential in helping and motivating them to maintain their condition under control. Most of them explained that they received a lot of encouragement from family members to follow a healthy diet as prescribed by their doctors and maintain a consistent exercise routine such as brisk walking. In addition, adherence to medicine, calling to find out how they were faring, frequent visits from family members, etc., were also mentioned as important motivating factors for the study participants. Participants also indicated that their immediate family members such as their spouse and children acted as a source of financial support to meet their medical bills and cost of living, especially those participants who were sixty-six years old and above and on retirement from active work.

Comparing the above findings with the literature reviewed, most of the findings are consistent with the literature. For instance, according to Uchino (2006), healthcare providers work towards providing medical homes for chronically ill patients, it is becoming apparent that family provides the most important home for many patients' daily self-management and that family members can play critical roles in the health care system. Managing chronic illnesses such as diabetes and hypertension is difficult for patients and healthcare providers. To avoid disease complications, patients are advised to take medicines at scheduled times, eat certain types and quantities of food daily, be physically active, and avoid stress. Patients and healthcare providers often find it difficult to manage these routines (Uchino, 2006). Again, Paez et al. (2009) found that family and friends affect patient self-management since daily eating, physical activity, and stress management of diabetics/hypertensives happen in the setting of social activities and relationships. Family members often decide which food to keep in the house, what to prepare for meals, and how health is prioritized among other family needs. Family members usually provide the emotional support that helps patients handle the stresses of illness. People with family support follow their self-care regimen more regularly, which is vital to maintaining their health. For many chronically ill patients, sharing their burden with intimate friends and trusted family members makes living with their disease not only possible physically but also worthwhile emotionally and spiritually (Paez et al., 2009). Some studies have shown competing demands between patients and family members as barriers to self-management (Gallant et al., 2007). For example, family members may not want to eat the same foods as a diabetic patient trying to maintain a healthier diet. Such competing demands limit patients' time and energy and introduce stress that can negatively affect patients trying to juggle multiple family roles while living with the illness (Gallant et al., 2007). However, in this study, there were no competing demands from family members.

Conclusion

This study examined the health-seeking behaviors of patients with

diabetes and hypertension in rural communities of Ghana. The paper established that the participants use only the orthodox hospitals for their health-seeking treatment of their conditions. This probably is due to the education they received from their association. They faced several problems and challenges in their quest for treatment and management of their conditions. These include financial problems, social isolation and stigmatization. Based on the findings, it is recommended that the National Health Insurance Scheme should have a special package for people with chronic diseases, particularly diabetes and hypertension. This will boost patients' confidence in the usage and patronage of the Scheme. It is also suggested that registered traditional medicine practitioners should collaborate with the Ghana Health Service to intensify education on the importance of using standardized or certified traditional medicines in the treatment and management of diabetes and hypertension; it is again recommended that people with chronic diseases such as diabetes and hypertension who are sixty years and above should be given special doctors at the various hospitals to attend to them to avoid the long queues at the hospitals. This will encourage them to visit the hospitals regularly. These recommendations will help improve the health-seeking behavior and management of diabetic and hypertensive patient situations in Ghana.

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