EXPERIENCES OF PEOPLE LIVING WITH DIABETES IN QUTHING

By

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Roma

DECLARATION

Name: Tšireletso Germinah Mahetlane

Degree: Master of Science in Health and Medical Sociology

I declare that the study entitled “Experiences of People Living with Diabetes in Quthing” is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

CERTIFICATION

This is to certify that this dissertation has been read and supervised as having met the requirements of the Faculty of Social Sciences, National University of Lesotho, for the award of the Degree of Master of Social Work OR Master of Science in Sociology.

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EXTERNAL EXAMINER

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ABSTRACT

Diabetes mellitus constitutes a significant and escalating global health challenge, necessitating a comprehensive investigation into the experiences of individuals grappling with this chronic condition. The diagnosis of diabetes presents a multifaceted challenge for patients, encompassing physiological, psychological, and socio-economic dimensions that warrant in-depth exploration. In Lesotho, a paramount concern revolves around the suboptimal adherence to recommended self-care practices among individuals living with diabetes, coupled with a noticeable gap in comprehensive knowledge pertaining to effective self-management strategies. The study objectives were to determine whether living with diabetes was a biographical disruption to people living with it and to explore the health seeking behaviour of people living with diabetes.

The study employed a qualitative research approach and used a case study design to explore the experiences of people living with diabetes. The study population was males and females living with diabetes and residing in Quthing aged forty years and above. A sample of 15 people who had been diagnosed with diabetes for at least two years was selected purposefully with the aid of snowball sampling. An interview guide was used in the semi-structured interviews that were then transcribed verbatim. Thematic analysis was used to analyse the study findings.

The study's results show that living with diabetes complicated participants' lives, as they had to adjust their lifestyles after diagnosis. The results also revealed that participants sought medical help because of knowledge of the disease, presence and severity of symptoms of the condition. *Adherence,* compliance, complementary and alternative medicines were also reported to be amongst approaches used in diabetes management. Participants indicated that they managed diabetes using oral medication and insulin injection while also complementing them with lifestyle modifications such as diet adjustment and physical activities.

The study concludes that the diagnosis of diabetes emerged as a significant biographical disruption, demanding adjustments to daily routines, lifestyles, and self-perceptions. Participants demonstrated a multifaceted interplay of factors influencing their health-seeking behaviours, incorporating disease knowledge, symptom

presentation, and perceived severity, all of which collectively shaped their decisions to seek medical care and engage with healthcare providers in the management of the condition. Adherence to prescribed treatments and compliance with medical advice reflected the assorted strategies taken by individuals in their pursuit of glycaemic control and overall well-being.

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CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND TO DIABETES

Individuals of all ages, genders, and socioeconomic backgrounds are susceptible to diabetes, also known as diabetes mellitus (DM), a worldwide non-communicable disease. According to Saeedi et al. (2019), 463 million adults between the ages of 20 and 79 were anticipated to have diabetes in 2019, and by 2045, that figure is expected to rise to 700 million, making it a major global public health concern. An individual with diabetes can lead an ideal quality of life when the disease is detected early and treated effectively, minimizing its effects (Modi, 2007). Both clinically and publicly, diabetes is a serious ailment, and its alarming rise is reason for great concern. Diabetes Mellitus, according to Vaishnavi and Mishara (2021), is a chronic progressive metabolic disease marked by hyperglycemia and micro and macrovascular problems that affect every organ in the body, including the heart, kidneys, and eyes. Bury (1982) says that chronic illnesses such as diabetes leads to disrupted biographies; whereby biographical disruption stresses how the diagnosis of a chronic illness can disrupt the structure of everyday lives and how it challenges an individual’s sense of self.

Type 1 diabetes and Type 2 diabetes are the two forms of the disease that exist today. While Type 2 diabetes is the most prevalent type, accounting for 90% to 95% of all occurrences of diabetes, Type 1 diabetes is caused by an autoimmune reaction that prevents the body from secreting insulin and can be diagnosed at any age (Kishore et al. 2015). Due to its prevalence in adults, type 2 diabetes was formerly classified as adult-onset diabetes; however, in recent years, it has also been detected in children (Gungor and Arslanian, 2002). During pregnancy, gestational diabetes develops, although it usually goes away once the baby is born. Nonetheless, Type 2 diabetes is more likely to strike women who have had gestational diabetes in the future (Lappas et al. 2015). Pre-diabetes is another disorder connected to diabetes in which a person's blood glucose levels are higher than normal but not high enough to qualify them for a Type 2 Diabetes diagnosis. Individuals who have this pre-diabetic syndrome are also more likely to become Type 2 Diabetes later on (Ahmed, 2025).

Between 90% and 95% of people in Sub-Saharan Africa have Type 2 Diabetes (T2DM), the most common form of the disease that is mostly avoidable (Tuei et al. 2010). An ongoing shift from traditional to more modern eating patterns is being brought on by the globalization of food markets and the rapid urbanization linked to demographic and socioeconomic changes. These factors are also to blame for the rise in the prevalence of type 2 diabetes in sub-Saharan Africa (Van den Berg et al. 2019). In the past, people lived diabetes-free lives by eating low-fat, high-fibre diets, consuming a variety of wild and domestically grown fruits and vegetables, and leading physically active lives (Asif, 2011; Dias and Imai, 2017). On the other hand, highly processed diets have taken the place of all those practices. The region's population currently leads increasingly sedentary or deskbound lives, consumes low-fibre, high-fat, and sugar-laden diets, and consumes insufficient amounts of fruits and vegetables (Dempsey et al., 2018). All of these behaviours raise a person's risk of being overweight and obese, which is recognized to be a risk factor for diabetes.

Genetics and family history are thought to play a role in Type 1 Diabetes (Okurumeh et al. 2022). However, a variety of factors, including family history, ethnic origin, obesity, and other environmental factors, can lead to Type 2 Diabetes (Goyal et al., 2023). It has been shown that being overweight causes insulin resistance, which aids in the treatment of diabetes. According to Nakhla and Polychronakos (2005), African Americans, Alaska Natives, Asian Americans, Hispanics or Latinos, and Pacific Islander Americans are among the ethnic groups reported to be more prone to diabetes. A person who has a parent, sister, or brother with diabetes is likely to have the disease themselves, according to family history.

Saeedi et al. (2019) report that the world has 463 million people diagnosed with diabetes and 88 million people of that number are from the South East Asia region. It is estimated that by 2045, the number of people living with diabetes in this region will rise to 153 million (Vaishnavi and Mishara, 2021), which implies that the efforts being made to curb diabetes are not adequate to stop or at least decrease the rate at which diabetes is growing (Bonilla et al. 2016). International Diabetes Federation reveals that Singapore has the second highest proportion of diabetic patients in developed nations (Lai, 2015). The estimation of adults who had diabetes in 2017 was 450 000 adults in

Singapore and was predicted to potentially increase to 670 000 by 2030 and one million by 2050, especially if there are no measures taken to slow down the rate of diabetes prevalence (Khalil, 2017). Low and middle-income countries carry almost 80% of the diabetes burden.

The surge in diabetes cases mirrors global trends, with projections indicating a substantial rise in the number of adults affected by this chronic condition (Noubiap, 2015). Sedentary lifestyles, dietary shifts towards energy-dense foods, and increasing rates of obesity are major contributing factors to this rise (Abo et al., 2007). Type 2 diabetes, which accounts for the vast majority of diabetes cases, is particularly concerning due to its preventable nature through lifestyle modifications (Manyara et al., 2024). This problem across the African continent is exacerbated by insufficient economic resources, community support, inadequacies in healthcare system advancement and chronic disease management coupled with poor education and a deficiency in preventative and diagnostic initiatives, intensifying the gravity of diabetes crisis (Glezeya et al., 2017).

In Lesotho, a small landlocked country in Southern Africa, the prevalence of diabetes has been steadily increasing, driven by urbanisation, sedentary lifestyles and negative changes in people's dietary habits (Atun et al. 2016). It is estimated that in Lesotho, 31 000 people, out of the 2.1 million population, suffer the daily effects of diabetes (Lekulo, 2021). This indicates that in 2021, 4.6% of the population aged 20-79 had diabetes. Because it is a developing country, families in Lesotho may not afford means to healthy meals, which help in diabetes management and minimising the chances of developing diabetes (Makinga, 2013). The primary staple food for the majority of Basotho who live in the rural areas of Lesotho is boiled corn meal, known in Sesotho (the language of the Basotho) as 'papa,' which is highly rich in carbohydrates; which are known to exacerbate diabetes (Van den Berg et al, 2019).

1.2 STATEMENT OF THE PROBLEM

According to Holmstrom and Soderberg (2021), living with a life-long illness such as diabetes significantly influences every aspect of patients' lives. How an individual perceives the illness, the meaning of the illness, and the treatment regime present some of the important issues an individual is faced with from the day they are diagnosed because diabetes is a lifelong disease and it requires a controlled lifestyle. Non-communicable diseases such as diabetes considerably increase premature morbidity and mortality. This in turn poses a double burden of diseases onto the health of an individual through increased medication utilisation and overall treatment costs. This implies that diabetes leads to the development of new illnesses such as hypertension; which subsequently leads to increased costs of care for patients (De Boer et al., 2017).

Thinyane et al. (2014) indicate that in Lesotho, the biggest problem among people living with diabetes is the suboptimal adherence to self-care recommendations, together with lack of knowledge about diabetes self-management. For example, smoking or alcohol consumption is common among people living with diabetes because they do not know that it is a risk factor for diabetes or know that there is a correlation between diabetes and smoking as well as alcohol consumption. Because of this lack of knowledge, the diabetes patients decide to satisfy their cravings over self-care. Thus, the current study sought to explore the experiences of people living with diabetes.

1.3 OBJECTIVES OF THE STUDY

This study was guided by the following research objectives:

GENERAL OBJECTIVE

To explore the experiences of people living with diabetes in Quthing

SPECIFIC OBJECTIVES

a) To determine whether living with diabetes is a biographical disruption.

b) To explore the factors influencing health seeking behaviour of people living with diabetes.

c) To investigate the illness management strategies used by people living with diabetes to manage their illness.

1.4 RESEARCH QUESTIONS

a) Is living with diabetes a biographical disruption?

b) What factors influence the health-seeking behaviour of people living with diabetes?

c) Which illness management strategies do people living with diabetes use to manage their illness?

1.5 JUSTIFICATION OF THE STUDY

Diabetes is an illness that affects millions of people globally. Its occurrence does not only pose a significant burden on the affected patients, but it also has a negative impact on their families and society as a whole. Through this study, diabetes patients may feel motivated to seek help when necessary; their experiences may be taken into consideration and influence policy making and implementation. Studying experiences of people living with diabetes in Quthing highlights a crucial research gap as people undergo total alteration of lifestyle after diagnosis, which may be costly. Besides, lifestyle of Quthing residents warrants a study of the experiences of people living with diabetes.

Studying the experiences of people living with diabetes is essential for comprehending the broader implications of the disease. Living with diabetes often requires substantial lifestyle adjustments, inclusive of diet modifications, regular blood sugar monitoring, and adherence to medication regimens, which disrupt patients' daily routines and overall life plans (Rad et al. 2013). Considering that diabetes can affect an individual's sense of self and identity, altering their self-concept and life trajectory (Bury, 1982), it is important to explore the experiences of people living with diabetes and to comprehend how they are affected by the illness.

The disease affects physical health and has psychological implications on patients, revealing the challenges they face and coping mechanisms developed by those who are affected. Diabetes also influences social relationships and interactions, affecting dynamics with family, friends, and colleagues so the study will help in the understanding of how social relationships and interactions of patients are affected by the diagnosis. Despite of the prevalence of the burden diabetes carries in Lesotho; there is lack of research on it, which specifically explores experiences of people living with diabetes in rural areas such as Quthing. The current study, adds to the existing pool of social science knowledge and will serve as a valuable source of data for future researchers in Lesotho.

Recognising and understanding the experiences of people, living with diabetes is essential for developing health strategies and health policies that are patient-centred and cater for all people regardless of the social class they may belong to. This would bridge the gap of health disparities caused by the oversight of the experiences of people living with diabetes and their health-seeking behaviour. Diabetes forms a significant part of health and economic development hindrance, which ultimately leads to poverty.

Improvements in the delivery of healthcare, patient adherence and ensuring adequate therapies and education on diabetes self-management can be established to overcome the challenges faced by people living with diabetes in their healthcare journey. Thus, it is vital to determine experiences that could include their knowledge and attitudes toward diabetes. It is thus important to undertake the study on the experiences of people living with diabetes considering the prevalence of the illness in Lesotho and its association with individuals' lifestyles and practices.

1.6 DEFINITION OF CONCEPTS

For purposes of this study, adherence refers to complying with health practitioners' orders and taking medication as prescribed by physicians (Mir, 2023).

Health seeking behaviour refers to any action undertaken by individuals who perceive themselves to have a health problem in order to find appropriate remedy (Mahmood., et al, 2009)

The concept of biographical disruption stresses how the diagnosis of a chronic illness can disrupt the structure of everyday lives and how it challenges an individual's sense of self (Bury, 1982)

1.7 CHAPTER SUMMARY

This chapter discussed the background of the study; specifically the background related to diabetes. The statement of the problem was then outlined, followed by the research objectives together with the corresponding research questions. The chapter also covered the justification of conducting the study and finally terms key to the study were defined.

CHAPTER TWO: THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 INTRODUCTION

Diabetes is a chronic condition that affects millions of individuals globally. It presents a significant burden for those living with it because it affects their physical, emotional, and social well-being. The experiences of individuals living with diabetes are assorted and multifaceted, incorporating a wide range of challenges and accomplishments shaping their daily lives. By delving into the present research, the review of literature seeks to gain an understanding of the health-seeking behaviour among individuals living with diabetes. Other objectives of the study, which will be covered in the literature review, are to investigate the illness management strategies of people living with diabetes and to determine whether living with diabetes is a biographical disruption.

2.2 THEORETICAL FRAMEWORK

The concept of biographical disruption stresses how the diagnosis of a chronic illness can disrupt the structure of everyday lives and how it challenges an individual's sense of self (Bury, 1982). The biographical disruption is divided into three stages to demonstrate how individuals living with chronic illnesses go through different experiences and these are the onset, the problems of explanation and legitimation stage; the impact of treatment regimens and the adapting to regimens stages.

STAGE 1: THE ONSET AND THE PROBLEMS OF EXPLANATION AND LEGITIMATION STAGE

The onset of chronic illness presents an offense to the individual's physical self and sense of identity, which subsequently leads to self-doubting. Once person self-doubts, they begin to lose their confidence and that leads to a loss in the engagement in social interactions. Bury (1982) terms the onset of chronic illness a biographical disruption. Bury (1982) also indicates that meaning and context in chronic illness cannot be separated and together, they form biography. Thus, there are two types of meaning in chronic illness; the first type is consequence for the individual who is diagnosed and the second type is the significance the chronic illness carries.

The consequence for the individual reflects the effects of the onset disruptive symptoms on daily life both at home and at work. These consequences are inclusive of having difficulty in managing the illness symptoms, shortage of resources in the management of the illness and issues of uncertainty of plans, which may lead to stress.

The second type of meaning in the chronic illness is the significance that the chronic illness carries. This is to say that different illnesses carry with them different connotations and imaginations. It influences how individuals view themselves and how they believe others perceive them. How individuals view themselves and the belief of how others regard themselves normally affect adaptation to diagnosis. As individuals respond to the illness, they try to test the meanings attached to their altered situations against their everyday experiences.

EXPLANATION AND LEGITIMATION

After the initial onset and the impact of the condition have occurred, the individual faces with the longer-term implications of the illness because of their altered circumstances. During this phase, an individual seeks information to help explain and legitimise his or her condition, especially on the causes and the prognosis in an attempt to answer the questions which people normally ask them when something bad (being ill) happens to them; including questions such as “why me?” “why now?” and many other questions. When the illness has occurred, medical knowledge on the illness becomes essential to patients in order for them to be treated. This all forms the explanation in the biographical disruption (Bury 1982). Medical explanations of the illnesses are supplemented by narrative reconstructions, which try to place those medical explanations to a more meaningful biographical context.

Legitimation, on the other hand, describes the process of attempting to restore what has been disrupted and to create an acceptable, credible place for the condition within the individuals’ lives (Bury, 1991). Since it has been established that the onset of the illness threatens a sense of self and a person may be isolated after diagnosis, legitimation comes in to retain personal integrity and decrease the threat to one’s social status in altered conditions (Bury, 2005). This is normally achieved through multiple diagnoses to validate the condition. When symptoms become visible, it becomes important to illustrate the definition of the situation by physical deterioration.

STAGE 2: THE IMPACT OF TREATMENT REGIMENS

Bury (1991) indicates that in the experience of living with chronic illness, there is the impact of treatment regimens stage, as a second stage of disrupted biography. One of the impacts experienced here is the hope that people living with chronic illness have because of the modern scientific advances in the medical sphere. People living with chronic illness may become experts about drug usage (Bury, 1991). This is to say since chronic illnesses are life-long illnesses; people living with them spend years on treatment regimens, making them knowledgeable about medication side effects and how to cope with those effects. However, there are certain negative impacts of treatment regimens, including that the modern scientific advances can still be limited to what they can achieve in treating the illness. Sometimes, treatment regimens cause unpleasant side effects, which lead to new problems in addition to those initially treated. This creates feelings of indecision about continuing or abandoning those regimens and practitioners may be blamed for the results of the treatment (Bury, 1982). This is to say that treatment may be part of the solution and the problem at the same time as the burden is placed on the people living with the chronic illness and their families.

People living with chronic illnesses may feel as if they are being punished if there is little or no positive health change over a long period of being on treatment. It becomes discouraging for them to be on treatment, which does not yield results corresponding with their treatment loyalty. It becomes even harder for people living with chronic illnesses to weigh costs and benefits of treatment so conflicts or clashes are created between adhering to treatment regimens and being socially acceptable (Bury, 1982).

STAGE 3: ADAPTING TO CHRONIC ILLNESS

According to Bury (1991), the third stage of the biographical stage is adapting to chronic illness, which entails coping, strategy and style. Williams (2000), however, calls this stage the practical response and it entails mobilisation of resources such as physical, social, temporal, financial, medical and cultural resources. For Bury (1991), coping, strategy and style as the ways of adapting to chronic illness should be differentiated as demonstrated below.

COPING

Coping refers to the cognitive processes where the diagnosed patient learns how to live with the effects of the illness. That is to say, an individual living with a chronic illness must maintain a feeling of personal worth and a sense of coherence in the face of disruption to cope with stress. One way of coping is normalisation, which refers to treating an illness and its medication as something not new and ensuring that it is fully included in an individual’s way of living. This can be achieved through disclosing the illness to family members in order to gain their support and communicating about it to avoid disruptions and to lead a meaningful life.

STRATEGY

Strategy means those actions taken by the people living with chronic illnesses to reduce the effects they experience because of living with chronic illnesses (Williams, 2000). Bury (2012) indicates that strategy is the manipulation of social settings where resources are being mobilised to ensure that the effects of living with chronic illness are minimised.

STYLE

In the context of chronic illness, the term "style" refers to how individuals present and respond to their condition. Style takes into consideration the "cultural repertoires" that people can use to present their altered physical appearances and social circumstances when discussing important aspects of their illnesses or treatment plans. This concept is similar to coping and strategic action, but distinguishes itself by highlighting differences in symbolic meanings and social practices across cultures (Bury, 1991).

2.2.1 Understanding diabetes as a biographical disruption

Living with diabetes is a profound and life-altering experience that fundamentally disrupts an individual's biographical trajectory. The constant need for self-management and adherence to treatment regimens place a significant psychological burden on individuals living with diabetes (Debono and Cachia, 2007). Daily tasks of monitoring blood glucose levels, administering insulin injections, and following dietary restrictions are overwhelming to patients, thereby leading to feelings of frustration, anxiety, and burnout. The fear of diabetes-related complications, such as neuropathy, retinopathy, or cardiovascular disease, further compounds the psychological stress experienced by individuals living with diabetes and it also heightens their levels of anxiety and depression (Egede, 2004).

Tembo (2017) postulates that being hospitalised because of a chronic illness disrupts an individual's existential being, more especially if the person is attached to the technology. This does not exclude people living with diabetes, as sometimes, their conditions may need them to be hospitalised. Tembo (2017) is also of the view that disruptions do not only occur in daily routines, but they also occur in meanings, relationships and affairs of people. Larsson and Grassman (2012) highlight that people with both normal (lived with the illness from childhood) and chronic illness experience threatened identities. Larsson and Grassman (2012) further indicate that due to restricted dietary demands and the need for regular check-ups; people with normal and chronic illnesses lose job opportunities because of their conditions, which consequently hinders their career progression. This is to say that growing up with and living with a chronic illness disrupts one's daily life by potentially making them lose job opportunities. This subsequently leads to diminished cherished self-image and social identity, and a person living with diabetes may end up withdrawing from social interactions because of not feeling valued.

People with diabetes live with a range of negative experiences related to their bodies, including general body weakness, pain, dizziness, headaches, wounds, visual impairment, sexual organ dysfunction, frequent urination, and fatigue (Moawd, 2022). Tembo (2017) shares the same sentiments, indicating that disruption takes place on different levels, which are inclusive of pain, discomfort, suffering and ultimately, death. Tembo (2017) goes on to highlight that all these disruptions cause uncertainties, which end up shattering hopes and plans for patients. The illness also disrupts one's life through an increased level of dependency on others, consequently prohibiting social and mutual dependency. Despite disruptions, people living with diabetes adapt by developing coping strategies. Building a support network, engaging in diabetes education and embracing lifestyle changes come in handy in mitigating the impact of the diagnosis.

The onset of diabetes frequently leads individuals to seek medical help, which is a disruptive experience on its own. The regular interaction with healthcare professionals for check-ups and medication collection requires significant time and emotional investment from patients, which means a person is disrupted on his or her daily routine such as going to work (Hansen et al., 2018). Health seeking behaviour is not just one time action; it is an on-going process and for some people it may be a source of frustration and stress especially if it overlaps with routines such as work (Kuske et al., 2017).

Diabetes management requires individuals to make continuous, often intrusive, adjustments to their daily lives (Chawla et al., 2009). Monitoring blood glucose levels, adhering to strict dietary guidelines, taking medications, and adjusting physical activity are new behaviours that may contrast sharply with previous habits of newly diagnosed diabetes patients (Ahola et al., 2013). However some scholars have shown that Bury's concept of biographical disruption is too narrow to capture complex experiences of people living with diabetes.

2.3 FACTORS INFLUENCING HEALTH SEEKING BEHAVIOUR OF PEOPLE LIVING WITH DIABETES

Disease incidence, prevalence, and complications are directly correlated with health-seeking behaviour (Robinson et al., 2000). Patient morbidity and mortality rates can be decreased by early symptom recognition, consultation at medical facilities, and adherence to appropriate therapy (Charlebois, 2005). Since diabetes is a common condition that significantly increases morbidity and mortality, appropriate health-seeking behaviour may aid in the planning of diabetes care and management at the time of diagnosis in order to minimize complications and enhance the quality of life for patients with diabetes (Abidin et al., 2014).

2.3.1 Socio-economic status

Socio-economic status (SES) ranges among the top socio-cultural factors, which influence the healthcare seeking behaviours among all patients (Benova, 2015). Socio-economic status is defined by Uppara (2017) as an indicator position of a person within a hierarchical social structure position. Cockerham (2017) divides socio-economic status according to three variables; income, occupational prestige and level of education. Research has consistently demonstrated a strong association between low SES and a higher prevalence of diabetes. Kim (2015) indicates that this is common in women with lower household income and education level. Cockerham (2017) states that the level of SES a person holds such as money, knowledge, power and social connections, either protect or cause premature mortality. This is to say that people of a higher SES can manipulate resources for preventative care and treatment of diseases while people of lower economic status do not have the liberty to utilise preventative care as they may wish because of a lack of resources.

It is, however, reported that the relationship between diabetes prevalence and SES differs by country with a positive correlation in developing countries and a negative correlation in developed countries (Xu, 2007). SES influences multiple aspects of diabetes management, including quality of healthcare, availability of community resources and acquisition of diabetes related knowledge (Tao, 2016). Higher SES is typically linked to better quality healthcare, including more frequent medical check-ups, access to specialists, and advanced treatment options. In contrast, individuals with lower SES may face barriers to access to healthcare such as limited healthcare facilities, higher medical costs, and inadequate health insurance coverage, which can impede effective diabetes management (Cockerham, 2017).

INCOME

While still noting the significance of SES in diabetes management, individuals' income becomes an interesting element that influences health-seeking behaviour. According to Pancholi et al. (2023), diabetes patients are disproportionally affected by income because of altered lifestyles and the burden of going to regular check-ups. In high-income countries, people with lower SES are more susceptible to diabetes and experience excess diabetes morbidity and early mortality than those in countries with higher socio-economic status (Rabi et al., 2006). This is exemplified through a person who earns lower income and cannot afford a healthy diet. However, a study in a rural Croatian population did not find a significant association between income and diabetes prevalence (Abramovic et al., 2023), which means diabetes occurrence in that population is not affected by patients' level of income. While low income is generally associated with higher diabetes prevalence and incidence, the relationship can vary by gender, age, and geographic location. In some high-income countries, higher income and education levels are associated with increased diabetes risk, which may reflect lifestyle factors associated with affluence. Conversely, in low and middle-income countries and among certain populations in high-income countries, lower income is a clear risk factor for diabetes (Hayashino et al., 2010).

OCCUPATIONAL PRESTIGE

According to Cockerham (2017), occupational prestige presents as one's job status, responsibility at work, physical activities, together with health risks associated with one's work. It can also refer to the societal value and respect accorded to various occupations. Higher occupational prestige is often associated with jobs that provide greater autonomy, higher income, better working conditions, and more comprehensive health benefits (Cockerham, 2017). These factors collectively contribute to a lower risk of diabetes diagnosis among individuals with high-prestige occupations. Higher-prestige occupations typically offer higher salaries, enabling individuals to afford healthier food options, engage in regular physical activity, and access quality healthcare; these factors are critical in preventing and managing diabetes (Allen and McFarland 2020).

Jobs with higher prestige often entail less physical strain and lower exposure to hazardous conditions (Clougherty et al., 2010). They also usually provide a more supportive work environment with less stress, which is beneficial since chronic stress is a known risk factor for diabetes (Allen and McFarland 2020). Prestigious occupations are more likely to come with comprehensive health insurance and benefits, which can influence regular medical check-ups, early diagnosis, and effective management of diabetes. Individuals in high-prestige occupations often have higher levels of education, which is associated with better health literacy (Cockerham, 2017). This enables them to understand and act on health information, adhere to medical advice, and engage in preventive health behaviours better.

Conversely, lower occupational prestige is linked to jobs with lower pay, less autonomy, and poorer working conditions (Allen and McFarland 2020). These jobs might involve labour that is more physical, longer working hours, and higher levels of stress, all of which can increase the risk of developing diabetes. Additionally, lower-prestige jobs often lack adequate health benefits, making it harder for individuals to access the necessary medical care and manage their health effectively (Cockerham, 2017).

EDUCATIONAL LEVEL

Amongst other socio-economic variables, which determine the health seeking behaviour of people living with diabetes is their educational level. Hills-briggs and Fitzpatrick (2023) demonstrate that diabetes incidence and prevalence correlate with the level of education of patients in a stepwise pattern. They show that the prevalence is highest among adults with less than a high school education, followed by those with a high school education and lastly, those with more than a high school education. Education is the strongest health predictor because it predicts an individual’s chances of getting a proper, well-paying and stable job so that he or she can afford resources for managing diabetes (Day, 2000). The underlying belief is that the higher the education level, the better an individual’s health. The rationale behind this belief is that well-educated people, especially those with a university education, are generally more informed about the merits of healthy lifestyles (Cockerham, 2017).

Health literacy is another factor influencing health-seeking behaviour among people living with diabetes (Elsous et al., 2017). According to Pourhabibi et al. (2022), in as much as adherence to treatment is the most appropriate way to control Type 2 Diabetes, limited health literacy is an important barrier to patients’ adherence to treatment instructions. This is because diabetes related education equips an individual with literacy needed for reading instructions on the medications (Heller and Elliot, 2021). The level of health literacy in patients with Type 2 Diabetes is mostly low, and it is necessary to increase the level of health literacy in these patients by using strategies such as simplifying information or using simple and understandable trainings of the specific type of diabetes (Pourhabibi et al. 2022).

2.3.2 Severity and the presence of symptoms

Nimesh et al. (2019) demonstrates that there are also need factors to be considered in the study of experiences of people living with diabetes. Nimesh et al (2019) further posits that these are the immediate causes of service use as factors influencing health-seeking behaviour. Jaya (2011) indicates that they are inclusive of the severity of the diabetes and the presence of symptoms. At the onset, signs indicating diabetes may be taken for granted and there is no clear explanation of what the problem may be. As the disease progresses, patients then recognise the severity of the illness and want to seek for a cure. In the process of seeking a cure, patients normally seek information from various sources such as mass media, complementary and alternative medicine providers, and diabetes care providers. This multiple source of information may result in a patient using multiple remedies at the same time or sometimes a person could be in denial that they have diabetes, which acts as a barrier to illness management (Milewski and Chen, 2010).

2.3.3 Culture

Cultural practices' association with health seeking behaviour amongst people living with diabetes in Lesotho is very closely related and apparent (Thinyane et al., 2014). This association is influenced by various factors; including cultural beliefs, one's priorities, and access to healthcare services. Campbell and Long (2014) state that culturally shaped notions of health and illness have a strong impact on how individuals engage in help seeking behaviour and how they view health services use when they are ill. The influence of cultural practices on health seeking behaviour in a given population is significant because it affects the overall health outcomes of that population. For example, cultural practices shape perceptions of health, illness, and death; influence beliefs about causes of disease, and affect approaches to health promotion. Additionally, cultural practices dictate coping mechanisms and responses, affecting how illness and pain are experienced and expressed, as well as where, when, and how patients seek help. Cultural practices have always been part of people's societies and they have always been intertwined with health seeking behaviours (Farhana, 2017).

It is worth noting that cultural practices vary across societies, thus, health-seeking behaviours will also vary depending on the cultural context within which a person with diabetes exists. Cultural practices are pivotal determinants, which people consider before making health related decisions (Chibwana et al., 2009). In some cultures, health is regarded as lack of illness whereas other cultures view it as a full state of health in terms of people's physical, mental, and social well-being (Uskul, 2010).

According to Babila (2022), certain beliefs about health and medical care are universal to all cultures, depending on the beliefs given by manifested culture through cultural practices; people may or may not be open to therapy. The major concern is that cultural practices can either facilitate or hinder access to healthcare services; thereby leading to disparities in health outcomes. For example, in the context of Lesotho, where men are expected to act tough in relation to abiding with the saying '*monna ke nku ha lle*'; which means a man must act tough and not cry regardless of how painful his situation might be, this cultural practice makes it difficult for men to seek healthcare services even when they have serious ill health symptoms (Stender and Rozario, 2020).

Owoseni et al. (2014) observe that Africans believe that diseases and accidents have spiritual components that need to be addressed along with the modern treatment of diseases. It is further stated by Shaikh and Hatcher (2004) that culture often leads to self-care, utilisation of home remedies, delayed health seeking and consultation with traditional healers, especially in rural areas. This implies that when people living with diabetes firstly experience signs of ill health, they try home remedies before seeking conventional modern medicine and they normally go for conventional modern medicine when their situations intensifies (Abidin et al., 2014). The implication here is that people behave the way they do because they are influenced by factors such as denial, the absence of significant physical symptoms or complications in the early stages of diabetes, and the impact of the diagnosis on the individual and their family (Kalra et al., 2018). This pattern of behaviour has significant implications for the management of diabetes. It may delay the timely intervention and management of the condition, potentially leading to the exacerbation of symptoms and other complications (Sinclair and Abdelhafiz, 2020).

2.3.4 Access to healthcare services

Other important factors, which determine whether a diabetic person will seek, help or not are factors known as enabling factors. Nimesh et al. (2019) define enabling factors as those logistical aspects of obtaining care and they are inclusive of availability, accessibility, acceptability and affordability of healthcare services. Enabling factors, as the name suggests, are factors, which allow an individual to utilise health services according to their needs and in a desired manner (Davitadze and Aleksandrova, 2023).

Gulliford et al. (2002) posit that it is meaningful to consider healthcare accessibility in terms of whether those who need care get into the healthcare system or not. It is further suggested that access might describe probable or actual entry of a given individual or group into the health care system. Therefore, having access to healthcare services implies having potential to utilise a healthcare service if required. For people living with diabetes in this case, if a person does not feel well; having access to healthcare service will mean being able to consult a physician at that given time (Andersen and Aday, 1978).

Gulliford et al. (2002) indicate that four dimensions of accessibility are service availability; utilisation of services and barriers to access; relevance, effectiveness and access; as well as equity and access. Gulliford et al. (2002) point out that having access to healthcare services requires adequate supply of healthcare services. Service availability is traditionally measured using the number of doctors or hospital beds per capita (Jia et al., 2019). This is implies that a diabetic patient should not lack access to a hospital bed when their condition is severe and needs to be under a doctor‘s watch when needed. Utilisation of healthcare services is influenced by factors such as availability, affordability, and awareness of the services, while barriers to access as per Ensor and Cooper (2004) and Jacobs et al. (2012) include SES, geographic location, and cultural differences of diabetic patients. Relevance and effectiveness are crucial for ensuring that healthcare services meet the needs of diverse populations and that they produce positive outcomes. Equity and access to healthcare services focus on providing fair opportunities for all individuals with diabetes to receive services address disparities and ensure inclusivity (Sharma et al. 2024).

2.3.5 Barriers to access healthcare services

The public and the private sector (Brekke and Sogard, 2007) provide health services. The government runs the public health delivery system and it consists of the district health systems (village health teams, health care centres, district general hospitals, together with regional and national referral hospitals. Traditional and complementary medicine practitioners, inclusive of traditional healers, bonesetters and herbalists are also found in this category; however, they are not fully integrated into the national health system (Krah et al., 2017). In health seeking behaviour of people living with diabetes, a person can choose treatment from the aforementioned available health sectors, even though there might be barriers hindering access to them. There are different barriers that could hinder one from getting the necessary healthcare from these assortments of sectors and they are listed below.

PERSONAL BARRRIERS

When considering the access dimension of healthcare services, it is important to look beyond just their availability. According to Azar et al. (2020), the utilisation of health services involves more than just their existence. It also involves the possibility of actually using these services. An important aspect to consider is the presence of barriers that may hinder individuals from accessing healthcare services. These barriers can be personal in nature, encompassing an individual's perceptions, attitudes, beliefs, and previous experiences with health services, (Ghafari et al., 2014). Access to health services also implies that individuals must recognise their own illness and that they accept the need for health services in order to recover from the illness (Nowak, 2009).

ORGANISATIONAL BARRIERS

Organisational barriers also form an important part of the barriers associated with attaining healthcare services for people living with diabetes. Gulliford et al. (2002) indicate that the existence of long waiting lists (red tape) and times are indicators of barriers to access of healthcare services, which lead to inefficient use of available health facilities. As an illustration, physicians might not receive adequate compensation for their work, leading them to respond to the organisation by implementing tactics such as work slowdowns or strikes. Unfortunately, these actions have a disproportionately larger impact on patients compared to the organisation the healthcare workers work for (Ogunbanjo and Bogaert, 2009). For instance, a physician may arrive at work at ten o'clock, only begin seeing patients at 11 o'clock, take a lunch break at 12 o'clock, and return at quarter past two as a slowdown from work, (Tuffs, 2002).

Limited access to healthcare and resources also poses significant challenge in the management of diabetes. This can be a significant barrier to diabetes management, especially in low-income or rural areas where access to healthcare facilities and specialised diabetes care may be limited (Unnikrishnan et al., 2016). Sometimes clinics or hospitals in rural areas are very far from where people living with diabetes can easily access them; that is, the patients have to walk very long distances or have to incur large sums of money for transportation to healthcare centres and this presents a challenge in managing diabetes (Petrazzuoli, 2020).

2.4 APPROACHES IN DIABETES MANAGEMENT

As a prevalent and complex chronic condition, Diabetes Mellitus and its various management strategies has been the subject of extensive research. Diabetes management has evolved significantly over the years, with distinct approaches emerging to address the complexities of this chronic condition (Montori and Charles, 2006). Diabetes management involves a multifaceted approach that encompasses various aspects of lifestyle, medication, and individualised care (Lambrinou et al., 2019). The key approaches to diabetes management, which will be discussed in this section, involve the traditional approach and the modern approach.

2.4.1 Traditional approaches in diabetes management

The traditional approach to diabetes management incorporates fundamental strategies that comprise lifestyle modifications, medication regimens, attentive monitoring, patient education, and on-going support (Tiwari, 2015). The components work together to achieve and maintain a patient's target blood glucose levels, thereby, reducing the risk of cardiovascular disease, kidney dysfunction, nerve damage, and other associated complications (Tiwari, 2015). Through a structured regimen of dietary adjustments, regular physical activity, and thorough monitoring of blood glucose levels, traditional management strategies aim to empower individuals with diabetes to effectively control their condition and enhance their quality of life (Rao, 2015).

2.4.1.1 LIFESTYLE MODIFICATIONS

Under lifestyle modifications of a diabetes patient, there are elements of changing their diet, as well as physical activities to manage diabetes and they are outlined below.

The first one is dietary changes, whose emphasis is on a balanced diet, often with an attention on controlling carbohydrate intake to manage blood glucose levels (Feinman et al., 2015). This may include portion control, choosing foods with lower glycemic index, and avoiding sugary beverages and snacks (American Diabetes Association, 2004).

The last one is physical activity, which has to do with regular exercise, helps to improve insulin sensitivity, and can aid in weight management. Recommendations for physical activity often include both aerobic exercises (inclusive of walking, jogging, or swimming) and resistance training (American Diabetes Association, 2004).

2.4.1.2 MEDICATION

There are different medications that could be taken by a diabetic. However, this section only discusses two. Firstly, a diabetic can be treated with oral medications. For Type 2 Diabetes, medications like metformin, sulfonylureas, DPP-4 inhibitors, SGLT2 inhibitors, and others are commonly prescribed to help regulate blood sugar levels (Bolen et al., 2007). Secondly, another treatment is insulin therapy. It is often used for Type 1 Diabetes and sometimes required for Type 2 Diabetes if other medications are insufficient to control the blood glucose (Janez et al., 2020).

2.4.1.3 SUPPORT NETWORKS

Encouraging patients to join support groups or to attend counselling sessions can provide emotional support and practical advice for managing diabetes (Fisher et al., 2012).

2.4.1.4 REGULAR MEDICAL CHECK-UPS:

Scheduled visits with healthcare providers are essential to monitor overall health, screen for complications, adjust treatment plans, and to provide on-going education and support (Cooley et al., 2011).

These traditional approaches aim to achieve and maintain blood glucose levels within a target range in order to reduce the risk of long-term complications such as cardiovascular disease, kidney disease, nerve damage, and vision problems; which are associated with diabetes.

2.4.2 Modern approaches in diabetes management

Modern approaches to diabetes management build upon traditional methods while also combining advancements in technology, personalised medicine, and patient empowerment. The following are some key components of modern approaches to diabetes management.

2.4.2.1. CONTINUOS GLUCOSE MONITORING (CGM):

CGM devices provide real-time glucose readings throughout the day and night, allowing individuals with diabetes to track glucose level trends and helping them to make informed decisions about diet, exercise, and medication adjustments (Reddy and Oliver, 2024). Some CGM systems also provide alerts for high and low glucose levels, helping to prevent severe hypoglycemia or hyperglycemia.

2.4.2.2. INSULIN PUMP THERAPY:

Insulin pumps distribute insulin to diabetic patients continuously throughout the day, impersonating the body's natural insulin release more closely than multiple daily injections (Iyer, 2022). Modern pumps offer features like automated insulin delivery (closed-loop systems), which adjust insulin delivery based on CGM readings, thereby reducing the need for manual adjustments.

2.4.2.3. DIABETIC REMOTE MONITORING AND MANAGEMENT SYSTEM

The diabetic remote monitoring and management system, according to Katalenich et al. (2015), consists primarily of an automated system with a small amount of human input. It uses patients' landlines and phones to send automated voice or text messages. The primary goal of this system's design, according to Sciamanna et al. (2004), was to remind patients to check their blood glucose and report the results, along with the medications they take, including their insulin dosage. Customizing the suggested modifications to self-management based on patient data was another justification for implementing the system (Songs et al., 2023). When glucose parameters deviate from recommended values, this technology automatically provides emergency backup human assistance. Medical professionals can as also monitor the progress of their patients through the web.

Overall, modern diabetes management focuses on leveraging technology, personalised approaches, and patient-centred care to achieve better glycemic control, reduce complications, and enhance quality of life for individuals living with diabetes. These advancements aim to empower patients, improve treatment outcomes, and support long-term health.

2.4.3 Challenges in the management of diabetes

Managing diabetes presents a complex on-going process requiring attention to various aspects of the disease. Factors such as poverty, unemployment, unstable income streams and food insecurity intersect with diabetes management in many ways (Vijayaraghavan et al., 2011). These limitations to diabetes management exacerbate stress and affect adherence to treatment regimens (De Groot et al., 2016).

Effective management of diabetes requires strong and consistent cooperation of the patient (Mc Gill et al., 2017). Self-care practices, which include self-monitoring of blood sugar levels, diet management, physical exercise, and adherence to medications, are the cornerstone of diabetes management, which could prevent or delay complications and possible deaths associated with diabetes (Magkos et al., 2020). Thus, it is important to consistently adhere to treatment regimens for better quality of life. Often, the complications associated with managing diabetes are highly attributable to the failure to adhere to treatment and self-care recommendations. The poor self-discipline, lack of support from family members and from physicians, poverty and lack of access to health facilities are some of the major factors for failing to comply with diabetes treatment (Tewahido et al., 2017).

Below is the list of some of the challenges in the management of diabetes

Unsatisfactory delivery of healthcare services to people living with diabetes

Blonde (2005) emphasizes that one of the biggest obstacles to controlling diabetes is the inadequate provision of healthcare services to those who have the disease. The absence of infrastructure, tools, and qualified staff required to deliver quality health-based care is the root cause of this problem. For instance, most people in Lesotho rely on government institutions to provide them with affordable medical treatment. These hospitals now frequently prescribe drugs that are not available on-site, forcing patients to buy them from privately held pharmacies (Dusetzina, 2014), which raises the cost. Since many patients seek treatment at government hospitals due to their inability to pay for private healthcare, this condition is especially troublesome (Stenson, 2001).

The inefficiency and irrelevance of the existing healthcare services is another issue contributing to the inadequate quality of care for individuals with diabetes. According to Levesque et al. (2013), delivering the appropriate healthcare service at the appropriate time in the appropriate location is what constitutes excellent access to healthcare. This suggests that in addition to having equipment, a medical institution should have equipment that is useful and efficient in assisting those who come for treatment (Salt, 2003). For example, for diabetes, there should be insulin pens and pumps, which work perfectly in administering insulin without having them while they lack certain aspects for them to function fully (Lian, 2021). This is to say that health care centres should have equipment, which is ready for use.

Poor adherence

Poor medication adherence seems to be a significant barrier to the attainment of positive clinical outcomes among people living with diabetes (Sharma et al., 2014). Regimens cannot heal an individual who does not take them or the one who takes them occasionally. Joshi et al. (2017) indicate that non-adherence to medication wastes resources and it leads to preventable deaths; so people living with diabetes are encouraged to adhere to their medication to avoid such. They further indicate that adherence does not only improve health outcomes, but it also saves resources for the country. Other challenges in the management of diabetes include lifestyle changes. This is a major challenge in diabetes management as patients may struggle to consistently follow their prescribed medication regimen, monitor their blood sugar levels, and make the necessary lifestyle changes (Blonde, 2005). To manage diabetes effectively, people should adhere to medication.

Stigma

According to Debono and Cachia (2007), stigma significantly impacts diabetes management. Building from Goffman's (1961) concept of stigma, which refers to a mark of disgrace associated with a particular circumstances, quality, or person, Lindsay et al. (2015) add that stigma among people with diabetes can manifest as feelings of shame or guilt, fear of judgment or discrimination or isolation, and the emotional burden of living with a chronic condition. People living with diabetes often encounter misconceptions, stereotypes, and negative attitudes from others in the community, as a result leading to feelings of shame and social isolation (Inagaki et al., 2022). These emotional and social challenges complicate the effective management of diabetes, highlighting the importance of addressing stigma in people living with diabetes.

Presence of co-morbidity

Another issue that prevents people with diabetes from obtaining appropriate medical care is co-morbidity, which results from their inability to determine which condition requires more urgent care (Matima, 2016). Co-morbidity is defined as a person having two or more medical illnesses at the same time. According to Kerr et al. (2007), 40% of diabetics have at least three chronic illnesses, and older adults have two or more chronic ailments. Rekha (2012) reports that 84% of individuals with Type 2 Diabetes had co-morbid illnesses overall, with hypertension being the most common (62%), followed by acid reflux syndrome (28%), chronic back pain (22%), and osteoarthritis (21%).

According to John and Kerr (2006), co-morbidities can significantly affect a patient's capacity to handle their needs for self-care. According to Cheah et al. (2020), people with arthritis and depression have trouble functioning and face major obstacles when it comes to changing their lifestyles and taking their medications as prescribed. In addition to diabetes, conditions like emphysema and chronic low back pain can have a very weak and infirm impact on a patient's health state. Sadly, these conditions are among the most important factors that determine a diabetic patient's functioning and mental health (Isaias et al., 2022). Furthermore, patients are unable to meet normal diabetes self-care goals due to incapacitating illnesses like dementia and advanced heart failure (Christogianni and Suroya, 2023. Even though co-morbid diseases do not necessarily cause people to be unable to control their diabetes on their own, they do operate as conflicting demands. Co-morbidity conditions, in summary, restrict the amount of time that can be spent managing diabetes, and when patients are taking medicine for more than one illness, medical adherence becomes an issue.

Impacts on Family Dynamics and Caregiver Strain

Beyond the individual, diabetes care has an impact on interpersonal interactions and family dynamics (Wiebe et al., 2016). As they manage the difficulties of caring for a loved one with diabetes, caregivers—who are frequently family members—may feel emotionally strained and burdened (Alnassar, 2025). Caregivers may experience emotional stress, weariness, and guilt because of juggling caring obligations with other commitments, such as employment or housework, which may have an adverse effect on their own mental health and general well-being (Kayaalp et al., 2020). Additionally, the individual receiving care could feel guilty and like a burden. Then, when family members attempt to support the person with the condition, they become angry, making it difficult to follow the recommended lifestyle changes.

2.5 CHAPTER SUMMARY

The chapter discussed the biographical disruptions caused by living with diabetes. Various studies identified factors that influenced the health seeking behaviour of people living with diabetes, which included socio-economic status, severity of the symptoms and culture. Traditional and modern approaches to diabetes management were also explored, highlighting the likes of physical activities, life modifications and the use of medication. The chapter finally discussed challenges experienced by people living with diabetes in the management of the illness.

CHAPTER THREE: METHODOLOGY

3.1 INTRODUCTION

This chapter focuses on the research methodology used to ascertain the experiences of people living with diabetes in Quthing. The central idea of this chapter is to describe and provide information about the specific methods chosen for the research problem. The key components, which will be covered in this chapter, are inclusive of the research approach, research design, study setting, study population, sampling technique, data collection method and data collection tool as well as ethical considerations.

3.2 RESEARCH APPROACH

This study followed a qualitative research approach, which is explained by Dawson (2002) as a research approach for exploring attitudes, behaviour and experiences of the study subjects. Creswell (2014) defines the qualitative approach as an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. Creswell (2014) further indicates that in this kind of approach, the research process involves questions and procedures emerging, data being collected from participant settings, data analysis inductively being built from particulars to general themes and the researcher formulating interpretations of the meaning of the data. Fossey (2000) indicates that qualitative research aims to address questions concerned with developing an understanding of the meaning and experience of people's lives coupled with new reality of living with diabetes.

3.2.1 Advantages of using qualitative approach

One of the greatest strengths of using the qualitative approach in this study is that it gets an in-depth understanding of diabetes from the participants through the longer contact made with a few participants; allowing for deeper insights of the phenomenon because of its descriptive and inductive nature (Berg and Lune, 2017). Besides that, the qualitative approach was advantageous because of its flexible nature; the researcher had liberty of modifying design decisions, to collect and analyse data simultaneously and to do adjustments based on new developments.

3.3 RESEARCH DESIGN

The study used a case study research design. Schoch (2020) indicates that case study research design is inclusive of a detailed and intensive particular event, situation, organisation, or social unit. According to Ridder (2017), a case study scientifically investigates a real-life phenomenon occurring within its environmental context in-depth. In a case study, a case could be an individual, a group, an organisation or a problem (Burawoy, 2009). There is no representation of a larger population in a case study because the research sample follows a non-random sampling. In contrast to quantitative research, the case study is selected because it is of interest in a study or it is chosen for theoretical reasons.

3.3.1 Advantages of using a case study

Schoch (2020) shows that a case study is advantageous because it offers benefits in terms of a study's process and outcome. The case study used in this research allowed the researcher to learn from the cases they were dealing with and it also allowed the researcher to apply those principles and lessons learnt from other cases to other situations they encounter (Easton, 1992).

3.4 STUDY SETTING

A study setting refers to the physical, social or virtual environment in which research takes place (Prigerson and Maciejewski, 2008). A study setting is chosen depending on various factors such as accessibility, denoting whether a researcher will be able to gain access and engage with the chosen setting (geographical locations, means of transport as well as logistical considerations), ethical considerations (ensuring that selected area does not go against ethical principles, feasibility, diversity, cultural sensitivity and collaboration with stakeholders).

The study setting for this study was Quthing. The choice of a village in Quthing as the study site was primarily driven by the need to understand the lived experiences of individuals living with diabetes in a resource-constrained, rural setting because of their lifestyle.

3.5 STUDY POPULATION

A study population is described as the entire group of individuals or elements meeting the criteria of inclusion in a research study (Krieger, 2012). The study population serves as the foundation for selecting study participants. Rahul (2022) indicates that Diabetes Mellitus is more prevalent in older populations; thus, the study population of the current study was males and female who are living with diabetes and are aged forty years old and above and are also from Quthing. The sample size for this study was fifteen (15) people who have been living with diabetes for at least two years because they were believed to have recovered from the impact of finding out that they have diabetes and they had the needed experience of living with diabetes.

3.6 SAMPLING TECHNIQUE

Palys (2008) says that researchers need to know what they want to accomplish in order for them to choose appropriate sampling techniques. The present study employed the purposive sampling technique, also known as judgmental sampling or selective sampling, which is a non-probability sampling technique. Purposive sampling is a sampling technique whereby a researcher relies on their judgment on the traits of the participants. Tongco (2007) defines the purposive sampling technique as the deliberate choice of a study informant due to the traits that informant has and their potential to inform the study. Cresswell (2014) indicates that purposeful sampling encompasses choosing people to participate in a study because the researcher believes that they might have what the researcher is looking for.

The snowball sampling was also adopted in the study. Snowball sampling is a non-probability sampling technique whereby existing participants recruit other participants with the same qualities to participate in the study. It is advantageous to use when the population of the study are difficult to find (Flynn, 1973).

In this study, the initial participant was deliberately selected and that participant provided names of other individuals living with diabetes who were also willing to voluntarily participate in the study. This process was repeated after each interview, with the researcher asking participants to suggest more people living with diabetes until fifteen(15) interviews were completed. Although some participants were initially reluctant to share names of other people living with diabetes, they eventually provided the required information, including the locations of those individuals.

The study identified a fixed number of 15 participants where the inclusion criteria was males and females from age 40 who had 2 years or more living with diabetes. While working with this sample, participants gave a comprehensive range of perspectives relevant to the study's objectives, this sample was sufficient for reaching saturation. This is because there was no substantial diversity or new themes, which continued to emerge; therefore data saturation was reached with fewer than fifteen participants and the remaining interviews provided valuable confirmation of existing themes, thereby enhancing dependability.

3.7 DATA COLLECTION METHOD

3.7.1 Data collection

This study employed semi-structured interviews as a method of data collection. According to Dawson (2002), in semi-structured interviews, the researcher aims at knowing specific information for comparing and contrasting with other information gained from other interviews. To achieve this, the same questions were asked in each interview with the aid of interview schedule. Semi-structured interviews consist of asking participants a set of open-ended questions and follow-up questions being made through probing to further explore participants' responses (Dean, 2020). With this probing, new ideas were brought up during the interviews, which implied that it had the ability to elicit richer data (Bearman, 2019).

Semi-structured interviews are good to use because they allowed the researcher to guide participants to where her interest was (Adams, 2015). They were also advantageous because of their two-way communication nature, which allowed themes to originally emerge (Barrick, 2020).

The strength of semi-structured interviews in the study was that they allowed the interviewer to cover areas that were appropriate for the interview, meaning they had the flexibility advantage. Their flexibility was also seen when the researcher and a participant exercised their liberty to explore additional points and change the direction of the process where necessary. Abawi (2017) supports this, saying that semi-structured interviews are flexible and that they are inclusive of planned questions, yet the interviewer has more freedom in changing or modifying the wording and the order of questions.

3.7.2 Data collection tool

The data collection tool used was an interview guide. It is a tool used for qualitative research to structure and guide the flow of the interview. An interview guide is a powerful tool for in-depth data collection, allowing researchers to delve into the experiences, perspectives, and nuances of a particular phenomenon.

The interview guide was translated into Sesotho for better communication with the participants. The interview guide ensured that all topics and questions were covered; allowing for consistency and organised data.

3.7.3 Tape recorder

For a better way of preserving an accurate and complete record of interview, a tape recorder was used. However, in as much as it is lawful to record the interview, it was in the researcher's best interest to inform participants that they are going to be recorded in order to obtain their consent. Many of the participants agreed to be recorded except for two participants who were doubtful but the researcher convinced them that the recording is only done for the purpose of the current study and then they agreed to being recorded. McGrath et al. (2018) indicate that a tape recorder is used in data collection to assist in solving problems that were incurred during the interview process. These problems include failure of memory of the interviewer, archetypal memory and the inability to accurately transcribe expressions of the mood of interviewees. The records indeed proved helpful as the researcher could not remember all the answers provided for each question from the fifteen participants.

According to Treasa and Mattimoe (2004), it is advantageous to use a tape recorder in an interview as it allows an interviewer to concentrate on listening to what participants say without worrying about writing content down. This means that there will be rich data if a researcher is able to listen attentively. A tape recorder also allowed a researcher to maintain eye contact with the participants, making it possible to see facial expressions when talking about their experiences. Using a tape recorder results in having the benefit of not missing any data but rather having a complete record of interviews for analysis, including what was said in the interaction between interviewer and interviewee. Recording the interviews for the current study provided plenty of useful quotations for the report.

Although relying on equipment is not reliable and the researcher may not listen attentively because of knowing that the interviews are recorded (Tessier, 2012), to overcome equipment failure, the researcher practiced the recording process beforehand. It was also beneficial to check the equipment throughout the interview process without drawing attention to the machine. It was also crucial to take some notes to avoid disappointments of loss of data in case the equipment failed or ran out of battery. As the researcher transcribed, the researcher also referred to the hand written notes.

3.7.3.1 ADVANTAGES OF TAKING NOTES DURING THE INTERVIEW

According to Tessier (2012), note taking during an interview is the cheapest method of data collection on a very limited budget because only a pen and the note pad are required. Participants want to feel valued so taking notes encourages them to say more on their experiences and opinions because they thought the researcher is taking notes due to the importance of what they are saying, thus adding more information to the study. During the interview process in the current study, participants also seemed to remember some information as the researcher was writing. There were pertinent points, which a researcher wanted to return to later or use it to remind one of what has not been asked so note taking came in handy as the researcher went back to the notes for such. Sometimes some participants do not want to be recorded because of the sensitivity of what is being discussed so writing down the material is the only mode of recording what is being said in such cases. For the current study, however, all participants gave consent to be recorded.

3.8 DATA ANALYSIS

The thematic analysis was used to analyse data. Thematic analysis is a widely used qualitative research method that is used to identify, analyse, and report patterns or themes within data (Majumdar, 2019). It emphasises identifying themes or patterns that are important in describing and understanding a phenomenon. One of its advantages is that thematic analysis can be applied across various research designs and it is not bound to specific theoretical frameworks. The process of thematic analysis typically involves six steps, as proposed by Clarke and Braun (2017), which will be applied in relation to research questions and data availability.

3.8.1 Steps followed in thematic analysis

3.8.1.1. Familiarization with the Data

To get thoroughly familiar with the data, the researcher immersed in the raw data by reading and re-reading transcripts, listening to audio recordings, and reviewing field notes. This stage involved taking notes and making initial observations that will guide further analysis of the data.

3.8.1.2. Generating Initial Codes

To begin organising the data into meaningful groups, the researcher systematically worked through the data; identified interesting features and assigned short labels (codes) to segments of text that seem relevant to the research question. The coding helped to break down the data into smaller chunks that were easier to analyse and categorise.

3.8.1.3. Searching for Themes

To group similar codes into broader themes that capture key ideas, the researcher reviewed the codes and looked for patterns or connections between them. Codes that relate to similar concepts were grouped together under potential themes. At this stage, a theme is regarded as broader than a single code and should capture an important aspect of the data in relation to the research question.

3.8.1.4. Reviewing Themes

To refine the themes and ensure that they represent the data accurately, the researcher re-examined each theme to ensure that it fit well with the coded data and the overall dataset. Some themes may have needed to be combined, separated, or discarded if they did not hold enough meaningful data. The researcher therefore checked that the themes accurately reflected the research question and the data set as a whole.

3.8.1.5. Defining and Naming Themes

To define the scope and focus of each theme, the researcher clearly described each theme, identifying what was unique and important about it. This stage involved writing a detailed account of each theme and how it relates to the any of the study's research questions. The researcher also assigned a brief and meaningful name to each theme.

3.8.1.6. Producing the Final Report

To present the findings in a coherent and compelling way, the researcher wrote the analysis, explaining how the themes emerged from the data and providing illustrative examples (such as quotes from participants). The report typically included an introduction, an overview of the themes and subthemes, and a discussion of how the findings contribute to understanding the research question being tackled.

Broad themes which included people living with diabetes as biographical disruption, health-seeking behaviour of people living with diabetes and illness management strategies of people living with diabetes were identified. Sub-themes were then outlined from the themes and were described below each theme. What participants said was used to exemplify and clarify the subthemes as data was presented and organised.

3. 9 TRUSTWORTHINESS IN THE RESEARCH

According to Connelly (2016), trustworthiness is essential to the usefulness and integrity of study research findings, alongside its ethical considerations. Cope (2014), as cited in Connelly (2016), highlights the importance of trustworthiness in ensuring quality outcomes in research. Additionally, Pilot and Beck (2014), also cited in Connelly (2016), describe trustworthiness, or rigor, as "the degree of confidence in data, interpretation, and methods used to ensure the quality of a study." Gunawan (2015) indicates that trustworthiness in research is divided into four parts; credibility, dependability, confirmability and transferability. Connelly (2016) shows that there was an addition of authenticity as another part forming trustworthiness.

3.9.1 Credibility

Credibility in this study was achieved through spending longer times with the participants while they talked about their experiences of living with diabetes in order to ensure that the information they provide is trustworthy.

3.9.2 Dependability

Connelly (2015) describes dependability as how stable the data is over time and the conditions of the study. In this study, the researcher ensured trustworthiness within the dependability criterion through the maintenance of all the notes written during interviews, which indicated all activities that happened and the decisions taken in conducting the study. Besides that, the researcher presented findings to a colleague (peer debriefing) to seek validation.

3.9.3 Confirmability

Confirmability is described as the degree to which the study can produce consistent findings (Shenton, 2004). This was achieved through member checking to ensure that the findings emerge from the data collected from the study and not the researchers' own predispositions.

3.9.4 Transferability

Transferability, on the other hand, represents the extent to which the findings could be useful to other people in different locations and be relevant to other researchers researching the same or related problem. Shenton (2004) indicates that to allow transferability, sufficient details of the context of the fieldwork must be provided, therefore, the researcher ensured that different realities of participants were captured transparently and that they were indicating their true experiences.

3.10 ETHICAL CONSIDERATIONS

Ethical considerations are very important standards, which should be taken into consideration whenever a study is being conducted. Babbie (2007) defines ethics as abiding by the code of conduct of a given profession or group. In social research, participants and respondents have ethical considerations, which govern them. Babbie (2007) outlines four of these ethical considerations and indicates that informed consent is the umbrella term for both voluntary participation and no harm to participants. Babbie (2007) indicates that this ethical norm shows that participants get involved in a research with a full understanding of potential risks involved. As the researcher began to collect data, the researcher gave a full explanation of what the study was about and sought permission from respective participants to collect the data from them. When participants gave the consent to participate in the study, the researcher gave them a printed consent form to sign. Participants were also asked to consent to being recorded and they all agreed; except for two who needed to be convinced that the recordings were entirely meant for the study and the ultimately both agreed to the recording.

3.10.1 Notion of no harm

These are inclusive of the notion of no harm, which is explained by Berg and Lune (2017) as ensuring that there is no physical or emotional damage to the participants as a result to the research being conducted. The notion of no harm is about not hurting people who partake in a study. For example, an interview should be carefully designed to avoid causing emotional distress to participants, which may include asking questions the study subjects deem as sensitive. In this study, participants were protected against any potential harm. A letter from the University was also presented to convince participants that they would not be harmed.

3.10.2 Voluntary participation

Babbie (2007) suggests that voluntary participation is one of the most important tenets of ethical considerations as knocking on someone’s door or receiving an email, which requires energy and focus from the receiver may be very disrupting to one’s regular activities. This ethic is implying that no one should be forced to partake in a study if she or he has no desire of doing so. It is the responsibility of the researcher to handle the rejection by participants with care so that all other ethics are respected. For the purpose of this study, participation was voluntary without deceiving participants that there were some benefits they will get if they participate.

During data collection, the researcher conducted interviews at times that were convenient for the participants. One participant, who was about to go to the bar at the time the researcher asked for an interview informed the researcher that she would prefer to do the interview the following day, and the researcher accepted that. Another participant offered to do the interview while continuing with her household chores, as long as the researcher did not mind, and the researcher agreed to those terms.

3.10.3 Anonymity and confidentiality

Babbie (2010) demonstrates that protecting participants' identity in the research is the greatest concern since if their identity is revealed; they can be injured in some cases. This ethical consideration is normally characterised as anonymity and confidentiality. Babbie (2010) differentiates between these two terms and shows that anonymity is guaranteed in a research project when both researchers and readers cannot align certain responses with a given respondent whereas confidentiality refers to when a researcher can identify a given person's response but promises not to reveal it publicly. For this study, the researcher assigned pseudonyms to the participants as a way of ensuring confidentiality.

3.10.4 Deception

Another important ethical issue, which should be taken into consideration, is deception. Babbie (2010) says that it is unethical to deceive participants in order for them to take part in the study therefore; a researcher has to identify and reveal themselves as a researcher to the people being studied. Even though this might make some participants lose interest in participating, especially if the interview is taking too long, they have the right to know that they are cooperating with a researcher without any benefit to them. The researcher revealed herself as a researcher from the time she met all participants such that without knowing he researcher; one participant was hesitant to open the gate because she believed it was someone from Jehovah's Witnesses Church.

3.11 POSITIONALITY STATUS

Understanding one's positionality is crucial because it directly shapes how knowledge is constructed, interpreted, and presented within a qualitative research paradigm, particularly in sensitive areas such as chronic illness (Mellinger, 2020) (Holmes, 2020).The researcher's unique perspective, informed by personal background, values, and experiences, inevitably influences the research design, data collection, and analytical processes (Goundar, 2025). This study endeavours to present a purely academic exploration of its subject matter, devoid of any commercial or personal interests. It is an academic undertaking which is solely dedicated to advancing existing knowledge within the field, without direct implications for practical application or personal gain. The study strictly adheres to the established conventions of academic discourse, prioritizing objectivity, precision, and the rigorous presentation of evidence.

3.12 CHAPTER SUMMARY

The chapter discussed the methods that were deemed suitable for the current study and the justification for the choice of those methods used to collect and analyse data. The chapter started firstly by discussing the research approach and citing justification for its usage in the study. Other research components, which were discussed in the chapter, are the research design, study setting, study population, sampling technique, and data collection methods, data collection tool and data analysis method. Finally, the ethical considerations and the trustworthiness of the research were discussed.

CHAPTER FOUR: PRESENTATION AND ANALYSIS OF THE STUDY FINDINGS

4.1 INTRODUCTION

The chapter presents the findings of the study based on the experiences of people living with diabetes in Quthing. The chapter starts by presenting the participants' demographic characteristics. It then presents and analyses data, which is generated basing itself on the three study objectives, which are:

i. To determine whether living with diabetes is a biographical disruption.

ii. To explore the health seeking behaviour of people living with diabetes.

iii. To investigate the illness management strategies of people living with diabetes.

4.2 PARTICIPANTS' DEMOGRAPHIC CHARACTERISTICS

The total number of participants who were interviewed in this study was fifteen (15) and all the participants were Quthing residents. There were twelve women and three men in the sample used and of these, nine women were widowed, three were married and all of the men were married. The participants' age ranged from 49 to 84. Eleven women indicated that they were unemployed while two of them retired earlier than the required age of sixty because of sickness. Four women said that they depend on old age pension provided by the government for survival while seven of them, including a terminally sick one and a retired one said that they received support from their children. Only one woman said that she was self-employed but all the men were self-employed.

On the educational aspect, there was only one participant who had completed the minimum twelve years required for one to obtain a Cambridge Oversees School Certificate (COSC)/ Lesotho General Certificate of Secondary Education (LGCSE). Two participants had gone up to only 10 years in school, which is the Juniour Certificate level. Two other participants finished nine years of school (Form B). Only one participant had only completed eight years of school (Form A). Three participants had attended seven years of school (Primary School Leaving Examination). Five participants had finished less than seven years of school and one participant did not go to school at all. Table 1 below shows the demographic characteristics of the participants.

Table 1. DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

Variable	**Frequency**	**Percentage**
SEX		
Female	12	80
Male	3	20
AGE		
40-49	2	13.3
50-59	6	40
60-69	3	20
70-79	2	13.3
80+	2	13.3
EMPLOYMENT STATUS		
Self-employed	4	26.7
Not employed	9	60
Retired	1	6.7
Not working due to illness	1	6.7
EDUCATION LEVEL		
No schooling	1	6.7

Variable	**Frequency**	**Percentage**
Primary	8	53.3
Secondary	5	33.3
High school	1	6.7
NUMBER OF YEARS DIAGNOSED WITH DIABETES		
Less than 1 year	0	0
1 - 3 years	2	13.3
4 - 6 years	5	33.3
7 – 9 years	1	6.7
10 years and above	3	20
Did not remember	4	26.7

4.3 LIVING WITH DIABETES AS A BIOGRAPHICAL DISRUPTION

Being diagnosed with diabetes changed the lives of all the participants. The majority of these changes were described as disruptive changes that made life difficult for the people living with diabetes. Some participants said they were concerned about their future because of diabetes while others showed that they were worried about hypoglycaemia. The majority of the participants mentioned that dietary restrictions were very challenging. Other participants reported that they experienced financial burden because of the illness. Other disruptions that were reported included diminished sexual health and chronic pain.

4.3.1 Concerns about the future

Seven participants reported that they were concerned about the future. One of the concerns that were reported was long-term health complications such as impaired vision (diabetic retinopathy) and poor wound healing, which may lead to amputations. Other participants reported that they worried about shortened life span, as there was a possibility of diabetes killing them. Two participants indicated that they were worried about how diabetes would affect their professional lives or career prospects, especially if the illness complications arise and interfered with work. Mathe, a 45 year old man who had been living with diabetes for 10 years, indicated that:

> There were so many thoughts about the future because of my diabetes diagnosis. The first thought that came to mind after being diagnosed was whether I would still be able to work and how my future was going to look like, especially if even getting a scar was a bigger problem for people living with diabetes because one would not heal. I also had thoughts about people who have amputations related to diabetes and I felt emotionally affected.

Mangaka, a 50-year-old woman who could remember how long she had been living with diabetes and had stroke said:

> Healthwise, I am afraid of what is going to happen next. First, it was a stroke, and then I keep asking myself if a limb amputation is next. I actually live in fear because of those thoughts. Mashapha, a 58 year old man who had been living with diabetes for six years indicated that he is concerned about his two daughters possibly inheriting the illness. He said:
>
> I have two girls, so my fear is that they can inherit the diabetes.

4.3.2 Concerns about vision

Out of 15 participants, four reported that they had vision problems. They indicated that they had poor eyesight and they feared that in the end, they would totally go blind. Makhotso,a woman aged 59 years who had had diabetes for six years showed a concern and shared that:

> … I did not know who was going to help me to earn a living if I lost my vision. That I could potentially be blind stressed me a lot, because I loved working for myself. I also raise my grandchildren so it saddened me that I will not be able to give them the same love as I gave my children.

She added that:

> I was afraid that I was going to lose sight at the end of the day.

The 49-year-old woman, Mahlalefang, who had been diagnosed with diabetes for six years was also worried about losing eyesight and said:

> Life had changed because diabetes affects eyesight. My vision has since become poor after my diagnosis. Actually, I had become blind, but after taking my diabetes medication for some time, I started seeing. However, lately, I had realised that my eyesight was becoming poorer again and I feared that I was going to be blind again.

4.3.3 Concerns about death

Only five participants indicated that they feared death because of having diabetes. They showed that they live their lives always thinking about possibly dying. A 72-year-old woman, Mamoroeng, who has lived with diabetes for 13 years said:

> My biggest concern was that there might be funeral [for me] any time.

Makoro, a 57-year-old woman who had had diabetes for eleven years added that:

> It did not worry me immediately when I was diagnosed because I was given counselling and told “to have diabetes did not mean that it was the end of the world”. I was also told that diabetes is treatable if one could adhere to medication, eat well, do some exercises and that individuals who had it could live for many years but when I got home, I got home I started to get worried and had thoughts like “oh my goodness; am I going to die?”

4.3.4 Hypoclycemia

Hypoclycemia is a condition whereby people living with diabetes have low blood glucose levels; thereby leading to their brain and body being unable to get enough glucose to function properly. Its symptoms range from mild to severe and they are inclusive of being anxious or nervous, light-headedness, difficulty concentrating, confusion or disorientation, seizures and loss of consciousness. Three out of 15 participants have shown that since their diabetes diagnosis, they have experienced hypoclycemia and revealed that they have had feelings of confusion, difficulty in concentration and loss of control because of it. Mamoroeng, a 72-year-old woman who had lived with diabetes for 13 years narrated that:

> …Again, when my blood sugar was too high, I lost my mind, as in, I became very crazy (felt confused and foggy, unable to concentrate). When it happened, I felt very hot and I took my clothes and blankets off, not seeming to know what I was doing and myself. When I came back to my senses, I was shivering because I felt cold and as though I had woken up from sleep. When I asked those who were around what was happening, I was told that I had been doing weird things.

The next segment details how the researcher and Malinkeng - a woman aged 84 years old who did not remember how long she has been living with diabetes' - conversation transpired. She outlines how her life has changed since getting her diagnosis.

> Interviewee: Yes, I do adhere but I forget sometimes. I sometimes get lightheaded.
>
> Interviewer: Have you noticed on which occasions you become lightheaded?
>
> Interviewee: No, I have not noticed. However, the people I stay with said it mostly happened when I have not eaten well. I believed them. For instance, during one check-up, my doctor asked me what I had eaten, and I told him I only ate an apple. He mentioned that he wished I had eaten a banana instead, as my blood glucose was very low. The doctor explained that consuming something sweet would help raise my blood sugar levels a bit, or else I could feel unwell if the levels stayed that low.

Manokeng, woman who was 68 years old and did not remember how long she has been living with diabetes, shared her experience as follows:

> I became lightheaded. My neighbour who had now realised that when my blood sugar is low, I became confused and unable to concentrate; asked her child to accompany me to the hospital and take money for bills because I was going to leave it. I put money everywhere when my blood sugar was low; I even took off my clothes. I once left money and went to the hospital without it and some woman from another village settled my bills out of goodwill and said I could not leave hospital without getting medication costing just M15.

Other two participants reported that they have unusual forgetfulness or memory loss because of diabetes. When asked about the changes that happened after their diagnosis, Makhotso, 59 year woman who had diabetes for six years, shared that:

> I forget almost everything. Even if I had a key in my hand, I could forget it and go look for it somewhere.

4.3.5 Diminished sexual health

Two male participants reported that their sexual performance had decreased ever since they got their diabetes diagnosis.

Sixty- seven year old Mathe, who had lived with diabetes for ten years, confided that:

> Even in the bedroom, my performance has decreased because diabetes kills muscles, I no longer perform in the same way I used to before I got the diabetes diagnosis. You can never hear a person with diabetes being accused of rape, NEVER! It is impossible. (The man was so bold in his indication that a person living with diabetes can never be accused of rape).

Motsamai, a 49-year-old man who was diagnosed with diabetes for five years indicated that since the diagnosis, his sexual performance had decreased but luckily, he has a supportive wife who does not make him feel less of a man. He said:

> Again, my sex drive has lowered; I still have sexual feelings but they are not as they were before I was diagnosed with diabetes.

4.3.6 Dietary adjustments

All the participants reported that living with diabetes has forced them to adjust their diet for managing their blood sugar levels in an effort to promote overall good health. They said that they are encouraged to prioritise fibre rich foods; lower their carbohydrates intake; limit sugar and fats consumption; and control their food portions. These dietary adjustments affect individuals in different ways; some reported that they lost weight while some gained weight because of the adjustment. A man I called Mashapha who is 58 years old and had been diagnosed the past five years shared that:

> I was not okay with the changes and when I began with those changes, I even lost weight so they were stressful. Some dietary changes that were encouraged include the suggestion to remove the skin from chicken; using KFC as an example, you know it's delicious taste emanates from the skin but we were told to remove it. Even with the case of red meat, we were told to remove excessive fat before eating it. I now do not eat mutton because every time I had consumed it, I got very tired such that I felt as if my heart was going to stop. Therefore, I told myself that I would stop eating it.

Manyakallo, a 70-year-old woman with diagnosis duration of seven years outlined that:

> The first time I went to a public hospital regarding my diabetes, I was not given any guidance on managing the illness. I was given guidance when I went for a check-up. I was advised to eat wheat, which could be African beans, wheat grain stew or wheat bread but not the white ones. I was further encouraged to eat sorghum, especially as pap or as porridge. I was also told to eat African beans, sorghum grain stew and maize grain stew. Furthermore, I was to also eat yellow pap instead of the white one; you must have seen it when you entered the house. I was also told to avoid sugar so I drink tea with only milk; without sugar.

Motsamai, a 49 year old man, who had the illness for five years said:

> Self-acceptance was essential in everything because even with counselling, it would not be effective if you were still in denial. Additionally, once you became aware of living with a certain condition, it is important to adjust your lifestyle

> accordingly. For example, if you know you should not consume fatty foods, do so; you may even limit yourself to eating only half a banana because it is also to be avoided. Consuming too much of certain foods could cause blood sugar levels to spike or drop. Therefore, a proper diet is the key to managing diabetes. While medication was important, maintaining a healthy diet was the foundation of treatment. In addition, instead of eating large meals, it is better to have smaller, more frequent portions.

4.3.7 Financial burden

Living with diabetes often introduces a significant financial burden on the sick person, which can disrupt various other aspects of one's life. Managing diabetes requires on-going expenses, including costs for medications like insulin, testing strips, and regular healthcare visits. In some cases, individuals may also incur costs for dietary adjustments. Mapitsa, who is a 57 year old woman, lost her job before her diabetes diagnosis, which was diagnosed three years described her experience living with diabetes as follows when asked about her feelings about the given diabetes guidance:

> I was sad because I was already unemployed, so being told not to eat certain foods and to eat in a certain manner meant higher food costs for a non-working person. At the time, I did not even eat white pap, I ate yellow pap. With rice as well, I used the brown one and not the white one. Therefore, the guidance cost me a lot of stress and worrying about how expensive these diabetes foods cost.

Mashapha, a 57-year-old man who had been living with diabetes for five years and is self- employed (as a constructor) shared Mapitsa's sentiments; highlighting that:

> The challenge I experienced was a financial one because as contractors, our payments are sometimes delayed so I sometimes lacked the food that we were encouraged to eat such as yellow maize meal and brown rice. Thus, if I happened to eat white pap, rice or samp, I got hungry quickly and I sometimes felt as though I had lost my vision. I only ate white pap when I was away from my home.

Manyakallo, a 70-year-old woman having lived with diabetes for seven years explained that she uses injection to treat her illness and showed that:

> I sometimes had no money for eating healthy foods such as green apples and I sometimes I lacked the money to buy them. Money was everything; so lack of money was the greatest challenge I have to face.

She went further to show how money was a challenge to her, especially since she is using diabetes injection:

> I was told to put my injection medication in the fridge and I inquired what should happen if I did not have it and I was told to put on the floor for some cooler temperatures. I was asking this because I could not afford to buy a fridge except for if my children would volunteer to buy one for me.

4.3.8 Chronic pain

Five participants indicated that they have persistent pains in their bodies even though for others, it might not be felt daily. Makhotso, a 59 year old woman with a six-year period living with diabetes recounted that:

> I have experienced painful body and stomach aches and asked myself if it was a result of diabetes or if not, what was happening with my body because some days, I woke up feeling okay and other days, the whole body was in agonising pain.

Makoro, a 57 year old woman who had been diagnosed for eleven years narrated that:

> I was also having painful joints because of the illness. Sometimes, I got confused as to whether it was still diabetes or arthritis. I also got sick frequently after diagnosis. I sometimes believed that frequently getting sick was caused by the diminished immune system due to many kinds of medication I intake, which then damage the liver.

Malireko, a 84 year old woman who did not remember how long she had been living with diabetes, shared the same sentiments and indicated that she is no longer able to do anything on her own due to painful shoulders, feet and knees as a result of diabetes.

She even indicated that she no longer goes to church for the same reason. She gave the following account:

> Malireko: I had painful feet, shoulders and knees.
>
> Interviewer: did you have any concerns about living with diabetes?
>
> Malireko: yes I did. Having a painful body was one of the concerns.
>
> Interviewer: what were the biggest concerns about living with diabetes?
>
> Malireko: not being able to do anything on my own, which means I have to be fully dependent on other people. Even going to church, I no longer do.

4.4 HEALTH SEEKING BEHAVIOUR OF PEOPLE LIVING WITH DIABETES

Living with diabetes incorporates numerous changes and concerns; therefore, it requires regular health seeking as a critical aspect of managing medical conditions effectively. Participants have reported different health seeking behaviours depending on different factors, which influenced their behaviour.

4.4.1 Knowledge about the disease

Results revealed that some of the participants consulted a doctor because they were experiencing symptoms, which they suspected were indicative of having diabetes. They suspected that they were symptoms of diabetes either because they had family members who showed the same symptoms when they were diagnosed with diabetes or they worked at a hospital so they were equipped with the knowledge about various illnesses at the hospitals. Mangaka, a 50-year-old woman who worked as a nurse and the researcher conversed as follows:

> Mangaka: I had frequent urination, increased thirst, unexplained weight loss and fatigue hence I told one of my colleagues that I suspected that I have diabetes and she made fun of me. I secretly consulted a doctor and my suspicions were confirmed.
>
> Interviewer: did you consult a doctor immediately after realising those symptoms?

> Mangaka: no, I delayed a bit because I was afraid and became more afraid after I shared my thoughts of possibly having diabetes with the colleague who laughed at me.

Malipankela, a 61 year old woman with having lived with the sickness for three years reported that she was also working at a hospital but she did not reveal the position she held. She gave the following narration:

> I was working at the hospital so we were taught about various illnesses. Actually, for me, I was not diagnosed by a doctor but I was already certain that I had it even before going to consult with the doctor as I noticed those symptoms that were taught about. Consequently, I asked to be tested for diabetes and the nurse on duty was surprised as to why I was demanding a diabetes test. I told her that I have some of the symptoms of diabetes and she knew that we were provided with education for these various illnesses.
>
> She did as I asked but I noticed that while doing it, she was scared. She started first by checking my blood pressure and it was high because they go hand in hand with diabetes. After she tested me for diabetes, she got more scared, I asked what was happening, and to that, she told me that diabetes is uncontrollable and it does not have numbers. I said to her “I told you”. She got up and tried to help me standing up, thinking that I would fall but I told her that I could stand on my own. We went to the doctor, then the doctor immediately put on his overall and then I was put on the drip.

Mahlalefang, a 49 year old woman living diabetes for six years demonstrated that she had had knowledge about the illness prior to her diagnosis because she had numerous family members who displayed the same symptoms before being diagnosed. In her answer to the question of how she knew she had diabetes, she explained that:

> I would get very thirsty; so much that I needed to drink a lot of water. I drank about 20L of water in a day, I know this because I used to monitor where the level of water was when I first drank it. Eventually, I suspected that I might be diabetic. One day, my urine mistakenly dripped on the floor and I was surprised because it glued on the floor. I realised that indeed this is diabetes.

The researcher probed to find out how she knew that it was diabetes when she got thirsty and urinated a lot and she responded that it began the same way as her mother's.

Some participants consulted a doctor because their daughters were nurses so they were knowledgeable about certain illnesses. Malinkeng, a woman aged 84 shared this information when asked about how she knew she had diabetes.

> I was walking from Makatseng to my daughter's place on foot and during the journey, I felt thirsty that I was unable to walk. I then found a well nearby and drank from it. Because of the extreme thirst and weakness, I even lost a key but I still managed to make it home. Upon hearing about the incident, my daughter who was a nurse working at Lesotho Planned Parenthood Association (LPPA) took me to the hospital.

4.4.2 Severity

Some participants were influenced to seek help by the severity of their diabetes symptoms. They reported that they did not seek help until they realised that their symptoms were not getting any better after they self-medicated. Manokeng, 68 years old woman who did not remember how long she lived with diabetes, disclosed that:

> I was sick; including scratching myself in the vagina and in the eyes and I thought I had genital herpes. My eyes looked as red as blood. When I realised that I did not get any better, I then went to a clinic in the village.

Mashapha, a 58 years old man with a five-year period living with diabetes, expressed the same sentiments as Manokeng's and indicated that:

> I had frequent urination at night; such that a 10-litre bucket would be full. I thought I had genital herpes so I used traditional herbs, inclusive of *hloenya* (dicoma anomala) and *sehalahala sa matlaka* (cape camomile) trying to treat what I thought was genital herpes. When I then realised that there was no change; I decided to go see a specialist, more especially because my skin was getting dry and I would get so tired that I could not even drive.

Manyakallo, a 70 year old woman having lived with it for seven years, also reported that she sought medical help when she noticed that she was not getting any better from her two-month sickness. When asked about how she coped for two months while still suffering from common cold, she answered thus:

> I used to self-treat with all kinds of herbs which some were bitter and some had really awful taste. Amongst the herbs that I used was phefo, peperebomo, lengana and many others. My throat was even sore due to those herbs. From there, I bought common cold medication from the chemist but nothing helped so my children encouraged me to go see a doctor and at the consultation, tests were performed.

4.5 ILLNESS MANAGEMENT STRATEGIES

Illness management strategies are critical for individuals living with both acute and chronic illnesses. The study results revealed that people living with diabetes used different illness management strategies depending on the state of their illness. The following are some of the strategies used.

4.5.1 Medication

The findings reveal that there were two kinds of medication used by the participants in this study; oral medication (pills) and insulin therapy taken through injection. Out of the 15 participants, ten used pills as treatment, three used insulin therapy and the last two used both pills and insulin therapy.

Manyakallo, a 72 seventy-year-old woman with a history of seven years living with diabetes explained as follows when asked about the treatment she was using:

> Interviewer: what kind of treatment are you currently receiving for your diabetes?
>
> Manyakallo: I use pills.

She went further to explain that she uses both the pills and injection to complement each other as diabetes treatment strategies.

> I also use injection for diabetes treatment. I use three types of pills. For diabetes, for hypertension and the one I did not know what it was for. Fortunately, my child told me that the one, which I did not know, was for stress.

The researcher inquired if Manyakallo was given both the pills and the injection from the diagnosis stage and she explained that:

> No, I was given injection in the sometime after diagnosis because I was regularly taken to hospital due to fainting so they decided to give me the injection to compliment the pills.

When asked if injection was the first treatment she received, the 49-year-old woman Mahlalefang stated that:

> No, I was using pills, but my diabetes did not come under control. That was when I was given the injection as an alternative treatment. They put me under injection treatment after a year.

Mamoroeng, 72 year old woman with a thirteen-year period living with diabetes also shared the same experience and she recounted as she was asked if her first treatment was pills:

> Yes from 2011 until last year (2024) when my situation was uncontrollable, I was using pills. I was regularly going to the hospital and at one point; I was transferred to Maseru because I was not showing any hope of living. I was then given insulin therapy. My blood glucose was amounting to 31 at the time.

4.5.2 Lifestyle modifications

The findings reveal two kinds of lifestyle modifications by the diabetics being diet and the physical activities.

4.5.2.1The role of diet

The majority of the participants have shown that since receiving the diabetes diagnosis, they have adjusted their diets. They also mentioned drinking a lot of water as the other helping strategy to diabetes management. The small portion of food eaten regularly had also been reported to be crucial.

Makhotso, a 59 year old woman having lived with the illness for six years living mentioned that she drank water even when she was not thirsty. Additionally, Makoro, 57 year old woman who had lived with it for eleven years agreed with her and added "I drink water gradually throughout the day. I do not eat too much at once; instead, I ate small portions regularly, focusing on vegetables and foods high in fibre. If I didn't drink enough water, I feel tired."

Motsamai, a 49 year old man with a five-year duration living with diabetes also added that:

> The main change after diagnosis was that before the diagnosis, I ate almost everything in large quantities but now, I know that if I eat meat, I should avoid fats and eat at least two pieces of it.

Mapitsa, a 57 year old woman who has had three years living with diabetes, also shared her story of how she adjusted her diet:

> The doctor told me that he was giving me pills for its treatment. After that, some nurses who gave us some teaching on how we were supposed to cope with diabetes. We were told to avoid very fatty foods. We were also told about the sugar we are supposed to use which is called canderel. That sugar could be powdered or it could be in a pill form. Therefore, I cut out sugar altogether, but when I visit my neighbours and they offer me some tea, I use the normal sugar.

When asked about the sugar she was now using, Mapitsa woman of 57 years added:

> I had also switched from white salt to yellow or red salt and no longer use white salt at home. I only consumed white salt when visiting other people's homes. As for cooking oil, I now use olive oil.

4.5.2.2 The role of physical activities

The majority of participants shared that they engaged in physical activities such as walking, doing house chores, and dancing to help manage their illness. They explained that they learned about those practices from various sources; including their doctors, interactions with other patients, and even a WhatsApp group where they exchanged ideas and advice about the illness.

When asked about daily practices employed to manage the illness, Mashapha 58 year old man (with five years living with diabetes) replied:

> I have already indicated that eating well is one of them. I also take walks, which are also beneficial as they form part of exercising.

Mahlalefang, a 49 years woman who has had it for six years also replied to the same question, citing that:

> I danced, a lot. I was so good at it. I cleaned my garden, I worked hard. The doctor told me to exercise. He said in order to always be in good health, I should exercise by doing house chores and doing other work such as gardening. It helps to control my body weight.

Malipankela, a 61 years old woman who has been living with the illness for three years responded to the same question as follows:

> I normally went to town walking as an exercise and the taxi owners would be begging me to board their taxi, not knowing that I was exercising. In addition, I did household chores.

4.5.3 Adherence and compliance

The findings reveal that seven of the participants adhered to their prescribed medication and complied with their given guidelines to managing diabetes. Mamoroeng, a 72 year old woman with thirteen years of living with diabetes, indicated that her daughter helped her to adhere by always reminding to take her medication and bringing it to her to ensure that she did not miss her medication when she was asked if she adhered to the medication.

Malinkeng,84 year old woman who did not remember how long she has been living with diabetes, showed that she did not forget to take her medication at all, even if she could, her daughter would remind her, when she was asked if she has ever missed her dosage.

When asked if she has never missed her dosage, Makhotso a 59 years old woman (with six years living with diabetes) replied:

> No, I have not missed my dosage because even when I go somewhere, I take my medication with me so that I take it when the time for taking it comes.

i) Non-adherence

Some of the participants reported that they did not adhere to the prescribed medication because they decided to miss some of the medication, which was making them very thin. However, they reported that there was no visible change after cutting that medication off.

When asked the reason for skipping the other dosage, Makoro, a woman aged 57 who had lived with diabetes for 11 answered:

> I was getting very skinny, so I reduced the dosage and I got better. I wanted to consult the doctor and ask if there are no alternatives for metformin.

She was then asked how she knew that it was metformin that was causing her to be thin and this was her response:

> It was confirmed by people who lived with diabetes way before me that metformin was making me thin. As a result, they advised me to decrease the dosage and I took their advice.

Some of the participants reported that they avoided the dosages taken during the day because they would be out of their homes during the day or they would be working. They also reported that their blood sugar was not affected by not taking that dose. This was the response from Mapitsa, 57 year old woman who had had the disease for three years, when asked the reason for not taking the dosage taken during the day:

> Sometimes I would be out of my home. For that reason, I have made it a norm to take the medication only in the morning and in the evening.

Motsamai, 49 year old man who had lived with the illness for five years, also gave his account:

> I took one type of medication three times a day; morning, midday, and evening, but I usually deliberately missed the midday dose to see if it would make a difference. My main reason for missing it was that I was very busy during the day

> and often forgot to take it. I also took another type medication twice a day; in the morning and evening. Additionally, I was prescribed a third medication to address my morning tiredness, which I took in the evening before bed. Since starting that, I had noticed an improvement because I now felt tired at night like most people and I no longer experienced the same level of morning fatigue.

Two other participants stated that they missed other doses because it lowered their blood sugar, which poses a risk on their lives. Mathe, 67 years old man who had had it for ten years explained:

> As a person, I had my own common sense and my own was of how I viewed things. It did not mean that when a person is a doctor, he/she knows everything; he/she just has a clue of what he was treating people for. For that reason, I took my insulin injection once a day. However, when I checked my blood sugar levels, they appeared to be normal;. I took it once because taking it twice lowered my blood sugar, which would become a problem.

Makhotso, a 59 year old woman who had lived with the sickness for six years also provided her experience:

> I had observed that taking it three times a day caused my blood sugar to decrease radically. As a result, I experienced unexplained fatigue, shaking and some headaches.

One other participant reported that he missed the dose taken during the day because it made him very hungry. “It caused me severe hunger so I sometimes avoided taking it,”said Mashapha, a man with five years living with diabetes, said the following as he gave an account of his non-adherence to treatment.

Some participants reported that they unintentionally missed their dosage when they were on journeys and did not take enough dosage for a trip. Nonetheless, there were no major effects from none adherence because that rarely happened. They also reported that they sometimes took their medication an hour later than the recommended time instead of totally missing it.

4.6 CHAPTER SUMMARY

The chapter outlined the presentation and analysis of the study findings. The results revealed that more women are living with diabetes as they outnumbered the number of men in the study. As participants try to cope with living with diabetes, they are forced to seek medical help regularly and change their lifestyles in order to manage their illness. Majority of the participants reported that their main coping mechanism in living with diabetes is to adhere and comply with medication as well as to change their lifestyles in order to lead a better life and overcome the disruptions caused by living with the illness.

CHAPTER 5: DISCUSSION OF THE FINDINGS, INTERPRETATIONS, CONCLUSIONS AND IMPLICATIONS

5.1 INTRODUCTION

This chapter presents the discussion of the study findings, the interpretation of the findings, conclusions and implications of the study. The findings are discussed and interpreted based on three objectives, which are to determine whether living with diabetes is a biographical disruption, to explore the health seeking behaviour of people living with diabetes and lastly, to explore the illness management strategies of people living with diabetes. The conclusions were also drawn based on the findings of the study and ultimately, implications of the study were given in line with the study findings.

5.2 DISCUSSION OF FINDINGS

5.2.1 Living with diabetes as a biographical disruption

The findings reveal that people living with diabetes experience various disruptions, inclusive of concerns about their future, hypoglycemia, dietary restrictions, financial burdens, diminished sexual health and chronic health. Each sub-theme is discussed and interpreted below.

5.2.2 Concerns about the future

The findings show that living with diabetes often prompted significant concerns about the future, reflecting the pervasive and multifaceted impact of the condition. Participants expressed apprehension about long-term health complications of diabetes such as diabetic retinopathy (blurred vision) and poor wound healing, which can lead to severe outcomes such as amputations.

i) Concerns about vision

One of the most common eye illnesses caused by diabetes is diabetic retinopathy (Bhaskaran et al., 2023) and this was no exception for some of the participants in the study. Participants reported that the prospect of losing one's vision could be deeply an unsettling experience as it can profoundly affect an individual's sense of independence, livelihood, and ability to care for their loved ones. This aligns with literature, especially

(Thier and Holmberg, 2020), who suggest that vision impairment as a result of diabetes can have a profound impact on an individual's ability to engage in everyday tasks and activities. Coyne et al. (2004) supports that people suffering from diabetic retinopathy experience difficulty with driving, are especially at night.

ii) Concerns about death

Abidin et al. (2014) show that diabetes is a common disease and it causes significant morbidity and mortality. Similarly, the fear of death appeared to be a significant psychological burden for some of the participants living with diabetes. Among the participants, five mentioned their fear of death, emphasising that it permeates their daily lives. Participants exhibited psychological burden of living with diabetes, the persistent fear of mortality in particular. Not even counselling and reassurance saved participants from struggling with anxiety and dread about their future and death. Supporting literature emphasises that diabetes is not just a physical health issue, but it is also a psychological one. Debono and Cachia’s (2007) findings indicate that individuals with diabetes often experience heightened levels of anxiety, depression, and emotional distress due to the constant need for self-management and the fear of diabetes related complications and death.

5.2.3 Diminished sexual health

The study findings reveal the profound impact diabetes can have on intimate aspects of life, particularly sexual health and self-perception. Literature also indicates that living with diabetes is connected to a range of experiences relating to the body, which include sexual organ dysfunction (Moawd, 2022). Participants acknowledged that they experience decreased sexual performance because of diabetes. They indicated that the impossibility of a diabetic being accused of rape might stem from a perception of diminished masculinity or physical sexual capability of most diabetics. In as much as other participants acknowledged a decline in sexual performance, they reported that they found solace from their spouses, who are with them, understanding that the problem is a result of living with diabetes thereby not belittling their partners’ masculinity. Williams (2000) is also of the view that one way of adapting to chronic illness is through mobilising social resources (social support).

5.2.4 Dietary restrictions

Living with diabetes necessitates that a diabetic takes careful dietary management in order to maintain stable blood sugar levels. The findings reveal that all participants had to adjust their diet for managing their blood sugar levels while also maintaining their overall health. Participants said that they were advised to consume fibre rich foods, lower their carbohydrates intake, and limit their intake of sugar and fats and to control their food portions. Asif (2011) findings shares the same view; indicating that diabetes related dietary restrictions often required limiting carbohydrates, sugars, and processed foods while prioritising whole grains, lean proteins, healthy fats, and vegetables. Lean proteins such as chicken, fish, and beans; along with whole grains such as brown rice and whole wheat bread, are important for providing essential nutrients and aiding in blood sugar regulation (Asif, 2011). Participants even went further to show that adjusting their diets was their biggest diabetes related change and the majority of them indicated that they really struggled with this change because of how expensive their prescribed food costs.

5.2.5 Financial burden

The study findings reveal that participants struggle with finances due to the costs of managing their illness. The costs, according to participants, were inclusive of diabetes related complications, which required expensive regular medical check-ups. Participants also demonstrated that maintaining a diabetes-friendly diet could be expensive, especially if fresh vegetables, whole grains, or specialised low-carbohydrates products are required. Pancholi et al. (2023) second that, indicating that people living with diabetes experience financial burden because of altered lifestyles and the burden of regular check-ups.

5.2.6 Chronic pain

Chronic pain was also reported to be a significant disruptive aspect of living with diabetes. Participants stated that they experienced painful body parts, including painful joints, feet, shoulders and knees, which all interfered with their daily activities and mobility. This is in consistent with Tembo (2017), who indicated that disruption encompasses pain and discomfort; suffering and ultimately death. The pain may disrupt sleep; reduce productivity, and diminished one’s ability to engage in work or recreational activities. As indicated by some of the participants, they are no longer able go to church because of the same reason. Moawd (2022) had similar views and indicated that people with diabetes face a variety of bodily challenges, including general weakness, pain, dizziness, headaches, wounds, vision problems, sexual dysfunction, frequent urination, and persistent fatigue. Their emotional well-being is also impacted as chronic pain can lead to frustration, anxiety, or depression, therefore compounding the challenges of managing diabetes.

5.3 HEALTH SEEKING BEHAVIOUR

Participants exhibited various health seeking behaviours, which were influenced by different factors. Participants reported that their health seeking behaviour was mainly influenced by their knowledge about the disease and its symptoms’ severity.

5. 3.1 Knowledge about the disease

The findings suggest that participants' awareness and proactive health-seeking behaviour were influenced by their prior knowledge and experiences with the disease. Many participants chose to consult a doctor after recognising the symptoms such as frequent urination, severe hunger and frequently getting thirsty; which they associated with diabetes. This association often stemmed from either personal exposure to similar cases within their family or professional familiarity with illnesses due to participants’ work in healthcare settings. Family history also played a critical role, as participants observed parallels between their symptoms and those of relatives who were diagnosed with diabetes. This aligns with the findings from Okurumeh et al. (2022), which emphasise the influence of genetic predisposition and family history in the development of Type 1 Diabetes. Additionally, those with healthcare work experience demonstrated an enhanced ability to identify potential warning signs.

5.3.2 Symptoms severity

The findings revealed that the severity and persistence of symptoms played a significant role in influencing participants' decisions to seek professional help. Some participants initially relied on self-medication, perhaps underestimating the seriousness of their condition or hoping it would resolve on its own. This aligns with William (2000) who states that the onset stage incorporates diabetes symptoms being taken for granted. However, as their symptoms either worsened or failed to improve, they were compelled to re-evaluate their approach, eventually seeking medical assistance. This aligns with Bury (1982), who emphasises that the diabetes onset stage is characterised by ambiguity and the only way of finding out what is happening is through seeking professional help.

5.4 ILLNESS MANAGEMENT STRATEGIES

The findings reveal three kinds of illness management strategies with medication from health centres being the primary management strategy. Life modification was also reported as another essential strategy comprising of dietary adjustments and physical activities. Adherence and compliance was also found to be another fundamental illness management strategy.

5.4.1 Medication

The findings indicate that participants in the study utilised two primary forms of medication: oral medication (pills) and insulin therapy (through injection). Among the 15 participants, ten relied solely on pills for their treatment. Three participants exclusively used insulin therapy, while the remaining two combined both treatment methods. The findings are consistent with Bolen et al.’s (2007) findings, who indicate that Type 2 Diabetes makes use of medications such as metformin, sulfonylureas and others to regulate blood sugar levels. The findings also align with Janez et al.’s (2020) findings who have demonstrated that insulin therapy is often used for Type 1 Diabetes and is sometimes required for Type 2 Diabetes if other medications are insufficient to control blood glucose.

5.4.2 Lifestyle modifications

Participants reported that lifestyle modifications were a cornerstone in managing diabetes, complementing medical treatments such as medication or insulin therapy. These modifications include adopting a balanced diet, which helps in monitoring blood glucose levels and engaging in regular physical activity for managing stress and maintaining a healthy weight. Participants were to make dietary adjustments, focusing on lowering carbohydrates intake, emphasising whole grains, fruits, vegetables, lean proteins, and healthy fats intake while also minimising processed foods and added sugars. In a similar manner, Feinman et al. (2015) put emphasis on the consumption of a balanced diet, often with a focus on controlling carbohydrates intake to manage blood glucose levels. Participants also reported that they engaged in regular exercise to enhance insulin sensitivity, help maintain blood sugar levels, and support overall cardiovascular health. Participants conveyed that they took walks, did house chores, did gardening and danced as part of their physical exercises. American Diabetes Association (2004) shares the same view, indicating that regular exercise improves insulin sensitivity and it helps in managing weight.

5. 4.3 Adherence and compliance

The findings present the significance of adherence in managing diabetes, aligning with Sharma et al.’s (2014) insights, which indicate that poor adherence to treatment is a significant hindrance discouraging patients from attaining favourable health outcomes. The study participants reported that they adhered and complied with doctors’ guidelines because it was in their best interest to do so as there would be unpleasant consequences if they did not. Some participants even mentioned that they felt it in their bodies if they did not adhere or comply to their prescribed treatment. Joshi et al (2017) demonstrate that non-adherence to medication may cause deaths which could have been avoided had a patient complied. Cockerham (2017) highlights that social factors, including socioeconomic status, cultural beliefs, and access to healthcare, can significantly influence adherence and compliance behaviours. Participants in this study also reported that their socio-economic status played an important role in their adherence and compliance behaviours. They also showed that attainment of an income, as a component of socio-economic status, was critical for them to purchase all the necessities for proper management of diabetes. Participants further indicated that their adherence and compliance were affected by the availability of medication at the healthcare facilities they go to as they were sometimes told to buy medication at their own cost, which becomes a hurdle because of their low socio-economic status.

5.5 UNIQUE CONTRIBUTION THAT THE STUDY IS MAKING TO THE LITERATURE

This study offers original insights into the specific challenges and coping mechanisms of individuals navigating diabetes within the unique sociocultural and healthcare context of Quthing, Lesotho, thereby enriching the existing global understanding of diabetes management and patient experiences. Specifically, it adds to the existing literature in Global South especially the African Continent where such theory-driven studies are lacking. Furthermore, this research contributes by enlightening how traditional practices and beliefs intersect with conventional medical advice in a rural African context, a dimension often overlooked in diabetes literature. It also critically examines the availability and accessibility of healthcare services in Quthing, highlighting specific barriers to effective diabetes care delivery unique to this geographical region.

5. 6 INTERPRETATIONS USING THEORETICAL FRAMEWORK

The study employed biographical disruption as the framework through which the experiences of people living with diabetes were explored. Biographical disruption is a framework developed by Michael Bury to demonstrate how chronic illness disrupts people’s lives. According to Bury (1982), biographical disruption is divided into three stages; the onset and the problems of explanation and legitimation stage; the impact of treatment regimens; as well as adapting to regimens which are utilised to establish how people living with chronic illnesses go through various experiences.

5.6.1 The onset and the problem of explanation and legitimation stage

Participants reported that they recognised diabetes symptoms that suggested that they had diabetes before being diagnosed. Some participants took those symptoms for granted as they thought that they might represent acute illnesses such as a common cold and genital herpes; not knowing or being aware that those were diabetes symptoms. This is consistent with William’s’ (2000) findings, which indicate that there was part of the taken-for-granted disruption. As Bury (1982) states, in this stage, there is no clear explanation of what is going on, some participants sought help as soon as they realised the symptoms, as a way of finding out what was happening to their bodies. Additionally, there were participants who were suspecting that they might be suffering from diabetes because of the knowledge they had about the illness and they went to health facilities to ratify and legitimise their suspicions by performing the diabetes test. This all characterises health-seeking behaviour depending on various factors.

The essence of this stage is the importance of easy access to information to acquire knowledge for promoting early detection and intervention for chronic conditions such as diabetes. This was because either the majority of the participants sought medical help after applying their prior knowledge about diabetes, which was attained from working in the health sectors or they had a family member who suffered from the same illness. Additionally, the severity factor highlights a common tendency to delay seeking help until a threshold of discomfort or concern is reached, further underscoring the importance of education on early intervention and the risks of delaying professional care.

After consulting healthcare providers to legitimise that an individual has diabetes, diagnosed individuals embarked on the journey extending beyond commencement of treatment (Narayan and Williamson, 2009). This pre-treatment phase involves a range of intricate steps, including comprehensive education and guidance, which will equip individuals with the necessary knowledge, and skills to effectively manage diabetes, mitigate potential complications and improve their overall quality of life. Participants reported that they were given guidance on lifestyle modifications after diagnosis.

The pre-treatment phase is also inclusive of psychological preparation through counselling and acceptance. Participants reported that they were given counselling before they could start their treatment even though it was not very beneficial, as they could still not overcome the fear of death due to being diagnosed with diabetes. The majority of the participants reported that they accepted the diagnosis because there was nothing much they could do about it rather than accepting and beginning treatment.

5.6.2The impact of treatment regimens

Bury (1991) indicates that the second stage of biographical disruption is the impact of treatment regimens. Participants reported that they experienced various impacts of the treatment regimens of which some were positive while some were negative. As Bury (1991) notes, people living with chronic illnesses become experts in drug usage and in line with that, the study results also reveal that participants were now experts in their prescribed drug usage.

On the positive side, participants reported that they knew which medication had certain side effects (causing them severe hunger or making them very thin) and they knew how to avoid those effects without getting their blood sugar going up. This implies that using drugs for long period-equipped participants with the knowledge of the impact of the drugs they use, as well as how to manage those them.

On the negative side, some participants reported that they frequently got sick because of their medication so this discouraged them from using their prescribed medication. Some participants highlighted that they had chronic pain, while some said that their sexual health was diminished; and some mentioned that they had impaired vision. Bury (1982) indicates that unpleasant side effects caused by treatment lead to people doubting if they should continue using medication or not. This portrays the complexities of living with diabetes.

5.6.3 Adapting to chronic illness

According to Bury (1991), the third stage of biographical disruption is adapting to chronic illness, which incorporates coping, strategy and style. Williams (2000) refers to this stage to practical response incorporating organisation of resources such as physical, social, temporal, financial, medical and cultural. The results reveal that participants adapted to their diabetes illness through normalisation as a way of coping. Participants reported that they lived with diabetes fully incorporating the management strategies into their lives, which made them to feel unaffected by them. For example, some participants reported that they were unbothered by having some tea without sugar, explaining that they were used to it; it was no longer unusual for them to drink certain beverages without sugar. Other participants explained that they walked to town as a way of exercising; not because they lacked money for transport and that showed that they understood the importance of physical activities in people living with diabetes.

The findings exhibited self-acceptance as a major way of adapting to the illness as some participants explained that it does not help to get counselling or adhere to medication while an individual is still in denial that s/he is living with diabetes. The findings also reveal that participants adapt to the illness through sharing ideas on how best to live with diabetes; some participants reported that they use the WhatsApp application to share those ideas and some reported that they share those ideas when they were gathered at hospital for check-ups. This is consistent with Bury (2012), who suggests that strategy as another component of adapting to the chronic illness involves adjusting social contexts to mobile resources, aiming to lessen the challenges of living with chronic illness. The discussed findings portray that effectively managing diabetes involves more than just taking medication or insulin. The participants emphasise the significant role of lifestyle changes, including dietary adjustments, as well as physical activities, together with adherence and compliance.

The findings resonate with Bury's (2012) stages of disruption: the onset and problems of explanation and legitimation, the impacts of treatment regimens, and adapting to chronic illness. The onset stage highlighted a mix of confusion, misinterpretation of symptoms, and proactive health-seeking behaviours; reflecting the disruption of taken-for-granted assumptions. In the treatment stage, participants exhibited a duality of experiences ranging from mastery over medication management to the challenges of unpleasant side effects, affirming the nuanced impact of chronic illness regimens. Lastly, the adaptation stage underscored normalisation, self-acceptance, and community-based coping strategies, including sharing experiences and leveraging social networks such as WhatsApp for support and management of their ailment. These insights reaffirm Bury's (2012) conceptualisation while also illustrating the dynamic ways individuals navigate the complexities of chronic illness, ultimately achieving varying degrees of balance and quality of life.

5.7 CONCLUSIONS

Diabetes is a serious illness requiring complex management. Living with diabetes disrupts people's lives from the moment they realise the symptoms, to when they seek help and when they manage the illness. Therefore, the study concludes that participants' lives were subtly disrupted because of their diabetes diagnosis. The disruption happens from the point where an individual goes to the health centre to seek medical assistance and participants indicated that they did not have any concerns with not being aware that regular hospital visits interferes with their daily routines. Management activities such as regular exercises also interfere with their daily routines.

Again, the study concludes that health-seeking behaviour of people living with diabetes can vary depending on various factors such as the knowledge of the illness and the severity of the illness. The participants' experiences emphasised the critical need for accessible information to promote awareness and early detection of diabetes. Many delayed seeking help due to misinterpreting symptoms, consistent with the "taken-for-granted" disruptions identified in Bury's (2012) findings. For those with prior knowledge of diabetes, health-seeking behaviour was more proactive, highlighting the value of education and familiarity. Delayed responses due to the perceived severity of symptoms underscore the importance of timely intervention and public health education.

Together, these findings reflect the interplay between knowledge, perception, and action in managing chronic conditions. Lastly, the study concludes that people living with diabetes employ various illness management strategies including medication, life style modifications, adherence and compliance. Managing diabetes effectively exceeds interventions such as medications and insulin. It underscores the importance of embracing a holistic approach that integrates lifestyle changes by the diabetics. Dietary adjustments play a pivotal role in controlling blood sugar levels and preventing complications, while regular physical activity enhances overall health and aids in glucose management. Equally crucial are adherence and compliance to prescribed medical regimens and self-care practices, which form the foundation of successful diabetes management.

5.7 IMPLICATIONS OF THE STUDY

5.7.1 Contribution to the field of Sociology

Understanding the experiences of people living with diabetes has significant implications for illness narratives in sociology.

i) The adaptation phase reflects how individuals integrate chronic illness into their daily lives. This exemplifies how societal norms, support systems and cultural practices shape the coping strategies of people living with chronic illnesses.

ii) The management of diabetes requires a long-term relationship between doctors and patients. Doctors play an essential role in educating patients about diabetes self-management. Effective communication between the two parties fosters trust; enabling patients to share concerns about their condition and lifestyle more openly. However, a lack of trust or poor communication can lead to non-adherence to treatment plans.

5.7.2 Policy

Examining the experiences of individuals living with diabetes has important implications for the development of policies. By capturing the lived realities of individuals;

i) Patients' voices should be incorporated. Involving people living with diabetes in the design and implementation of healthcare policies and programmes to ensure that they address real-world challenges should be prioritised.

ii) Policymakers should address social determinants of health. Policies should focus on reducing socioeconomic disparities as factors such as income, education, and occupation significantly impact diabetes management and outcome. Patients' socioeconomic status has been identified as a key determinant of diabetes risk and outcomes. Individuals from lower-income backgrounds are more likely to experience food insecurity, limited access to quality healthcare, and greater exposure to environmental factors that can exacerbate the condition.

iii) Dedicated clinics for non-communicable diseases (NCDs), diabetes included should be established within existing health facilities.

iv) Mobile clinics to reach remote villages in Quthing should be deployed for screening, diagnosis as well as follow-up care.

v) There should be task- shifting whereby nurses and community health workers are trained to help in managing diabetes in order to reduce reliance on doctors.

5.8. Areas for further research

As the prevalence of diabetes continues to rise, it is crucial to understand the multifaceted implications for further research in Lesotho.

i) The role of individualised treatment should be examined since it is crucial in managing diabetes, as the study highlighted that adherence often involves tailoring regimens to personal needs.

ii) Finally, longitudinal studies have to be carried out to observe how experiences and needs evolve.

5.9 CHAPTER SUMMARY

The chapter covered an introduction, discussions of findings, interpretations of findings using theoretical framework, conclusions as well as the implications of the study.

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Phato 21, 2024

Cocobe, Quthing Lesotho
Morena,

Sehlooho: Kopo ea ho lumelloa ho etsa boithuto
Kea lumelisa ‘m’e/ntate.

Ke kopela Tsíreletso Mahetlane, moithuti sekolong se seholo sa sechaba, National University of Lesotho, ho etsa boithuto motseng oa Cocobe, khoeling ea Phato le Loetse 2024. Moithuti enoa o lakatsa ho utloisisa ka botebo maphelo a batho ba phelang le lefu la tsoekere (diabetes). ‘Me ka hona, o lakatsa ho buisana le bo-ntate le bo-’me ba ka lakatsang ho mo qokela ka maphelo a bana ho tloha nako eo ba tsebileng hore ba na le lefu lena. Morero ke ho qoka le batho ba ka bang leshome le metso e mehlano [15] ba bonyane lilemo tse leshome le metso e robele [18-year-old] le ho ea holimo.

Ke kopa ke hona ho khothalletsa batho ba phelang le tsoekere ba motseng ho thusa ‘M’e Tšireletso ka ho qoka le ena ka litaba tsa bophelo ba bona. Ke le tiisetsa hore litaba tsa baahi bana ba Cocobe li tla sebelisoa feela mabapi le boithuto ba M’e Tšireletso ba sekolong.Mabitso a bona kapa libaka tseo ba tsoang ho tsona, ‘moho lemetse eo ba batsoang ho eona, e tla ba lekunutu la ‘M’e Tšireletso le barupeli ba hae feela.

Ke tebello ea sekolo hore baithuti ba etse boithuto bona hore ba tle ba atlehe lithutong tsa bona, ‘me ke mo kopela hore le mo amohele le ho mo lumella ho etsa boithuto bona.

Ka boikokobetso,

R. Morojele.

Relebohile Morojele
Mokoetlisi ka NUL, Roma - +266.5221.3749

APPENDIX B: INFORMATION SHEET TO PARTICIPANTS

I am Tšireletso Mahetlane from the National University of Lesotho and I am currently conducting a study on The Experiences of People Living with Diabetes in Quthing as a prerequisite for the completion of my Master of Science. I am humbly requesting you to participate in the study regarding your experiences of living with diabetes. The purpose of the study is to explore the experiences of people living with diabetes in Cocobe in Quthing. The objectives of the study are as follows:

a) To determine whether living with diabetes is a biological disruption.
b) To explore the health seeking behaviour of people living with diabetes.
c) To explore the illness management strategies of people living with diabetes.

Please be aware that your participation in this study is voluntary and if you no longer want to be part of the study during an interview, you are free to end the interview. The interview will take approximately one hour. As a measure of providing assurance of no harm to you, whatever we discuss shall remain between you, my supervisor and me. While transcribing, your name and any other identifying detail such as your place of residence will not be included so that you are not linked to the information you provided.
If you consider participating in the study, please be aware that our interview will be recorded for the purpose of accurately capturing the information you will be providing; provided you do not have a problem being recorded. In addition, the information will be securely stored so that not everyone has access to it. Lastly, after the recordings have served their purpose, which is to provide accurate data, they will be permanently destroyed.

APPENDIX C: CONSENT FORM

I, the undersigned, confirm that (please tick the appropriate box)

1.	I have read and understood the information about the study, as provided.	☐
2.	I voluntarily agree to participate in the project.	☐
3.	I understand that I can withdraw at any time if/when I feel uncomfortable without being punished.	☐
4.	I have also been told that the interview will be recorded and I agree to being recorded.	☐

Name of participant ……………………………………………………

Signature of participant…………………………… Date ……………………(DD/MM/YYYY)

Statement by the researcher

I have accurately read the information regarding the potential participant and to the best of my ability ensured that the participant understood the objectives of the study and the rights he/she has if he/she partakes.

Signature of the researcher ………………… Date …………..(DD/MM/YYYY)

APPENDIX D: INTERVIEW GUIDE

DEMOGRAPHIC INFORMATION

Please tell me about yourself.

How old are you?

Have you attended school?

What is your highest educational qualification?

What is your employment status?

What is your marital status?

Participant's sex

MEDICAL HISTORY

1. When were you diagnosed with diabetes?
    - May you share more information about your initial reaction when you were told that you have diabetes?
2. What type of diabetes you are living with?
3. Tell me about your family history with diabetes.

FACTORS INFLUENCING HEALTH SEEKING BEHAVIOUR

1. How did you suspect that you have diabetes?
    - What was your reason for consulting a doctor?
    - Did you consult a doctor immediately after realising the symptoms?
    - If you did not go immediately, what were your reasons for delaying?

2. What happened when you consulted the doctor?
    - How did you feel when you were diagnosed with diabetes?
    - What did you do when you found out you have diabetes?
    - What are your thoughts about having been diagnosed with diabetes?
    - What does the illness mean to you?
    - What was the healthcare provider’s reaction to your response about the diagnosis?
    - What guidance did s/he give?
    - How did you feel about the given guidance?

LIVING WITH DIABETES

1. Has your life changed since you were diagnosed with diabetes?

- How did life change since you got the diabetes diagnosis?
- What was the biggest change you made after being diagnosed?
- How did you perceive those changes?
- How does having to take medication daily affect your daily routine?

2. Do you have any concerns about living with diabetes?
    - What are the biggest concerns about living with diabetes?
    - How do you feel about those concerns?

3. How do you view your general wellbeing?
    - How do you feel as though the diabetes diagnosis has affected your overall sense of wellbeing?
    - How has your quality of life been impacted by your diagnosis?

ILLNESS MANAGEMENT STRATEGIES

1. Are you receiving any kind of treatment?

- What kind of treatment are you currently receiving to treat diabetes?
- How did you feel when you started taking your treatment?
- How are you feeling currently?

2. How often is your medication taken?
    - Do you take it every day?
    - Do you adhere to the prescribed medication?
    - Given the answer above, what are your reasons?
    - How do you feel each time you take the medication?

4. Have you ever missed your dosages? If yes,
    - What were your reasons?
    - How do you feel when you miss your dosages?
    - What do you do when you experience those feelings?

5. What daily practices do you employ to manage the illness?
    - How did you know about them?
    - How do you feel about the practices, which have been added, in your daily routine to management of the illness?
    - What are the changes that have been observed because of those practices?
    - What are the challenges faced in employing practices that manage the illness?

We have reached the end of our interview. I highly appreciate your time and if there is any more information pertaining the study, please feel free to share it with me. Thank you.