Original Article

Self-Care Practices Of Adults With Type 2 Diabetes

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INTRODUCTION

Globally, diabetes mellitus (DM) is a severe health issue. Globally, 285 million individuals were estimated to have DM in 2010; by 2030, that number is expected to rise to 500 million. According to estimates from Shaw, Sicree, and Zimmet (2010), the number of adults impacted in developing nations will increase by 69%. In developing countries, those affected will be of working age (40–60 years; Jayawardena et al., 2012). In a developing nation, the prevalence of DM is approximately 26% in persons 60 and older and ranges from 4.3% to 12% in adults 30 years of age and older (Chhetri & Chapman, 2009). (Aryal et al., 2014; Sharma et al., 2011). Diabetes is a significant health problem due to rapid urbanization, a growing older population, and a lack of national health insurance nations, making examining diabetes self-care habits necessary.

SELF-CARE BEHAVIORS

According to Funnell et al. (2011), the multifaceted self-care regimen for DM includes, but is not limited to, diet control, exercise, blood glucose monitoring, foot care, stress management, and consumption of oral and injectable hypoglycemic agents. It is also influenced by various sociodemographic, psychological, and disease-related factors. According to Zulman, Rosland, Choi, Langa, and Heisler (2012), maintaining a multifaceted self-care regimen is challenging and hurts both physical and emotional health (Wang, Wu, & Hsu, 2011). The presence of social support, psychological traits like self-efficacy (Hunt, Grant, and Pritchard, 2012; Strom & Egede, 2012), socioeconomic factors (such as low income and employment status; Debussche, Balcou-Debussche, Besancon, and Traore, 2009), and demographic traits (such as gender, religion, marital status, educational attainment, and expectation regarding aging [ERA]; Kart, Kinney, Subedi, Basnyat. Diet and exercise were cited by participants in a longitudinal study of adults in the United States as the most challenging facets of self-care activity (Zulman et al., 2012). Similarly, Type 2 DM persons over 25 in Jordan reported that exercise and blood glucose self-monitoring were the least performed behaviors (Al-Khawaldeh, Al-Hassan, & Froelicher, 2012). However, self-monitoring of blood glucose in developing nations may be influenced by economic factors (Debussche et al., 2009). The management of DM needs to be improved by numerous patient and provider variables. Low adherence has been associated with polytherapy and the use of insulin. Similar to how patient beliefs, attitudes, understanding of the condition, cultural and socioeconomic characteristics, and social support have been linked to self-care practices, disease outcome, and poor glycemic control (Chlebowy, Hood, & LaJoie, 2010; Nam et al., 2011). Self-care habits in DM have also been linked to several physical and psychological aspects, including self-efficacy, psychological distress, and comorbidities (Zulman et al., 2012; Katon et al., 2010). Older persons have been found to engage in higher levels of self-care (Zulman et al., 2012). Adults with high levels of self-efficacy are more inclined to practice self-care (King et al., 2010). Self-care activities are hampered by a lack of or insufficient support from friends and family (Hunt et al., 2012; Rosland et al., 2008; Tang, Brown, Funnell, & Anderson, 2008). While newly diagnosed adults may experience overwhelmed feelings that cause discomfort while sticking to the recommended self-care practices, adults with longer histories of diabetes are reported to have better self-care habits (Song et al., 2012). Culture may impact how well people stick to self-care practices, including diet and lifestyle changes (Nam et al., 2011). The idea of ERA is commonly linked to effective aging and older persons. In contrast, Overall, where the average life expectancy is 68 years and the retirement age is 58 years, it is projected that as overall adults hit their forties, they are more likely to experience anxiety related to role strain, family obligations, aging, and imminent retirement. Previous studies have linked ERA with poor self-rated health and self-care behavior (Joshi, Malhotra, Lim, style, & Wong, 2010; Sarkisian, Prohaska, Wong, Hirsch, & Mangione, 2005). The majority of reported literature is quantitative studies carried out in developed countries, and the findings from these studies may need to be more generalizable to developing countries due to different sociodemographic factors and cultural differences, according to the literature review for the current study. The social structure (where significant gender differences in self-care practices and health-seeking behaviors), religious practices and preferences,

dietary patterns and timing, sedentary lifestyle, and unequal access to healthcare resources are specific factors influencing self-care behavior.

Additionally, socioeconomic characteristics such as poor income, education, and employment position have been proven to impact diabetic self-care in low-income, developing countries.
The self-care practices of persons with DM were examined in this study. The most common self-care habit was found to be taking medications, followed by controlling one's food. It was fascinating to see that, despite perceptions of DM as an expensive disease, taking medicine remained the most popular form of self-care. This may occur due to culture, where doctors are respected and highly regarded. Education affected diabetic self-care in two ways: directly and indirectly (via perceived social support).

Similarly, to this, having a job was linked to higher self-care. Additionally, having a job helped to improve self-efficacy, which in turn affected diabetes self-care indirectly. The nature of employment, however, was seen as a barrier to self-care, particularly in areas of food restrictions and exercise, as revealed by theme analysis. It was observed that work needs took precedence over self-care. When planning care for patients with DM, nurses must take the employment status and the nature of the job into account. Future research may examine varied work environments' direct and indirect effects on diabetic self-care. Through DMSE, DM duration only indirectly affected diabetes self-care. As patients gained self-efficacy over time, diabetes self-care was subsequently favorably facilitated. Encouraging self-efficacy among patients who have just received a diagnosis of DM will enable improved self-care because DM duration affects self-care through DMSE. Through DMSE, ERA had an indirect impact on diabetes self-care. Physical health, mental health, and cognitive function are the three areas in which ERA assesses the expected age-related decline. The relationship between ERA and DM is not well understood; however, studies of middle-aged and older persons (Joshi et al., 2010) have found a favorable association between ERA and subjective health. According to earlier research (Joshi et al., 2010; Kim, 2009), low ERA was substantially related to low DMSE. Identifying patients who can benefit from interventions to boost self-efficacy will be easier with the use of ERA assessment. The findings of this study showed how crucial it is to consider self-efficacy and perceived social support when formulating therapies for adults with DM; these interventions must be customized for each patient's gender and literacy level. Participants reported mixed feelings toward family. Therefore, caution must be taken when involving family members in care. It can be concluded from the qualitative component that adults with DM may benefit from both individual and group-based, personalized psychosocial interventions to enhance self-care. Religious activities, belief in God, and social networks were self-care boosters.

Compliance with ethical standards

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Disclosure of conflict of interest

There are no conflicts of interest declared by the authors.

REFERENCE

1. Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment, 52, 30–41. 10.1207/s15327752jpa5201_2.
2. Jayawardena, R., Ranasinghe, P., Byrne, N. M., Soares, M. J., Katulanda, P., & Hills, A. P. (2012). Prevalence and trends of the diabetes epidemic in South Asia: A systematic review and metaanalysis.BMC Public Health, 12, 380. doi:10.1186/1471-2458-12-380.
3. Chhetri, M. R., & Chapman, R. S. (2009). Prevalence and determinants of diabetes among the elderly population in the Kathmandu Valley of Nepal. Nepal Medical College Journal, 11, 34–38. http://www.nmcth.edu/images/gallery/Editorial/ f9mDcmr_chhetri.pdf.
4. Aryal, K. K. Neupane, S. Mehata, S. Vaidya, A. Singh, S. Pailn, F., … Singh, S. P. (2014). Non communicable diseases risk factors: STEPS survey Nepal 2013.Kathmandu,Nepal: Nepal Health Research Council.
5. Sharma, S. K., Ghimire, A., Radhakrishnan, J., Thapa, L., Shrestha, N. R., Paudel, N., … Brodie, D. (2011). Prevalence of hypertension, obesity, diabetes, and metabolic syndrome in Nepal. International Journal of Hypertension, 2011, 821971. doi:10.4061/2011/821971.
6. Bhandari, P., & Kim, M. (2016). Self-care behaviors of nepalese adults with type 2 diabetes: a mixed methods analysis. Nursing research, 65(3), 202-214.
7. Al-Khawaldeh, O. A., Al-Hassan, M. A., & Froelicher, E. S. (2012). Selfefficacy, self-management, and glycemic control in adults with type 2 diabetes mellitus. Journal of Diabetes and Its Complications, 26, 10–16. doi:10.1016/j.jdiacomp.2011.11.002.
8. Joshi, V. D., Malhotra, R., Lim, J. F., Østbye, T., & Wong, M. (2010). Validity and reliability of the expectations regarding aging (ERA-12) instrument among middle-aged Singaporeans. Annals of the Academy of Medicine, Singapore, 39, 394–398.
9. Kim, S. H. (2009). Older people's expectations regarding ageing,health-promoting behaviour and health status. Journal of Advanced Nursing, 65, 84–91. doi:10.1111/j.1365-2648.2008.04841.x.
10. Song, Y., Song, H. J., Han, H. R., Park, S. Y., Nam, S., & Kim, M. T. (2012). Unmet needs for social support and effects on diabetes self-care activities in Korean Americans with type 2 diabetes. Diabetes Educator, 38, 77–85. doi:10.1177/0145721711432456.