

Health seeking behaviour of small income market vendors: Diabetes primary care in Gulu Municipality, northern Uganda

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Abstract

Introduction: Uganda faces a serious threat of non-communicable diseases including type 2 diabetes; sedentary lifestyles predispose people to these diseases.

Objective: To understand the diabetes health seeking behaviour of market vendors at the main market, Gulu Municipality.

Method: This cross-sectional study used quantitative and qualitative methods to understand experiences of market vendors on health seeking behaviour. After general sensitization and mobilisation in the market, 400 participants were enrolled for the study, however quantitative analysis was done only on data from 375 participants (316 women and 59 men); 25 participants had missing data; 30 of these 375 were interviewed and the qualitative analyses of their responses offered further insight on health seeking – and is reported here. The qualitative data will be reported later.

Results: Mixed responses were obtained from these 30 market vendors about their health seeking behaviour for diabetes. The factors were responsible for their overall health seeking behaviour included crowded hospitals and low frequency of clinic days; lack of accurate knowledge, and uninformed beliefs on diabetes, and poor work-life balance. Major impediments to health seeking were the fear of losing work time and money, and feeling healthy and hence seeing no need for health check-ups or medical care.

Conclusion: Awareness of diabetes and the need to seek health care exists, but market vendors are not well informed on tests and care. We recommend that more comprehensive simple-message sensitisation is undertaken to change health seeking behaviour and prevent escalation of non-communicable diseases in northern Uganda and beyond.

Key words: health seeking behaviour; healthcare services; diabetes; sedentary lifestyle; hypertension; market vendors, Uganda

Introduction

Of the 56.4 million deaths occurring worldwide in 2015, more than half (54%) were due to the top 10 causes - of which diabetes was one.^[1] Diabetes is one of the multiple health challenges faced by developing countries.^[2]

A 2006 US study noted that diabetes, not obesity, increases the risk of critical illness, organ failure and early deaths.^[3]

“Globally, an estimated 422 million adults were living with diabetes in 2014, compared to 108 million in 1980. The global prevalence (age-standardized) of diabetes has nearly doubled since 1980, rising from 4.7% to 8.5% in the adult population. This reflects an increase in associated risk factors such as being overweight or obese. Over the past decade, diabetes prevalence has risen faster in low- and middle-income countries than in high-income countries.”^[5]

In 2006 the Commissioner for non-communicable diseases (NCDs) in Uganda

stated: “There is a new thrust of non-communicable diseases in the country, and among these is diabetes. It is a very serious problem. People are changing their lifestyles. Many no longer get enough exercise: they do not walk, and instead of walking they are driven in cars.”^[3] A Ministry of Health 2014 risk survey report on NCDs concluded that NCDs and their risk factors are a public health problem in Uganda.^[4]

The risk survey also noted the perceptions of the participants that: “.. *given the chronic nature of NCDs, health and help seeking regarding these conditions was mainly hierarchical whereby the patients first sought one type of care, if it failed resorted to another type*”.^[4]

NCD and, in particular, diabetes, awareness and prevalence in low income communities remain unclear, however several studies have proved that diabetes is on an upward trajectory; it is indeed a serious public health challenge in sub Saharan Africa. This is mainly due to rapid urbanisation and modern lifestyles, rapidly decreasing physical activity (sedentary lifestyle), changes in dietary habits and ageing of the population.^[5-9,10] Several factors determine health seeking behaviour, especially among low income populations in developing countries^[11], including health seeking behaviour towards diabetes treatment and care.

The health seeking behaviour of a community determines how health services are used and the health outcomes of populations. Factors that determine health behaviour may be physical, socio-economic, cultural or political. Indeed, the utilisation of a health care system may depend on educational levels, economic factors, cultural beliefs and practices.^[11,12]

A key determinant for health seeking behaviour is the organisation of the health care system.^[12] In many health systems, particularly in developing countries such as Uganda, illiteracy, poverty, underfunding of the health sector, inadequate water and poor sanitation facilities have a big impact on health indicators.^[12] In addition, cost of services, limited knowledge on illness and wellbeing, and cultural prescriptions are a barrier to the provision of health services.^[11,12] Subsequently, many people in developing countries fail to seek care in a timely manner or act in a way that prevent the occurrence of many diseases including diabetes.^[12,13]

Possible explanations for why households in developing countries often underinvest in preventative health care is that there is a lack of information on illness prevention or on the effectiveness and cost-effectiveness of preventative behaviours.^[13] Likewise, households buy drugs they do not need due to lack of information on medicines and the source of their illnesses and how to cure them.^[13]

Method

A one-month cross-sectional study was carried out in February 2017 in Gulu Municipality main market, Gulu district, northern Uganda. The study population included all market vendors (both proprietors and attendants) who were 18 years or above and had consented to the study. After getting permission from the market leaders, and explaining the study, we invited eligible vendors to be interviewed; 400 vendors were enrolled. For the quantitative arm of the study 375 respondents (316 women and 59 men) participated, 25 were left out in the analyses due to missing data. For the qualitative arm, 30 of these respondents, who had time for an extra interview; were consecutively interviewed while their anthropometric measurements were taken. A sample of 30 provided a full range of the different responses. This paper reports only the results from these 30 vendors.

The 30 vendors were asked open-ended questions based on those used in a Zimbabwe study.^[14] The key question was: “How do they come to know of their experience as persons at risk of diabetes and related illness?”^[15] All the responses were recorded on paper by the interviewer. Thereafter, the transcripts from the participants’ responses was content analysed to generate themes on their experiences.

Research and Ethics Review Committee of the Faculty of Medicine, Gulu University approved the study, and additional clearance was obtained from Uganda National Council for Science and Technology.

Results

Of the 30 participants interviewed 23 were females and 7 were males; their ages ranged from 20 to 46 years (mean 35 years) and their education ranged from primary to advanced secondary level. None had diabetes (all 375 participants had been tested for diabetes, a disease widely known in the community).

The responses reported here were selected to give an overview and examples of the issues raised and are grouped into the following categories:

- Efforts to visit health facilities for medical check-up and treatment,
- Knowledge, beliefs and attitude towards diabetes and related illness, and
- Factors related to livelihood and lifestyle.
- Effort to visit health facilities for medical check-up and treatment

Many factors affected respondents’ efforts to visit health facilities for medical check-ups and treatment including the availability of facilities for their care visits:

“...the government hospital is too crowded to give time for me to make check-up... the private clinics meanwhile are expensive”.

“...am told the clinic in the government hospital is done once a week and there are many people....so I feel it takes too much time”.

Respondents were also concerned with the capacity of the health systems to serve them adequately when they visit the health facility:

“. . . it appears the staff are also few to allow for efficient work with the patients...”;

“...at our hospital here once you are prescribed you get no drugs, so we depend on private clinics and drug shops. . .”

- Knowledge, beliefs and attitude towards diabetes and related illness:

The responses below indicate the respondents' knowledge, beliefs and attitudes towards diabetes:

“... I know about diabetes (the sugar disease), and I believe I do not have it...”; “...my weight is still not so big, so I feel am fine...”;

“.. I will watch my weight to ensure it is not so big...”

“... while I eat fried food sometimes, I am always eating Acholi traditional foods which are healthy, so I am less at risk...”

- Factors related to livelihood and lifestyle

Comments on these factors included:

“. . .my work here is very hectic and I have not been able to get time to visit the hospital for a proper check-up. . . .”

“...I am grateful that you are here in the market; I wanted to check myself but the time is limited; I will plan and come the next day...”

Discussion

Many factors affected the respondents' efforts to visit health facilities for medical check-ups and treatment.^[11-14] They were concerned about the availability of facilities for their care visits as well as with the health systems' capacity to serve them adequately.

Indeed, their knowledge, beliefs and attitudes towards diabetes depended on the health system and health promotion activities, and the accepted practices/traditions in the area.^[12,14]

Competing priorities of daily living create challenges to health seeking behaviour.^[11] These are individual factors, for example, personal resources such as time and social support, and work-related factors arising from job pressures, long working hours and unemployment.^[11,12]

Coupled with challenges in the health system which

discourage people from visiting health facilities, and desperation to work and support family livelihood, make care-seeking a secondary concern despite the apparent risks involved.^[11,12]

Conclusion

Health seeking behaviour of people is dependent on their perception regarding the quality of care at health centres. This can be changed through improved facilities and more trained personnel to manage the increasing NCD phenomenon, and correcting wrong perceptions about diabetes and related illnesses. Increased health promotion is required to enhance awareness and motivate communities to seek care regularly and early.

While diabetes awareness existed among our respondents, the findings show that knowledge is limited on how to prevent the disease and or manage it once acquired; many misrepresentations of facts on diabetes and its causes exist. The growing incidence of diabetes is due to many life stresses and difficult management of life-work balance.

Additionally, there are health system challenges in dealing with the problem of diabetes: inadequate health promotion by the health department, lack of trained staff to manage the growing numbers of people with diabetes and, most importantly, the problem of drug stock outs that is perennially common in health facilities.

It is important to correct wrong perceptions about diabetes through increased education to the public. We recommend that more comprehensive simple-message sensitisation is undertaken via mass communications, and at locations such as market stalls as well as health centres, in order to change health seeking behaviour and prevent escalation of NCDs in northern Uganda and beyond.

Competing interests: The authors declare that they have no competing interests.

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