Barriers to compliance among diabetics in Asir region

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ABSTRACT

Objective: The objective of this study was to explore the barriers to compliance with medical advice among the diabetic patients attending Wasat Abha Primary Health Care Center in Asir region, Saudi Arabia.

Methods: A total of 100 diabetic patients who were labeled as poor compliants were interviewed to look for the underlying barriers to comply with appointment, drug and diet.

Results: Forty percent of total diabetics were labeled as poor compliants. Twenty three percent were poorly compliant to diet, 21% to appointments and 19% to drugs. The most common reasons for poor compliance were unavailability of drugs at the primary health care center, social and behavioral barriers.

Conclusion: Non-compliance is high among diabetics, this requires more research to understand and tackle the underlying reasons.

Keywords: Compliance, diabetes mellitus, Primary Health Care Center.


Compliance, which is defined as the degree to which the patient adheres to medical advice,\(^1\) has to be high in diabetics in order to control disease and to prevent complications.\(^2\) Although, diabetes mellitus is a major health problem in Saudi Arabia,\(^3,4\) compliance seems to be poor.\(^2,5,6\) In order to improve compliance, it is important to understand the barriers preventing diabetics from being compliant with medical advice. Unfortunately, little work is carried out on this vital topic in our society.\(^7\) This paper explores some of the underlying barriers of keeping appointments, taking drugs and restricting to diet among diabetics in one primary health care center (PHCC) in Asir region.

Methods. This study was carried out during the last 6 months of 1998 at Wasat Abha Primary Health Care Center (WAPHCC) which is one of the 6 urban PHCCs in Abha, the capital city of Asir region. It serves 15000 inhabitants, of whom 400 are diabetics. Diabetic patients have been followed at diabetic mini-clinics since 1996. National Quality Assurance Protocol (NQAP) was used for diagnosis, treatment and follow up of diabetes in our practice.\(^7\) Assessment of diabetic compliance to appointments, diet and drugs is carried out regularly at each visit to the mini-clinic. Those who did not show up for more than 3 months, did not follow the diabetic diet at all, or those who take less than 80% of the amount of drugs prescribed in the past week were defined as poor compliants.\(^7,8\) Detailed interviews were carried out by one of the investigators to find out the barriers and reasons, by using formats designed previously by the investigators for this purpose. Patients who did not have diabetic files in the mini-clinic were excluded from this study. Data entrance and analysis was carried out by SPSS Statistical package and significant tests were used as appropriate.
Results. The total number of diabetic patients who attended our mini-clinic during the study period was 251 patients. Forty percent were labeled as poor compliants. Table 1 shows the characteristics of those patients. Poor compliance with appointment, diet, and drugs were 22%, 23% and 19%. Poor compliance with drugs and diet were found to be high among males, while poor compliance to appointment was high among females. However, there was no significant association between sex and compliance. Table 2 shows the barriers to keeping appointments, restriction to diabetic diet, and use of anti-diabetic drugs. The ability to access other medical facilities for treatment was the major cause for poor compliance to appointments, while invitation to social events like weddings, guest party (Azimah) were the predominant causes of poor compliance with diet. Unavailability of anti-diabetic drugs at the PHCC was the most common reason for poor compliance to drugs among diabetic patients in this study.

Discussion. It is easy to blame diabetics for their poor compliance with medical advice rather than exploring the underlying reasons. This study showed that the health system set up contributes significantly to this problem in addition to social customs. Unavailability of drugs at the PHCC and accessibility to many different medical facilities were the major barriers for not taking drugs and not keeping appointments. Such barriers could be managed effectively by establishing a good referral system between the PHCC and hospitals, appointment and recall systems at the PHCC, and providing the PHCC with adequate amounts of anti-diabetic drugs. Adherence to diet therapy is one of the most difficult problems facing the diabetic patients in our society. In the present study we found many barriers. However, social barriers such as invitations to social events and behavioral barriers, such as inability of diabetics to control themselves, were the most common barriers for compliance with diet therapy. There is a similar number of patients who reported that they were unable to comply with diet because of social and behavioral barriers. Those 2 factors could be mentioned together by the patients to avoid criticism by the physicians (Projection phenomenon). In spite of the real reason, those barriers have social and traditional background and dimensions, and it is necessary to carry out social and psychological studies to find out the real reasons and barriers, and to study the quality of life among those diabetics. Modification of the traditional diet, to meet the diabetics needs through health education of families and society is paramount. Lack of knowledge about diabetes could affect compliance. In the present study we found that a considerable proportion of diabetics were non-adherents to medical advice because of lack of knowledge about diabetic diet and drug importance. Such problems could be managed through consultation or various health education means, such as pamphlets, booklets, newspapers and television.

In conclusion, health care set up and social customs play major roles in non compliance with medical advice among diabetics in our practice. Many barriers could be corrected while some others need further studies.

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References


