

**FULL LENGTH ARTICLE****Healthcare Seeking Behavior and Lifestyle Modifications among Chronic Illness Patients' in Central and Southwestern Ethiopia**Dereje Wonde<sup>1</sup> Amanti Baru<sup>2</sup>

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Web Address: <http://www.ju.edu.et/cssljournal/>. Open access address: [journals.ju.edu.et](http://journals.ju.edu.et)**Abstract**

Chronic illnesses, in particular cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases, have become the major cause of morbidity and mortality globally. Chronic illness claimed 60% of all deaths worldwide and strikingly, 80% of these deaths occur in developing countries, making such illnesses one of the major development challenges of the global south. The main objective of this study was to investigate chronic illness patients' healthcare seeking behavior and lifestyle modifications. Both quantitative and qualitative research methods were employed in a triangulation fashion. Accordingly, 150 chronic illness outpatients visiting health facilities in the data collection period were surveyed in the study. The informants of qualitative studies were recruited by using purposive sampling technique based on availability. Descriptive and inferential statistics were employed to analyze the quantitative data, and the qualitative data were summarized and presented concurrently alongside the quantitative data by hiring thematic analysis. The study unveiled that people from all walks of life are vulnerable to chronic illnesses. Place of residence and educational attainment showcased significant association with the indicators of health seeking behavior of chronic illness patients. Lifestyle modification is in the front line treatment strategies in the process of chronic illness control and management. However, chronic illness patients reported that they are struggling to adapt and practice the desired modified lifestyles in their everyday life. Thus, the practice of healthy lifestyles should be promoted to arrest potential hazards of chronic illness on the socio-economic fabrics of the society.

**Key terms:** /Chronic illness/ Ethiopia/Health seeking behavior/Lifestyle modifications/

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## 1. Introduction

Chronic illnesses, in particular cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases have become the major cause of morbidity and mortality globally (WHO, 2014). Chronic illness accounts for two thirds of all deaths globally, more than double the number of deaths caused by infectious diseases, maternal and prenatal conditions, and nutritional deficiencies combined. Moreover, contrary to common misperception, the burden of chronic illness is worst in low- and middle-income countries where 80% of all chronic illnesses occur. In sub-Saharan African countries such as Ethiopia, increased urbanization and changing lifestyle have contributed to the rise in chronic illness. The emergence of epidemics of chronic illness is the result of demographic and epidemiological transitions, along with increases in levels of risk factors resulting from social and economic changes (WHO, 2003).

The magnitude of prevalence of chronic illness is escalating in the developing world including Ethiopia. Chronic illnesses constitute double burden in Ethiopia, adding to the already prevailing communicable diseases and other health problems exacerbated by the underlining nutritional disorders and the limited overall health awareness among the population at large (Ahmed, 2010). The prevalence of diabetes and hypertension, both self-reported and measured, was unsurprisingly higher in urban communities of Ethiopia. The high prevalence of risk factors in this group underlines the urgent need for policies for the prevention of these conditions (Prevett, 2012). The World Health Organization chronic illness profile of 2014 attributed 30% of deaths in Ethiopia to chronic illnesses such as cardiovascular disease, diabetes, cancer, hypertension, chronic kidney disease and chronic respiratory disease. However, chronic illness claimed about 51% of adult mortality in Addis Ababa according to domestic studies (Awoke, Damen, & Tekebash, 2012).

Health seeking behavior has been defined as all activity undertaken by the individuals who perceive to have a health problem for the purpose of finding an appropriate remedy (MacKian, 2003). The disruption of health might lead people to look after for its remedy in medically oriented institutions. However, in the era of chronic illness absolute remedy of the illness is unthinkable. Thus, victims of chronic illness are forced to develop a peculiar health seeking behavior and lifestyle modifications to improve their ill health conditions. Socio-economic status, high cost of managing chronic illness, accessibility of health facilities and misconceptions about the illness are the most important determinants for health seeking behavior of chronic illness patients (Faronbi, Olowokere, Ayamolowo, Faronbi, & Adebisi, 2017; Habibullah & Afsar, 2013). The treatment of chronic illnesses, which are most of the time happened due to poor lifestyle choices, is time consuming, complicated and requires specific skills. Lifestyle modifications address the poor lifestyle choices that are at the root causes of chronic illness. Lifestyle modifications embraces avoid of tobacco use, maintain a healthy weight, maintain daily physical activity, eat a healthy diet, and stress

management to correct the underlying causes of chronic illness and to avoid further complications of the illness (Hartley, 2014). Thus, chronic illness patients should be empowered with the required knowledge and skills to introduce lifestyle modifications by maintaining new habits needed to manage their chronic illness. The perceived threat of the illness plays an important role in the process of changing to a healthy lifestyle in patients with chronic illnesses (Vahedparast, Mohammadi, & Ahmadi, 2016). A study conducted in Ethiopia (Abel, Daniel, & Lemma, 2017) indicated that the rates of adherence to lifestyle changes among chronic illness patients were generally found to be low.

The problem of chronic illness has been a neglected issue in Ethiopia over the years in spite of high incidence of the condition. These days, there is a burgeoning of literature on the issue in Ethiopia. However, most of the studies conducted so far (Ahmed, 2010; Ayalew et al., 2012; Prevett, 2012; Yibeltal, Challi, & Dereje, 2011) were confined to epidemiological survey and quality of healthcare for chronic illnesses patients. Although insightful and useful, because they reveal prevalence of the illnesses and nature of the healthcare services, these studies ignore concerns central to people suffering from long-term chronic illness and do not give us the whole picture of everyday existence in the life of a chronically ill person. Other studies like (Awoke et al., 2012; Berhe et al., 2013) focused on verbal autopsies to examine the impact of chronic illnesses on the mortality rate of the community. Accordingly, mortality due to chronic illness was found to be very high in rural districts and urban areas. Such studies contributed for the mushrooming of literature on chronic illnesses in Ethiopia by disclosing the fact that chronic illnesses are becoming the major causes of death in the country. However, the health seeking behavior and lifestyle shifts in the patients need to be scrutinized by applying emic perspective.

In addition to the aforementioned endeavors, studies such as (Fikru, Byass, & Wall, 2009; Muluken et al., 2015; Nshisso et al., 2012; Solomon, Yemane, Alemayehu, & Assefa, 2015; Tesfa, Wendwesen, & Bayu, 2016; Yoseph, Etalem, Sarah, Gardiner, & Parry, 2007) were conducted with the primarily focus of identifying the magnitude of specific chronic illnesses like hypertension and diabetes in the country. These studies were confined in hospital walls or conducted in the communities to assess chronic illnesses through physical measurement of study participants. Accordingly, the subjective experience of chronically ill patients has been overlooked by these studies, which obsessed with identifying the objective aspects of chronic illness. In a nutshell, the current study aims to address the following research questions.

- ✓ What does the healthcare seeking behaviour of chronic illness victims look like?
- ✓ What lifestyle modifications do chronic illness patients adopt to improve their ill health conditions in Central and South-western Ethiopia?

## 2. Theoretical Framework

This study employed the conceptual framework of ‘chronic illness as biographical disruption’ model. Michael Bury (Bury, 1991) distinguished three dimensions of biographical disruption process. First, he argued that ‘coping’ refers to the cognitive processes employed by the chronically ill to sustain a sense of self-worth and to come to terms with an altered situation and an altered body. Second, the term ‘strategy’ refers to the actions and processes involved in the management of the condition and its impact on interaction and life chances. Third, chronic illness involves the adoption of a particular ‘style’ of living, or different ‘styles of adjustment.’ Lifestyle for the chronically ill often means deciding how much should be disclosed or disguised about the condition, how far the person should ‘come out’ and in what way, in interacting with others. For some groups, withdrawal from all but essential interaction has been observed. For others ‘normalization’ has meant integrating the disorder into an altered and public identity. In sum, chronic illness as ‘biographical disruption’ framework serves us to understand the circumstances of chronically ill people in the aftermath of their chronic illness including, the health seeking behavior and the modifications in lifestyles they adopted to sustain their life.

## 3. Research Methods

### 3.1. Study Settings

This study was conducted in Central and Southwestern part of Ethiopia. Addis Ababa city from the central and Jimma Zone from Southwestern Ethiopia were the study settings. Thus, Menelik II referral Hospital, Black Lion General Specialized Hospital, and Ethiopian Diabetes Association from Addis Ababa City were selected purposively to collect relevant primary data for the study. Whereas, Sokoru woreda health center, Shenen Gibe Hospital, and Jimma University Medical Center were selected from Jimma Zone as a study site for the study.

### 3.2. Methods and Instruments of Data Collection

**Sample Survey:** Survey was conducted on selected patients about different aspects of their chronic illness. The study participants were purposively selected chronic illness outpatients attending treatment services in the selected treatment centers during the study period. The inclusion criteria were age of 18 years and older, and being a chronic patient for a minimum of one year. Moreover, the survey data was collected from victims of selected chronic illnesses. Accordingly, six chronic illnesses (hypertension, diabetes, chronic renal illness, Asthma, cancer and chronic heart illness) which are the most prevalent in the country based on previous studies (Awoke et al.,

2012; Ayalew et al., 2012; Fikru et al., 2009; WHO, 2014, 2015) were selected. Patients who are outside the respective geographical zone, severely ill, not cooperative, having difficulty in hearing, and visual impairment were excluded from the study. Apart from these criteria, patients were purposively selected to embrace a wide variation in terms of socio-demographics characteristics. Interviewer administered questionnaire was prepared and administered in local languages (Amharic and Affan Oromo) to ease the interview process. The questionnaire has three parts. The first section addresses the socio-economic and demographic characteristics of respondents. The second part of the questionnaire includes the indicators of health seeking in which the first action patients took when symptoms appeared, the length of time to take the action, adherence to prescriptions, regular attendance of their follow-up appointments, preference between indigenous and biomedicine and discontinuity of treatments are surveyed to measure health seeking behavior. The third segment of the questionnaire indicates the lifestyle dimensions of diet, exercise, alcohol, cigarette, and stress management experiences of chronic illness patients. In sum, the survey was carried on during chronic illness outpatients' visit to the treatment center, while the patients are awaiting treatment services in the waiting area of health facilities.

**Illness Narratives:** This method was employed to generate depth qualitative data emanated from the lived experiences of selected patients of chronic illness. Thus, how they come to manage their illness and the way they responded to illness symptoms was investigated from their lived experience. Illness narratives play powerful role in eliciting the illness accounts that patients provide in restoring their sense of empowerment, agency, and care of the self (Winkelman, 2009). Since recently, the use of illness narratives and the patient's stories became prime sociological material in the process of understanding chronic illness. The ill person was listened to and was valued while telling his lived experience of the illness. Illness narratives show how the ill person's life is changed, and 'disrupted' by the illness (Bury, 2001). In-depth interview guide was prepared and illness narrative was conducted with purposively selected patients to gather the relevant information on the various aspects of chronic illness.

### 3.3. Sampling Design

The necessary sample for the survey research was selected by employing availability sampling technique. Availability or accidental sampling applies the selection of sampling units out of the available target groups. Chronic illness patients availability at a given health facility and time was the main factor for opting accidental sampling. Thus, this technique was used to generate data from the patients who are visiting health facilities for treatment in the time of data collection. The sample size of the survey was decided based on the number of outpatients attending treatment in the study health facilities due to impossibility of getting the sampling frame of all chronic illness patients. Accordingly, 150 chronic illness outpatients visiting health facilities in the data collection

period and eligible to be included in the study by the inclusion/exclusion criteria were surveyed in the study. The informants of qualitative studies were recruited by using purposive sampling technique based on availability basis. The qualitative data was collected from participants until saturation of key themes were achieved. Thus, 16 illness narratives informants were participated in the qualitative studies of the project.

### **3.4. Methods of Data Analysis**

The quantitative data, gathered through the use of questionnaire, were analyzed by using descriptive statistics which incorporates the use of frequency, percentages and mean distribution. Chi-square test was administered to make statistical test and inference of the quantitative data. The statistical analysis tool SPSS version 20.0 was employed for doing the task of analysis. On the other hand, the qualitative data, obtained through illness narratives were summarized and presented concurrently alongside with the quantitative data by hiring thematic analysis technique.

### **3.5. Ethical Considerations**

Observance of ethical norms plays pivotal roles in assuring the credibility of the reports of the study. Thus, before the start of data collection, the proposal was submitted to college of Social Science and Humanities research and postgraduate coordinator office of Jimma University. Supportive letter was delivered to the respective treatment centers and hospitals. Oral consent was obtained from the respondents and confidentiality has been assured for any information provided. All ethical issues of conducting scientific research were maintained and observed in this study.

## **4. Findings and Discussion**

### **4.1. Socio-Economic and Demographic Characteristics of the Respondents**

The collected quantitative data indicated that 54% of the survey respondents are male and the remaining 46% of them are female. The average age of the respondents is 49.16, which to some extent indicates that the popular perception and rhetoric of associating chronic illness with elderly should be challenged. More so, the majority (64%) of the respondents are married as of marital status is concerned. In terms of educational attainment, only 7.3% have got degree and above qualifications. About 52% and 43.3% of the respondents reported that Orthodox Christianity and Islam are their religions respectively. Moreover, 8% of the respondents accounted that they are currently unemployed as a result of their illness. The family size of the respondents has a computed mean of 5.41 people in their household. A fairly large number of respondents (32.7%) have earned less than or equal to 500 Birr per month. However, the calculated mean of the average monthly income of respondents is 1214.03 Birr per month. Finally,

about 60% of the survey respondents noted that their place of origin is urban and the rest 40% said that their residence area is rural. In sum, the socio-economic and demographic characteristics of respondents unearthed that people from all walks of life are vulnerable to chronic illnesses.

#### 4.2. Health Seeking Behavior of Chronic Illness Patients

There is a considerable variation in the health seeking behavior of acute illness victims and chronic illness patients. In the first group, you know that the illness is temporary and if you adhere to the prescriptions everything would be fixed. Paradoxically, in the case of the latter groups, whatever you did is to palliate the pains and to manage the illness, but curing is unachievable. Thus, patients develop a health seeking behavior according to their illness category. The first action patients took when symptoms appeared, the length of time to take the action, adherence to prescriptions, regular attendance of their follow-up appointments, preference between indigenous and biomedicine and discontinuity of treatments are discussed below as indicators of the health seeking behavior of chronic illness patients.

Accordingly, about 64.7% of the survey respondents reported that visiting healthcare facilities was the first action they took after the onset of the illness symptoms. In the contrary, the remaining 35.3% of respondents revealed that visiting either faith based healing places, traditional medicine centers, or use over the counter drugs were the actions taken to treat chronic illness. The majority of the respondents (88%) decided to visit healthcare facilities when their chronic illness gets worse and complicated. From the qualitative study, one illness narrative informant who has been victim of diabetes for 7 years seconded this by narrating the following.

*When the symptoms first appeared I did not take any action for a long time. The pain was on and off not demanding further action. After that I was convinced to visit health facilities by my intimates. Then I went to health center and told about the presence of diabetes in my blood (Illness narrative, Female, 46).*

Chronic illness patients let down symptoms for a considerable length of time without taking action. We should quote the experience of another informant as follows:

*I have had tonsillitis for a long period of time. I did not treat the pain of tonsillitis properly. Subsequently, when the situation is very painful I decided to consult a doctor. I came to hospital for the treatment of the tonsillitis, but I learned that it has transformed in to serious heart attack. Through this way I beware the presence of heart related illness on me since long ago (Illness narrative, Male, 54).*

Concerning the length of time to visit health centers for treatment, about 59.3% of the respondents reported that they have visited medical centers immediately after the onset of symptoms. The rest 40.3% of respondents failed to make immediate contact with healthcare providers as a result of factors like; distance of the nearby health facility, financial constraint, seeking treatment from indigenous medicine, perceptions of illness etiologies, and lesser pain of the illness. Some chronic illness patients failed to visit medical centers immediately when symptoms appeared by seeking treatment from faith based healing places. A qualitative study participant narrated the following experience in line with the above assertion.

*I believe that God send me this illness to teach me about his presence, power and mercy. I personally know that people who had been victims of illnesses similar to me were cured through the help of God. I came to hospital because I have been forced by my son. I know that I can get nothing from here (hospital). The solution is God. St. Eura<sup>3</sup>l is my medicine. I want to spend much of my time in the church of St.Eurael, but my son insisted me to stop visiting church. He said that I would be tired and the illness could be worsened (Illness narrative, Female, 53).*

About 42% of the respondents discontinued their treatment of chronic illness in the medical setting. Some of the factors accounted for treatment discontinuation are financial constraint, resort to non-biomedical treatment, ineffectiveness of modern medicine, clash between treatment and work schedule, and inaccessibility of health centers. The qualitative studies also support this habit. A 19 year old girl, who has diabetic for more than five years narrated as follows:

*..... I was taken to the church (she is protestant) by my parents. Prayer was made for me. I was totally cured. However, since I have to study hard to succeed in my schooling I did not follow the church service strictly. When I stopped visiting the church, the illness relapsed. I believe that Jesus will heal me, but as of the inconveniences I am not following the faith based healing seriously. That is my weakness and I will work on that to be free from the illness. Impediments of Health Seeking Behavior of Chronic Illness Patients*

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<sup>3</sup> Name of an Orthodox church in Addis Ababa



Table1: Cross tabulation of health seeking behavior indicators and social factors

| Health seeking behavior of chronic illness patients | Social Factors     |        |       |                        |          |       |
|---|--------------------|--------|-------|------------------------|----------|-------|
|   | Place of residence |        |       | Educational attainment |          |       |
| Immediate visit of health facilities                | Urban              | Rural  | Total | Non-literate           | Literate | Total |
| Yes   | 62                 | 27     | 89    | 15                     | 74       | 89    |
| No  | 28                 | 33     | 61    | 27                     | 34       | 61    |
| <b>Total</b>  | 90                 | 60     | 150   | 42                     | 108      | 150   |
| $\chi^2$  |                    | 8.514  |       | 13.393                 |          |       |
| <b>P value</b>                                      |                    | .004** |       | .000**                 |          |       |
| <b>Exp(B)</b>                                       |                    | 2.708  |       | 3.918                  |          |       |
|   | Place of residence |        |       | Educational attainment |          |       |
| Regularity of visiting healthcare facilities        | Urban              | Rural  | Total | Non-literate           | Literate | Total |
| Yes   | 74                 | 33     | 107   | 21                     | 86       | 107   |
| No  | 16                 | 27     | 43    | 21                     | 22       | 43    |
| <b>Total</b>  | 90                 | 60     | 150   | 42                     | 108      | 150   |
| $\chi^2$  |                    | 12.924 |       | 12.331                 |          |       |
| <b>P value</b>                                      |                    | .000** |       | .000**                 |          |       |
| <b>Exp(B)</b>                                       |                    | 3.784  |       | 3.909                  |          |       |
|   | Place of residence |        |       | Educational attainment |          |       |
| Discontinuity of started treatment                  | Urban              | Rural  | Total | Non-literate           | Literate | Total |
| Yes   | 28                 | 35     | 63    | 25                     | 38       | 63    |
| No  | 62                 | 25     | 87    | 17                     | 70       | 87    |
| <b>Total</b>  | 90                 | 60     | 150   | 42                     | 108      | 150   |
| $\chi^2$  |                    | 10.987 |       | 7.302                  |          |       |
| <b>P value</b>                                      |                    | .001** |       | .007**                 |          |       |
| <b>Exp(B)</b>                                       |                    | 3.10   |       | 2.709                  |          |       |

\*p&lt; 0.05, \*\*p&lt;0.01

As the above table 1 depicted, Chi-square test was used to see the association between variables. Accordingly, highly significant association was found between place of origin and indicators of health seeking behavior of chronic illness patients. Thus, chronic illness patients residing in rural area and lack of immediate visit to health facilities when illness symptoms appeared are associated. The computed Chi-square test statistics revealed that the  $p$  value (.004) is significant at  $\alpha = 0.01$ . Consequently, living in rural area is a risk factor for chronic illness patients for not visiting healthcare facilities immediately. The odds ratio is 2.708. Thus, the odds of rural area chronic illness patients' failure to make immediate visit of health facilities is 2.708 than that of chronic illness patients in urban areas. In a nutshell, rural place of residence is a risk factor for not making immediate visit, while urban residence is a protective factor. Moreover, the data from the qualitative studies claimed that the above assertion is a valid one. A chronic illness patient informant from rural area narrated the scenario as follows:

*We did not have such new illnesses in the past. We rural people were healthy and we did not even know health centers in the past. But now things have changed rapidly and such chronic or other types of illnesses are knocking everyone's door. Getting healthy people are becoming difficult. After the introduction of manufactured edible oils and fertilizers, rural inhabitants are contaminated with innumerable illnesses. In the good old days we did have plenty of butter and milk, which were the reasons for our stamina, but now such things are hardly available. After all, most of the rural people have the habit to wait until the illness made them bedridden. For instance, I have attempted myriads of successful and unsuccessful treatment techniques in my locality before I finally decided to visit modern healthcare facilities (Illness narrative informant, Male, 57).*

Health seeking behavior of chronic illness patients is also affected by educational attainment. The Chi-square test statistics unearthed that non-literate segments of the patients failed to visit healthcare facilities after the onset of illness symptoms., where the  $P$  value (.000) is significant at  $\alpha = 0.01$  and the odds ratio is 3.918. Thus, the odds of the non-literate chronic illness patients' failure to make immediate visit of health facilities is 3.918 than that of the literate counterparts.

The other indicator of health seeking behavior is regularity of visit of health centers to treat chronic illness. In this regard, the Chi-square test indicated that chronic illness patients who are living in urban areas and those who are literate attend their follow-up appointments by making regular visit than the patients living in rural areas and non-literate. The  $P$  value (.000) is significant at  $\alpha = 0.01$  and the odds ratio is 3.784 for place of residence and regular visit. The odds of rural area chronic illness patients not to make regular visit of health facilities is 3.784 than the chronic illness patients residing in urban areas. Whereas, regular visit of health facilities for the treatment of chronic illness

and educational status has a P value (.000) is significant at  $\alpha = 0.01$  and the odds ratio is 3.909. Thus, the odds of non-literate chronic illness patients' failure to regularly visit health facilities are 3.909 than the literate chronic illness patients. The last indicator of health seeking behavior of chronic illness patients is the discontinuity of started treatment. In line with this, patients living in rural areas are vulnerable to terminate their treatment three fold times than their urban counter parts. The Chi-square test statistics has a P value (.001) which is significant at  $\alpha = 0.01$  and the odds ratio is 3.10. The odds of rural area chronic illness patients discontinuity of started treatments is 3.10 than that of the urban area chronic illness patients. The Chi-square test statistics has indicated the presence of highly significant association between educational status and discontinuity of started treatment where the P value (.001) is significant at  $\alpha = 0.01$  and the odds ratio is 2.709. The odds of non-literate chronic illness patients discontinuity of started treatment is 2.709 than the literate patients.

#### **4.3. The Practice of Lifestyle Modification among Chronic Illness Patients**

Chronic illnesses are sometimes called lifestyle disease in order to emphasis how far individuals life choices and living styles are determinant to its occurrence. By the same token, lifestyle modifications are recommended strategies in the treatment of chronic illness. In the period of chronic illness, the magic bullet of medicine is not functioning. Therefore, this section assesses how much chronic illness patients introduced and practiced a modified lifestyle in order to facilitate the treatment and management of their chronic illness.

Table 2 the practice of lifestyle modifications by chronic illness patients

|   |                                       | Frequency<br>(N==150) | Percent      |
|---|---------------------------------------|-----------------------|--------------|
| <b>How often you are visiting health facilities for a medical checkup after the onset of your illness</b>   | Usually                               | 44                    | 29.3         |
|   | Sometimes                             | 63                    | 42.0         |
|   | Rarely                                | 43                    | 28.7         |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |
| <b>Do you limit the amount of fat and cholesterol in your diet after the illness</b>  | Never                                 | 47                    | 31.3         |
|   | Rarely                                | 28                    | 18.7         |
|   | Sometimes                             | 26                    | 17.3         |
|   | Regularly                             | 49                    | 32.7         |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |
| <b>Do you try to control the amount of salt in your diet after the illness</b>  | Never                                 | 31                    | 20.7         |
|   | Rarely                                | 39                    | 26.0         |
|   | Sometimes                             | 35                    | 23.3         |
|   | Regularly                             | 45                    | 30.0         |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |
| <b>Do you take vitamins (fruits) or minerals after the illness</b>  | Never                                 | 16                    | 10.7         |
|   | Rarely                                | 56                    | 37.3         |
|   | Sometimes                             | 67                    | 44.7         |
|   | Regularly                             | 11                    | 7.3          |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |
| <b>Do you find ways to reduce tension after the illness</b>   | Never                                 | 50                    | 33.3         |
|   | Rarely                                | 26                    | 17.3         |
|   | Sometimes                             | 20                    | 13.3         |
|   | Regularly                             | 54                    | 36.0         |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |
| <b>How often did you smoke after the illness</b>  | I was none smoker before the illness  | 126                   | 84.0         |
|   | stopped after the illness             | 12                    | 8.0          |
|   | Rarely                                | 11                    | 7.3          |
|   | Regularly                             | 1                     | .7           |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |
| <b>How often did you drink alcoholic beverage after the illness</b>   | I was none drinker before the illness | 96                    | 64.0         |
|   | stopped after the illness             | 28                    | 18.7         |
|   | Rarely                                | 23                    | 15.3         |
|   | Regularly                             | 3                     | 2.0          |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |
| <b>Did you reserve time for exercise after the illness</b>  | Never                                 | 67                    | 44.7         |
|   | Rarely                                | 34                    | 22.7         |
|   | Sometimes                             | 26                    | 17.3         |
|   | Regularly                             | 23                    | 15.3         |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |
| <b>How much your chronic illness affected your participation in social activities (like visiting friends, relatives, attending wedding/funeral and other ceremonies</b> | Extremely                             | 38                    | 25.3         |
|   | Moderately                            | 63                    | 42.0         |
|   | A little bit                          | 22                    | 14.7         |
|   | Not at all                            | 27                    | 18.0         |
|   | <b>Total</b>                          | <b>150</b>            | <b>100.0</b> |

The findings of this study indicated that chronic illness patients registered lifestyle modifications in arrays of life dimensions. In the aftermath of the illness, about 29.3% and 42% of survey respondents are visiting health facilities for general medical checkup usually and sometimes respectively. This tendency has its own advantages in identifying co-morbidities earlier and empowered patients to notice the changes in the status of their illness. Next to medical checkup, modifying nutritional habit is the required qualities among chronic illness patients. Subsequently, 69.7% patients more or less tried to avoid fat and cholesterol from their diet. Moreover, 79.3% and 89.3% of survey respondents more or less attempted to control the amount of salt and added vitamins/fruits in their meal respectively. Sedentary and monotonous working and living styles are often associated with the development of chronic illness. This type of lifestyle may lead to chronic tension, which in turn leads people to end up with different chronic illnesses. With respect to this, survey respondents were asked to specify their habits of tension reduction. Accordingly, 36% of the patients reported that they regularly search ways to reduce tension after the onset of the illness.

The other lifestyle modification areas include smoking and alcohol consumption. In this regard, a fairly large number of respondents (84% and 64%) respectively reported that they were non-smoker and non-drinker before the illness. However, about 8% and 18.7% of patients stopped smoking and drinking alcohol after the illness respectively. Thus, chronic illness patients are forced to avoid smoking and excessive alcohol consumption to facilitate the management of their illness. But 8% and 17.3% of patients preserved the habit of smoking and drinking respectively despite of their chronic illness. From the qualitative studies, A 50 year old cancer patient noted that he has made the unhealthy behavior history by saying “I used to chew *khat*<sup>4</sup> regularly and drink alcohol intermittently before the onset of the illness, but I stopped everything after the illness.” In terms of exercising, majority of the survey respondents (65.3%) reserve time for exercise from occasionally to regularly. The participants of the qualitative study also indicated their experiences of adapting healthy lifestyles. A 54 year old chronic heart illness patient noted his experience by saying “I avoid salt from my diet. I changed my food preference from meat to vegetables. I start my day with moderate exercise. In general, I brought paradigm shift lifestyle modification after the onset of the illness. One big motivating factor is that I have to live for my children.”

Another dimension of lifestyles modifications is associated with dressing style, which is specifically a desired quality for diabetic patients. A 19 year old girl, who has been diabetic for more than three years, noted “I modified my dressing styles due to the illness. I tried my best to be very friendly with the illness. Flat shoes and soft and wide clothes are most recommended to avoid wounds on body and I am behaving accordingly.” Moreover, chronic illness forced patients to modify their social life in a certain direction. Hence, 82% of patients reported that their chronic illness prevents them

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<sup>4</sup> Khat leaves are chewed for stimulation purpose by many people in Ethiopia

from participating in social gatherings and ceremonies either extremely, moderately, or a little bit. Chronic illness patients experienced a number of social problems partly emanating from their modified lifestyles. The data collected by the qualitative studies also consolidate what is stated above. Regarding this one patient informant stated the following:

*.....The illness also caused problems associated with my social life and social interaction. As of the prescriptions, I avoided taking foods items which are not friendly with my illness. In my locality, it is common for people to prepare festive on the name of Righteous and Saints, besides wedding and holidays. They called their neighbors to eat and drink what they have prepared. As a member of the community, I should attend such ceremonies. However, I am not willing to eat and drink what they have prepared as a result of my condition. People started to label me that I am negligent and trifle with their festive meal, despite of they are conscious about my illness. Only few understand my situation. Salt is not added to the food I am eating. Most of the time food is cooked once for the family. My children's complain about the lack of salt in the diet. This trend is affecting the intimacy with my family (Illness narrative, Male, 59).*

Chronic illness patients also modified their spiritual life in the aftermath of the illness. An informant of a heart disease victim noted the following in relation with this:

*The illness vastly changed my spiritual life. I became more religious after the illness. I started praying to Lord Day and night after the illness, but I was too dormant in terms of religious life before the onset of the illness. After I accomplished all prayers and rituals I become comfortable and strong psychologically. More so, I become addictive of the meditations of the praying ceremony in the church. I also became voracious reader of spiritual texts and scientific articles about my illness (Illness narrative informant, Male, 54).*

A 50 year old heart illness patient narrated the following in accordance with what is said above. "When I suddenly became dependent on others, I lost my confidence and principles immediately. I understand that people are easily breakable and defenseless, unless God maintained their health and wellbeing. I approach my God more than I was behaving before." The incidence of chronic illness helped patients to strengthen their spiritual life. Chronic illness is none curable, but manageable illness reality from the medical professionals point of view. However, some chronic illness patients challenged this assertion and seek relief from the illness by leaning to their religion and the associated rituals. Thus, chronic illness makes victims more pious in their life.

Chronic illness forced people to develop a new orientation about their life in general and their spiritual life in particular. The occurrence of chronic illness leads one's

life in to different destination. Patients of chronic illness sharply altered their life philosophy in many ways. One participant noted the following in line with this:

*My life mentality was changed after the onset of the illness. I understood that life could take different forms with a fraction of seconds. I become more concerned about spiritual life due to the illness. Not only my life philosophy, but also other aspects of my life have been changed drastically following the incident (Illness narrative informant, Female, 60).*

The realities of chronic illness forced people to socialize themselves with death. Patients altered their understanding and attitude towards death as a result of their chronic illness. One participant of the study stated the following in line with aforementioned assertion:

*When you are sick, the glass you adapted to look life is very different. I realized this after the illness. Besides, the severity of the pains sometimes erodes all your principles automatically. For instance, I hate myself and my life when I experienced serious pain. I wish I could die rather than suffering alive. The illness made me ready to welcome death, which I feared a lot when I was normal. I am socializing with the process of dying and the realities of death as a result of the illness (Illness narrative informant, Female, 43).*

Chronic illness also leads patients to hate their life. Since it is lifelong health problem and the associated miseries instigated patients to wish death than suffering alive. A 50 year old adult suffering from cancer stated that “I feel happy if I died easily by car accident than experiencing the pains of this illness.” Another diabetic patient informant endorsed this by saying that “I wished that Allah should have given me HIV than diabetes to die quickly.” One major feature of most chronic illnesses is that it elongates the suffering time of people instead of killing them suddenly.

On the other hand, for some participants of the study the incidence of chronic illness is considered as a turning point to specify their life aspirations. A type one diabetes patient shared her experience as follows:

*I was highly motivated to read and know more about diabetes after the illness. It was the turning point in my life. I have read numerous issues about diabetes. I also joined Ethiopian diabetes association and serving as a volunteer. The illness motivated me to join the medical profession and to search a better treatment drug. I am studying hard to be a physician and to contribute in the process of controlling and treating diabetes. I hope my dreams will come true through the help of God. Two things I have developed after the onset of the illness are; it made me hardworking student in my education and spiritual girl in my faith (Illness narrative informant, Female, 19).*

Chronic illness serves as incite cause to reverse longstanding stances and principles of people's life. For some, it is a blessing in disguise to enhance their spiritual life and to participate in benevolent activities by joining self help and community based associations. For others, chronic illness is their destiny and is the reason behind longing death in their everyday life.

Chronic illness patients confronted serious challenges in the process of adapting modified lifestyles. The treatment of chronic illness is more associated with lifestyle change than medication. However, practicing new lifestyles overnight is not an easy task. One informant articulated his lived experience like this: "I struggled to resocialize myself with the modified lifestyles, which demands giving up one's choices for prolonging one's life." Thus, starting to practice anew lifestyles is one of the challenges facing chronic illness patients, which could play a great role in the management of the illness if successfully implemented or aggravate the status of the illness if not.

## 5. Discussion

Chronic illness is emerging as a serious public health issue in the contemporary society. It is becoming a headache for global south countries by putting many families at risk. Chronic illness is creating a double burden for Ethiopian health system already whopped with the problem of acute illness. Chronic illness is blemishing the lives of individuals, families and the wider socio-economic fabrics of the society. As of the health seeking behavior of chronic illness is concerned, the current study revealed that chronic illness patients develop good health seeking behavior to treat their ill health condition. In Ethiopian reality, chronic illness patients received treatment from both biomedical and indigenous treatment centers. Chronic illness patients' health seeking behavior is influenced by social factors like education and place of residence. Thus, chronic illness patients residing in rural areas do not visit health centers immediately after the onset of illness, do not follow appointments regularly, and are more prone to discontinue the started treatment than their urban counter parts. This study also unearthed that the non-literate chronic illness patients have low level of health seeking behavior than the literate patients. A study conducted in Malaysia (Amal, Tee, Kaur, & Chinna, 2011) confirmed the findings of the current study, where health seeking behavior of chronic illness is determined by the geographical areas and level of education of patients.

In terms of lifestyle modifications, the present study indicated that most of the chronic illness patients introduced modified lifestyles to manage their chronic condition. However, their strict practice of the modified lifestyles is challenged when they are unable to easily give up their old habits as evidenced by the qualitative studies. The family and wider social forces are indicated by the participants of the study as factors which made lifestyle modification difficult for chronic illness patients. Previous studies also confirmed the findings of the present study. A study conducted in Ethiopia (Abel et



al., 2017) noted that the respondents' adherence to lifestyle modifications was only 23%, while in this study it is 35%, exhibiting some improvement. The lifestyle adherence was found to be better in females, patients who had comorbidities, had been knowledgeable about the disease, and among young adult respondents. A study conducted on the experiences of Iranian chronic illness patients (Vahedparast et al., 2016) indicated that the perceived threat of the illness plays an important role in the process of changing to a healthy lifestyle in patients with chronic illnesses. In the present study, 79.3% and 65.3% of the respondents strived to control the amount of salt and to reserve time for exercising respectively. In previous studies (Shibiru, Bayeta, Selamu, & Eliyas, 2016) 80% and 87.8% of chronic illness patients avoided salt from their diet and performed physical exercise to manage their illness respectively. The result is almost the same with regard to avoiding salt, but in terms of exercise there is a discrepancy. However, a study conducted in Botswana (Zungu, Djumbe, & Setswe, 2013) reported the same finding with the present study in which 65.6% of chronic illness patients undertake physical to manage their chronic illness.

Chronic illness patients adopted modified lifestyles to facilitate the treatment of their chronic illness. Prescriptions of medications do not always treat the underlying cause of the chronic illnesses. Most health care practitioners would agree that the majority of chronic diseases are the result of poor lifestyle choices. Thus, unhealthy lifestyles such as smoking, lack of exercise, bad food choices and stress are the factors behind the widespread prevalence of chronic illness. In line with this, chronic illness is named as lifestyle diseases in the literature. In the previous study (Hartley, 2014) noted that successful lifestyle modification could correct numerous underlying etiologies that contribute to the triggering and progression of chronic illness. Moreover, a study conducted in Botswana (Zungu et al., 2013) discussed that chronic illness patients showed lifestyle modifications associated with diet, exercise, smoking, and alcohol attributes in the aftermath of their illness. Accordingly, 96.4% of the respondents were non-smokers from the outset and 65.2% restricted from alcohol consumption after they contracted chronic illness. In the present study, about 84.0% of the respondents were non-smokers and 51.85% of the chronic illness patients stopped drinking alcohol after the onset of the illness.

Generally, the social factors of place of residence and being non-literate are impeding the health seeking behavior of chronic illness patients. Chronic illness patients are also struggling to practice lifestyle modification to manage their ill health conditions. Thus, health literacy and expansion of health facilities should be prioritized to promote the health seeking behavior of the patients and behavioral intervention should be undertaken to improve the patients' adherence to recommended lifestyles. In sum, chronic illness patients' acceptance and integration of the illness as part of their new identity reflects the coping element of the 'chronic illness as biographical disruption' theory and improved health seeking behavior is considered as strategies of the 'chronic illness as biographical disruption' model. The practice of lifestyle modifications and the

re-socialization of chronic illness patients manifested through changes in life philosophy, spiritual life and social life indicates the adjustments accomplished by patients to sustain their lives. Thus, the patient's life course and overall life domains are highly disrupted by the illness which results a paradigm shift biographical sketch transformation as evidenced by the findings of the current study.

## 6. Conclusion

Chronic illness is one of the grievous challenges encountering contemporary society and becoming not a merely personal trouble. Chronic illness patients sharply altered their life philosophy in the aftermath of the illness. After the onset of the illness, patients are socializing themselves with the inevitable death and the process of dying frequently than they were behaving previously. Chronic illness patients also resorted to spiritual life and seek cure from faith based healing system. The treatment of chronic illness requires unfailing commitment from the patients in developing good health seeking behavior. Chronic illness patients dominantly relied on the biomedical treatment services, but also make a hierarchical resort to indigenous and faith based treatment alternatives intermittently. From socio-demographic factors, place of residence and educational status were found to be the determinants of health seeking behavior of chronic illness patients. Thus, chronic illness victims who live in rural area and those who are not literate have low achievements across the three indicators of health seeking behavior. Moreover, the incompetence of service providers and poor treatment equipment's, expensive treatment service, and inaccessibility of health facilities were identified as the supply side barriers influencing the health seeking behavior of chronic illness patients.

Lifestyle modification is in the front line treatment strategies in the process of chronic illness control and management. However, chronic illness patients reported that they are struggling to adapt and practice the desired modified lifestyles in their everyday life. Some of the areas in which chronic illness patients are required to bring paradigm shift modifications are nutrition, cigarettes, alcohol, exercising and medical checkups. Patients who successfully re-socialized with the modified lifestyles reported improvements in the status of their chronic illness. In the contrary, patients who dropped the new lifestyles faced relapse of pains. As a result of their chronic illness and partly due to the modified lifestyles, patients are encountering serious problems in their social life. More so, chronic illness patients modified their spiritual life and most of them became religious after the onset of the illness. Patients of chronic illness also sharply altered their life philosophy in many ways. The problem of chronic illness is not just a health problem; rather it affects the overall functioning of the society. Thus, much has to be done to create chronic illness conscious society by using mass media and indigenous institutions to disseminate the required information about practicing health promoting

lifestyles to prevent chronic illnesses and lifestyle modifications to manage the occurred illness.

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