RESEARCH ARTICLE

Recognition of symptoms, mitigating mechanisms and self-care experiences of type 2 diabetes patients receiving insulin treatment in North-East Ethiopia [version 1; peer review: awaiting peer review]

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Abstract

Background: Compliance of patients with self-care practices is the mainstay of measures to manage diabetes. This study explored self-care practices of type 2 diabetes patients receiving insulin treatment in North-East Ethiopia.

Methods: The study employed an interpretive phenomenological approach using purposive sampling. The data were collected from 24 (11 males and 13 females) participants (July 2019 to January 2020) using in-depth interviews till theoretical saturation. The data were analyzed thematically and organized using QDA Miner Lite v2.0.8.

Results: The findings were categorized into: labeling diabetes, self-care maintenance experiences, recognition of symptoms, and mitigating mechanisms of symptoms. The self-care maintenance practice of patients was linked with diet input preferences and the effectiveness level of insulin. What guides the self-care behavior was the patients' preferentiality of strictly adhering to their preferred dietary inputs. Barley and wheat were the most common preferential and non-preferential inputs, respectively. The patients strictly adhered to insulin treatment because they found it effective. The most common hyperglycemia symptoms to be managed by taking an additional dose of insulin, were frequent urination, increased thirst, and their consequences (dehydration). Excessive sweating (initial), shivering (middle), and falling (final), respectively in severity, were the most common symptoms of hypoglycemia which were perceived to be treated with sweet snacks.

Originality: To our knowledge, this is the first research in Ethiopia to investigate the self-care experiences of type 2 diabetes patients receiving insulin using an interpretive phenomenological approach.

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Any reports and responses or comments on the article can be found at the end of the article.

Keywords

Type 2 diabetes, Symptom, Insulin, Self-care, Experience, Qualitative research

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Introduction

Self-care of chronic illness is somewhat different from the general issue of self-care, in that it should be illness-specific (Riegel *et al.*, 2012). Giving special attention to self-care is crucial and more important than drug treatment (Ausili *et al.*, 2014). The goal of diabetes management is to promote holistic wellbeing, an asymptomatic life, and good quality of life (QOL) by preventing complications (Ayubah & Peltonen, 2018) via self-care. Treatment begins with diet. Day-to-day carbohydrate intake and patient preferences, grounded on cultural context, are crucial (Hopper, 2007).

The critical factor to control diabetes is self-care: healthy lifestyles and adherence to treatment (Abraham *et al.*, 2011; Shrivastava *et al.*, 2013). Self-care requires the best strategies to decide the appropriate measures suitable for an individual's lifestyle issues and conditions (Abraham *et al.*, 2011; Adam, 2012; Moser *et al.*, 2008). The diabetes patients themselves are responsible for their disease management to the extent of 95% (Abraham *et al.*, 2011; Adam, 2012; Sharma & Joshi, 2016). The patients' beliefs impact their commitment and motivation to carry out self-care behaviors (Beverly *et al.*, 2014). The struggle to self manage and maintain new habits are influenced by the patient's perceived conditions (Ribu *et al.*, 2019).

Diabetes self-care is an ongoing process of learning to develop awareness or knowledge to survive with diabetes in a social context (Sekhar *et al.*, 2020). Knowledge of risk and a healthy lifestyle are mandatory in type 2 diabetes mellitus (T2DM) management (Tabong *et al.*, 2018). The consequence of poor adherence of diabetes patients to self-care results in poor health outcomes (Anitha Rani & Shriram, 2019). This study aimed to explore self-care practices of T2DM patients receiving insulin treatment in Dessie City Administration (DCA), North-East Ethiopia.

Methods

Ethical considerations

This study received approval from the Ethical Review Committee of Medicine and Health Science College of Wollo University (Ref. No. CMHS: 443/13/11). After the provision of sufficient information about the study, written informed consent was obtained and signed by all study participants before conducting interviews. The names of participants were not indicated, but coded for the convenience of data analysis. The information collected from all participants were kept confidential.

Design and setting

An interpretive phenomenological inquiry, July 2019 to January 2020, was used to deeply explore the experiences of the self-care practices of T2DM patients receiving insulin treatment at Dessie Comprehensive Specialized hospital (DCSH), DCA, North-East Ethiopia (Table 1). It is the largest tertiary hospital, with the widest catchment area, in the North-East region of Ethiopia (Getachew, 2020).

Data collection tool and procedures

A semi-structured interview guide, prepared in Amharic, was used as a tool for data collection, and face-to-face in-depth

interviews were performed for collecting data using an audio recorder. All study materials including the interview guide can be found as extended data (Bayked *et al.*, 2021). Data collection started on 3 July 2019 and ended on 23 January 2020. The participants were identified preliminarily by the principal investigator (EMB) at the diabetes clinic from the diabetes patients' registration cards. And 24 participants following their treatment at DCSH were interviewed by EMB. The sample size was determined by theoretical saturation (the point at which no further themes were obtained). They were recruited purposively. Inclusion criteria were T2DM patients receiving insulin treatment, with no known or overt psychiatric problems, willing to participate, 18 years and above, with no type 1 and gestational diabetes and able to communicate.

The interviews were done in the patients' appointment time, and lasted for a range of 23 to 71 minutes with an average of 46 minutes, in quiet areas free from distractions: at separate places of the hospital compound, isolated spots of cafes, secured work areas, and homes of participants. Data collection ended when theoretical saturation was achieved.

Data processing and analysis

The interviews were transcribed verbatim into MS Word by the researchers themselves and rechecked. Transcripts were read repeatedly before translated into English to ensure good understanding. The coding and analysis procedures were started immediately after the first interview and done along with data collection. Interviews continued until all key themes were saturated. The coding activity was done by moving back and forth repeatedly to find out further emerging themes and to gain a detailed description of the themes. Each transcript was coded line by line and these codes were organized into higher-order conceptual themes. Sections of original transcripts and key quotes were considered to be illustrative of the emerging themes. Individual codes and themes were discussed at group meetings of the researchers until consensus was reached on basic themes and subthemes across the interviews. Finally, the themes were incorporated into a conceptual model of the participants and their perceptions of diabetes self-care practices and discussed using an interpretive paradigm. The data analysis was organized by using QDA Miner Lite v2.0.8.

The researchers pursued various strategies to assure quality data: the interview guide was tested on two individuals with similar cases and adjusted accordingly (personal experiences of mitigating symptoms were included), the transcripts and findings were shared with participants who confirmed that the interpretations accurately reflected their perceptions and experiences. The write-up was guided by the "Standards for Reporting Qualitative Research (SRQR) checklist" (O'Brien *et al.*, 2014).

Reflexivity

The data were collected by the principal investigator (EMB). He realizes that the results of this study come from the interaction of him and the research participants. He has been a part of the community since his childhood. He is grown with the communities' norms and is very familiar with the customary terms (local slang) that the community uses. This makes him

Table 1. Summary of the Description of Dessie City Administration (DCA), South Wollo Zone, Amhara Region, North-East Ethiopia, 2020.

Significance	Largest urban center in North-East Ethiopia (Dimon, 2018)
Population	Town (209,226), Rural (35,903), Total (245,129) (Central Statistical Agency, 2013)
Ethnic groups	Amhara (94.89%), Tigre (3.79%); Others (0.67%) (Central Statistical Agency, 2007)
Religions	Islam (58.62%), Orthodox (39.92), Protestant (1.15%), and Others (0.31%) (Central Statistical Agency, 2007)
Language	Amharic (95%), Tigrigna (4%); Others (1%) (Central Statistical Agency, 2007)
Economy	Economically active (50.85%), Economically inactive (49.15%) (Central Statistical Agency, 2007)
Employment	Employed (88%), Unemployed (12%) (Central Statistical Agency, 2007)

fit to understand and interpret every word which has been said by the participants from lay perspectives. EMB could also be an appropriate investigator since he is a BSc nurse familiar with nursing practice and a lecturer in social and administrative pharmacy (SAP). He has taught at different health science colleges in both fields. He has been currently teaching and researching with SAP at Wollo University, and practicing as a nurse in a private hospital. However, his prior knowledge of the local jargon and the medical terminologies and diabetes might have resulted in bias if he did not remain mindful throughout the research process. He was conscious of the biases, values, and experiences that he brought to the study and only interpreted the concepts raised by participants.

Results

As it is given in Table 2, a total of 24 patients (11 males and 13 females) were interviewed. The minimum and maximum ages of the participants were 35 and 75 years, respectively, with an approximate median age of 57 years. Their approximate average life with diabetes was 12 years, and with insulin treatment was 5 years.

The results of the study were grouped into four main themes: labeling diabetes, self-care maintenance experiences (lifestyle preferences and medication adherence), recognition of symptoms (hyperglycemia and hypoglycemia), and mitigating mechanisms of symptoms (hyperglycemia and hypoglycemia).

Labeling diabetes

In Amharic, diabetes mellitus is 'Ye-Siquar Beshita' which means 'The disease of Sugar' and the short-term diabetes is called 'Siquar' which means 'Sugar'. The term 'Siquar' is also used to express blood glucose as well as table sugar. Thus, 'Siquar' was being understood contextually whether it is said to express diabetes or blood glucose. The sweet snacks and drinks as a whole are called 'Tafachi' or 'Markesha' in Amharic. The most commonly used was 'Tafachi'. This term was used to express *any drink or food items which are supposed*

Table 2. Description of study participants (n = 24).

Description	No. of patients	Description	No. of patients
Age (years)		Occupational status	
30–39	4	Farmer	5
40–49	4	Merchant	3
50–59	6	Public servant	5
60–69	5	House wife	3
≥70	5	Retired	3
Marital status		Unemployed	5
Married	17	Diabetes duration (year)	
Widowed	6	1–5	6
Divorced	1	6–10	7
Religion		11–15	3
Orthodox	11	16–20	4
Muslim	12	21–25	2
Protestant	1	26–30	1
Educational status		31–35	1
Illiterate	11	Insulin use duration (years)	
Basic literacy	4	<1	4
Secondary school	4	1–5	13
Diploma	2	6–10	4
Graduate	2	11–15	1
Postgraduate	1	16–20	1
Residence		21–25	1
Urban	17		
Rural	7		

to be taken to ameliorate the hypoglycemia induced by insulin, but the second term 'Markesha' literally means 'antidote'.

Self-care maintenance experiences

Life-style preferences. The self-care maintenance practices of patients were expressed in line with what would be permitted or prohibited; the effect of the choice on blood glucose and the disease as well as their value to health and well-being. These were related to food (ingredient selection, preparation, content of carbohydrate or tastes), dressing (shoe size like narrow or wide, style like being heel or flat, being open or closed, manufacturing material like being rubber or leather), hygiene, and protection from physical hazards (trauma, extreme heat like cold and increased temperature). So, these could be classified as prohibited/non-preferential or permitted/preferential; they would also be categorized based on an approach in that they whether advised to be in a negative or positive approach. Physical activity and foot hygiene were the least expressed preferred practices.

To your surprise, what is important for 'Siquar' (diabetes) patients is wide cloth and wide shoes. And others tried for us to bathe if it (the water) is warm. If you get caught by 'Siquar', your body will get thin, and cold will extremely hurt you. And we wash after it was tried. (Male, 46 years)

Among the self-care practices by abstinence regarding food choice and feeding, the most common non-preferential practice or abstinence mentioned was not eating wheat followed by sweets, pea, and butter. It was also non-preferred to eat until the stomach is full. The others were white meat (fat), 'Tinkish' (type of sugar cane), potato, spaghetti, macaroni, and cattle meat. Almost all these food inputs are among foods with high carbohydrate content (sweets). On food preference, the most commonly stated ones were plant products. Accordingly, barley was the most commonly mentioned item (ingredient) followed by chickpea, Teff, lentil, salad, oat, and cabbage. The others were nuts, mango, corn, bean, tomato, egg, chicken, and milk. Common to all participants was that keeping away from sweet foods and drinks unless in case of hypoglycemia exerted by insulin.

Eating bread prepared from barley and oat has no problem, but it is not good to eat the bread of wheat. (Male, 52 years)

Concerning feeding, I use Barley, Teff, Corn, Beans, and Oats in my diet; I mix all together; compound all to make one, and use the mixture. Oh... no! I did not use sweets. As the doctor told me, if I eat, I will die", and I never touch it. (Male, 46 years)

I take care of myself a lot because it (diabetes) is a serious illness. And I do not miss the sweet food on the diet. I take recommended foods. I do not use prohibited items. I use everything that is not sweet. If I do not feel whim, I will not use butter too. (Female, 35 years)

Regarding food preparation, the most commonly mentioned were bread and 'Injera' (Soft flatbread) with their supplement or 'Shiro' ('watt' or main ingredient to make 'watt'). The preferentiality however is determined by the inputs whether prohibited or permitted. These are customary foods of the society. The others were 'Alcha' ('watt' with no red pepper), 'Kolo'

(roasted cereal), juice, 'Nifro' (boiled cereal), 'Shamet' (drink prepared as suspension from powdered roasted barley cereal), and biscuits. These were also preferred to ameliorate hypoglycemia; are also among the 'Markeshas' (antidotes of insulin).

If there is no biscuit, I will hold a loaf of bread in my pocket or highly cooked 'Nifro' of beans or 'Shamet' (drink prepared as suspension) with my bag; I hold it with its solvent right now too. (Male, 63 years)

On dressing, the most commonly mentioned preferred was comfortable open shoes; open or wide shoes to be protected from extreme cold and physical trauma. Closed and heel shoes especially shoes made from rubbers were mentioned as non-preferred, but open shoes were also expressed as non-preferred in case of a long journey especially if the weather condition was assumed to be very cold.

I wear sandals and normal shoes at home. I feel pain inside my feet. My feet are going to be dry. And while I go to bed, I use 'Vaseline' (ointment). I wear wide-closed shoes outside. Previously, before now, I was saved when I had worn narrow shoes; it wounded me and I was in pain for a long time. Then, I am very cautious; just be careful not to hurt the feet. (Female, 35 years)

Insulin adherence. Most of the participants had experienced the positive outcome of insulin. Most of the participants reported that there was a significant improvement in their overall health status after they started insulin treatment. They were strict in the utilization of their insulin treatment for the management of their disease which dictates that their adherence to their insulin treatment was appreciable. This was because it was found to be effective. The participants expressed their feelings hopefully and confidently as there would not be life if insulin was absent.

I have never forgotten to take it (insulin); not! So, how can I forget it? It is life; is there more than life? The injection (insulin) is fine; nothing strange with it. (Male, 58 years)

After I started insulin for the treatment of my 'Siquar' (diabetes), I got that it (insulin) is the spice of life. (Female, 38 years)

Recognition of symptoms

Most patients reported that they had no glucometer to monitor their blood glucose level, but they used symptoms to monitor the fluctuations of their blood glucose; i.e., they were practicing self-monitoring of blood glucose in being conscious of the symptoms of hypo- and hyperglycemia.

Hyperglycemia. These were symptoms used to monitor blood glucose levels and were used as alarms to remind the time of medication administration. The most common symptoms experienced by patients, while they are on insulin treatment, whether due to under-dose utilization or missed/forgot to use their medicine or skipped their schedule to take their medicine were frequent urination and increased thirst, and their consequences (dehydration). These symptoms were experienced by almost all patients; they were universal symptoms. These symptoms were expressed as alarming clocks to control elevated blood glucose.

If I missed to take it (insulin), it (blood glucose) becomes increased. When it does increase, you will feel increased thirst, frequent urination and your mouth will dry. It says you 'water.... water, urine...urine'. (Male, 66 years)

If I forgot it (insulin), water thirsts me. When I realized it was forgotten, I do not know my soul, and I immediately wake up to use it. (Male, 63 years)

The other expressed symptom was increased hunger. Fewer common symptoms, tremor, worrying, feeling of bad odor, and headache, were also mentioned.

If my medicine (insulin) fails to control it (blood glucose), it goes up. So, sometimes, at night, I feel hungry, and I eat 'Injera' (soft flatbread) with 'Berbere' (dried powdered red pepper). (Female, 71 years)

It (elevated blood sugar) brings me whatever could not be happened. When it becomes the worst, I assume me to be in death. If it is gone up, I feel the odor of black soil. (Female, 71 years)

Hypoglycemia. Shivering, excessive sweating, and falling were the most common symptoms of lowered blood glucose (hypoglycemia). Next to these were lethargy (tiredness) and grabbing (clutching) of the tongue. The most common initial and final symptoms were excessive sweating and falling, respectively.

When it (blood glucose) goes down, it causes me to sweat; it shakes my body and falls apart. (Female, 51 years)

When it (blood glucose) gets smaller, my sweat comes in; my body becomes watery; the whole of my body oozes hot water. Then, next, my mouth gets stuck; I speak incomprehensively, my body shakes, and finally lied down me on the ground. (Female, 45 years)

When it (blood glucose) goes down, it sweats me, shakes me, my body becomes lethargic, and it throws me away. (Male, 59 years)

Dizziness and drowsiness were symptoms magnifying the major symptoms of hypoglycemia but were the least common ones.

When it (blood glucose) lowered, I experienced excessive sweat; I feel dizzy, drowsy, and fainting. When the sweat dries, I fall. (Female, 70 years)

Mitigating mechanisms of symptoms

The most common management mechanism of hyperglycemia that patients experienced while on insulin treatment was taking an additional dose of insulin. Next to that was a checkup (consulting doctors) along with analyzing underlying causes. The third one was abstinence from sweet foods and drinks. The least common ones and seems to be strange were taking something bitter and bathing.

When the 'Siquar' (blood sugar) is lowered, I use "Mirinda" or sugar. Then I become fine. If it elevates, I use an additional amount of insulin, and I stop using sweat things. (Female, 38 years)

I will take a little something sweet when it (blood glucose) is going down. When it increases, I use something bitter; because, since the sugar is sweet, it should be opposed by something bitter like that of light is disappeared by dark... you should do the opposite...should take bitter to disappear the sweet. (Female, 55 years)

When it does increase, I would go into the shower and let it (my body) cool down. And stop something sweet; stop at all, and then everything becomes alright. (Male, 46 years)

The universal means of correcting lower blood glucose was taking foods with carbohydrate content (all sweet things as their accessibility). However, the most commonly and customarily used mechanisms were using 'Mirinda' (soft drink) and table sugar.

When the 'Siquar' (blood sugar) goes down, if you give me a little sugar, I will be better; if 'Mirinda' is at the house, I will use it. (Female, 45 years)

Discussion

Patients in this study perceived that self-care maintenance experiences include "abstaining from what is prohibited" and "doing what is allowed". These were labeled to be preferential (to be approached positively) and non-preferential (to be approached negatively). These both were labeled concerning food and dressing. The foods were also labeled based on their inputs in perception that whether these inputs contain carbohydrates or sometimes with no known reason (or only based on local cultural sayings). So, based on this perception, wheat followed by pea was labeled to be the most non-preferential input; in that, all food preparations containing it or prepared from it are prohibited. However, maybe due to the vitamin richness of whole wheat grain, a quantitative study showed, despite a significant positive correlation between white bread consumption and blood sugar, a high intake of whole grains is related to a reduced risk of T2DM (Askari *et al.*, 2013).

All sweet preparations were also labeled to be forbidden unless hypoglycemia is in place due to insulin excess. Similarly, according to a study in India, most patients made restrictions to sweet intake (Anitha Rani & Shriram, 2019). Barley was labeled to be the most preferential input in that all food preparations containing it or prepared from it are permissible. With no overlooking the strict classification of dietary preferences in this study, according to a quantitative study done in public hospitals of Addis Ababa (Ethiopia), there were similar classifications of dietary patterns by T2DM patients (T/Michael, 2016).

According to a review article, the seven essential self-care maintenance behaviors in people with diabetes were healthy eating, being physically active, monitoring of blood sugar, compliance with medications, good problem-solving skills, healthy coping skills, and risk-reduction behaviors (Shrivastava *et al.*, 2013). In supporting the perceptions of patients in this study, dietary patterns were reported to be effective for diabetes risk reduction if individual preferences are taken into account

(Guess, 2016). It was also recommended that, if possible, initial treatment of T2DM should be started with lifestyle changes (diet, exercise, and weight reduction) along with consultation of a registered dietitian and diabetes self-management education (Wexler, 2020). The compliance of self-care maintenance practices of patients concerning diet in India was high (Selvaraj *et al.*, 2016), but according to a study conducted in Addis Ababa (Ethiopia), patients did not adhere to dietary recommendations (Tewahido & Berhane, 2017).

However, no reports were found from other studies like the finding from this research towards strict stratification of self-care maintenance practices by patients concerning diet input preference. The participants in this study have also their own model of self-care maintenance practices. As their perceptions, they are strict because if they do “*what is prohibited*”, they will become sick, but healthy if not; also assured that they were experienced. As the beliefs of them, if they do “*what is prohibited*”, they will get a bad outcome, if not, good outcome and vice versa.

Most of the patients were reported that insulin was effective, and was resulted in positive outcomes (impacts). The most common perceived positive outcome of insulin from the experiences of patients was health improvement. They also explained that the reason for their strictest adherence to their insulin treatment was the outcome of insulin itself in that it was found to be effective. So, they perceived that their adherence was the outcome of its effectiveness, and their health improvement was the impact of their adherence. It increased their confidence to survive. They perceived that while diabetes took everything they had (physical capacity and psychosocial moods that they had been enjoying), insulin brings everything that they did not have (quality of life and emotional stabilities that they never expected). A cross-sectional study in Kuwait also reported that using an insulin pump was found to improve patients' glycemic control and QOL as a consequence of improved satisfaction and adherence to doses (Alsairafi *et al.*, 2018). Similarly, patients in Butajira and Addis Ababa (Ethiopia) have strictly adhered to their diabetes medicines (Habte *et al.*, 2016). Medication adherence was also found to be high in quantitative (Chinnappan *et al.*, 2020; Karthik *et al.*, 2020; Uma Maheshwari *et al.*, 2017) and qualitative (Selvaraj *et al.*, 2016) studies done in India. However, in contrast to this study, in a quantitative study in southwest Ethiopia, medication adherence was low with poor self-care behaviors (Kassahun *et al.*, 2016). In quantitative studies done in Harar and Dire Dawa (Ayele *et al.*, 2019), Benishangul Gumuz (Chali *et al.*, 2018), and Gondar (Aschalew *et al.*, 2019) (Ethiopia), most patients with diabetes did not adhere to diabetic self-care maintenance activities.

Frequent urination and increased thirst with dehydration (dryness of tongue/mouth) were the most common symptoms experienced by patients with diabetes. These symptoms were the most common reasons for patients to seek health care. These symptoms were experienced by patients in case of uncontrolled blood glucose (hyperglycemia) due to inappropriate time

or dose estimation of insulin or because of forgetting to take it. These symptoms thus were used by patients whether to seek health care or to monitor their blood glucose. These symptoms, frequent urination, and increased thirst with dehydration, were common symptoms of hyperglycemia (Hopper, 2007).

Regarding lowered blood glucose (iatrogenic Hypoglycemia), in their decreasing order of occurrence, excessive sweating (diaphoresis), shivering (shaking), and falling (fainting) were the most common symptoms. The most common initial (quickest) symptom of lowered blood glucose expressed was excessive sweat while the final (worst) symptom was falling. The symptom between these symptoms at the time of occurrence was shivering. These symptoms of hypoglycemia are also found to be neurogenic (shakiness, trembling, and sweating) and neuroglycopenic (difficulty speaking, ataxia, stupor, seizures, and coma) (Briscoe, 2006; Cryer, 2020; Diabetes Canada Clinical Practice Guidelines Expert Committee *et al.*, 2018). In supporting this finding, from another study, the symptoms were found to be key in diagnosing T2DM (Chege *et al.*, 2015). Nevertheless, no patients from other studies reported the symptoms of hypoglycemia in the level of their severities. The distinctiveness might be due to the patients in this study could be conscious of the temporal relationship of the symptoms in their time of occurrence. Such leveling and being conscious of symptoms in the order of severity should be taken as an input to incorporate in diabetes education.

The patients adapted different management mechanisms of hyperglycemia and hypoglycemia episodes while on treatment by using the major symptoms as alarm clocks (tools). During hyperglycemia, patients had an experience of taking an additional dose of insulin which is the most common followed by a check-up and getting management at the health institutions. Given the natural history of most patients with T2DM is the gradual rise of blood glucose, there should be a requirement of continuous treatment to maintain normoglycemia (Wexler, 2020). Thus, over time, additional prandial boluses of insulin may be required to maintain daytime normoglycemia (Bretzel *et al.*, 2009).

In the case of hypoglycemia, the experience of most patients was taking something sweet with carbohydrate content (being sugar and ‘*Mirinda*’ the most common). Apple or orange juice, regular soft drinks and sweet beverages have been recommended. However, milk and orange juice are slower to increase blood glucose levels and provide symptom relief (Diabetes Canada Clinical Practice Guidelines Expert Committee *et al.*, 2018). Since, iatrogenic hypoglycemia that occurs during treatment is the limiting factor in the glycemic management of diabetes (Cryer & Arbeláez, 2016; Cryer, 2020), reducing the danger of hypoglycemia necessitates recognizing it, and applying optimum glycemic therapy (Cryer & Arbeláez, 2016) with patient education and empowerment, regular self-monitoring of glycemia, individualized glycemic goals, flexible and rational insulin regimens, and ongoing professional guidance and support (Cryer, 2020).

Implications for the public

Since patients themselves are more responsible to manage diabetes, the level of their consciousness to bodily changes is the mainstay indicator to manage the condition, especially in self-care practices to maintain normoglycemia. Thus, the preferential principle of diet input experiences and the consciousness of hypoglycemia symptoms in the order of their severity situation should be taken as inputs to the diabetes education program. Incorporating these inputs in diabetes education with cultural contexts can improve diabetes self-care activities.

Strengths and limitations

The strengths of this study are that it was conducted at the largest tertiary hospital with the widest catchment in North-East Ethiopia and three indigenous investigators participated. It employed face-to-face in-depth interviews to deeply explore the self-care experiences of patients and to our knowledge is the first interpretive phenomenological study in Ethiopia conducted to explore the self-care experiences of T2DM patients with insulin regimen.

The limitations of this study are that it did not include type 1 and gestational diabetes patients. It did not also consider the experiences of patients attending treatment at private hospitals. Additionally, the nature of qualitative research is inductive and context-based; thus, it cannot be generalized to all diabetic patients and institutions.

Implications for future research

Diabetes self-management is almost up to the patients' activities, and since the activities in this study were linked to preferential principles, research that investigates driving behaviors for the preferentiality of self-care practices should be considered.

Conclusion

The self-care maintenance experiences of patients, concerning lifestyle issues, were labeled based on diet input preferences as preferential and non-preferential. The adherence to the preferential diet inputs and insulin treatment was strict. While the most common symptoms to recognize hyperglycemia were frequent

urination, increased thirst and their consequence (dehydration); excessive sweating (quickest or severe), shivering (middle or more severe), and falling (final or most severe) were alarms for hypoglycemia. The most common mitigating mechanisms of hyper- and hypoglycemia, respectively, were taking an additional dose of insulin and something sweet.

Data availability

Underlying data

All the data underlying the results, which did not bear confidentiality issues, are available as part of the article. If the de-identified transcripts are needed for scientific purposes, or to clarify ambiguities in the manuscript, they will be available from the corresponding author (ewunetie.mekashaw@wu.edu.et).

Extended data

Zenodo: Recognition of symptoms, mitigating mechanisms and self-care experiences of type 2 diabetes patients receiving insulin treatment in North-East Ethiopia. <http://doi.org/10.5281/zenodo.5112496> (Bayked *et al.*, 2021).

This project contains the following extended data:

- Patient information sheet.docx
- Research consent form.docx
- Semi-structured interview guide.docx
- Standards for Reporting Qualitative Research (SRQR) checklist.doc

Data are available under the terms of the [Creative Commons Attribution 4.0 International license](#) (CC-BY 4.0).

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