Original Article

Health-related quality of life and associated factors among patients with diabetes mellitus in Botswana

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Abstract

Background: Health-related quality of life (HRQOL) is an important aspect of diabetes mellitus care. The objective of the study was to determine the HRQOL of diabetes mellitus (DM) patients in Botswana as little known in Africa. Materials and methods: A cross-sectional study of 380 randomly selected DM patients in a tertiary clinic in Gaborone, Botswana was conducted to obtain data on HRQOL and structured questionnaire was used to collect information on sociodemographic and clinical characteristics. Multivariate logistic regression to determine sociodemographic and clinical characteristics associated. Results: Majority of patients were female with no formal education or primary level of education. Mean HbA1c was 7.97% (SD: 2.02) and most patients had poor glycaemic control. The majority had both worse physical composite score (PCS-12) and mental composite score (MCS-12), with worse proportions of the two. Female gender, older age >65 years, and the presence of three or more documented diabetic complications were associated with significant worse PCS-12. Presence of two diabetic complications, three or more diabetic complications, and musculoskeletal disease were associated with significant MCS-12. Conclusions: Diabetic patients in Botswana have relatively poor HRQOL. The fact that most patients presented late with complications calls for policy attention to diagnose diabetes mellitus early and prevent associated complications, ultimately improving health-related quality of life among diabetes mellitus patients.

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advantage in terms of incorporating chronic disease management strategies into routine care, leading to a reduction of both morbidity and mortality, including patients in developing countries.7–12 The psychosocial burden of living with diabetes mellitus is considerable as it affects self-care behaviors, leading to long term poor glycemic control, increased risk of long-term complications and poor quality of life.9,13–15 Understanding the measurements of HRQOL as well as the factors associated with poor quality of life has a benefit in terms of improving the physical and psychosocial burden associated with DM, ultimately reducing associated costs, morbidity and mortality.15,16

Published studies have found that DM patients without complications have higher overall utility values than those with complications.17 Currently, most of the published literature on HRQOL of patients with DM is based on developed countries with little known among developing countries. Whilst it is well acknowledged that there is better access to health in developed countries compared to developing countries, there are more associated morbidities of DM in developing countries,5 which will have a considerable impact on their HRQOL.12,18 Consequently, we sought to determine the HRQOL, and associated sociodemographic and clinical variables, among patients with DM in Botswana. The findings will be used to suggest future strategies in Botswana to improve the management of these patients if pertinent. The findings may also be of interest to other African countries with increasing rates of NCDs including diabetes.

2. Methods

2.1. Study area, design and participants recruitment

Details of study area, design and participants recruitment, inclusion and exclusion criteria and how sociodemographic and clinical data was collected have been described in details elsewhere.19 In summary, a cross-sectional study was conducted whereby 380 patients were randomly selected for the purpose of this study between July to September 2015 in Block 6 clinic, a tertiary unit in Gaborone, Botswana, and data was obtained by means of standard structured questionnaire interviews. Further data was obtained from patients’ hospital charts. This clinic was chosen as it offers services to over 3000 diabetic patients. In Botswana, medicines are provided free-of-charge to patients; consequently, copayment for medicines is not an issue.19 On average 1800 to 2000 diabetic patients visit the clinic monthly.

2.2. Sample size

The sample size was calculated from the formula of descriptive cross-sectional study, i.e. $N = \frac{Z^2 \times \text{p}(100 - \text{p})}{d^2}$; where: $N =$ estimated minimum sample size, $Z =$ Standard deviation of 1.96 at 95% confidence interval, $p =$ Response rate to the SF-12 quality of life questionnaire in the outpatient clinic20 which was 44.3%, and $d =$ the margin of error on $p$, which is approximately 0.05. Consequently, $N = 1.96 \times 1.96 \times 44.3 \times 55.7/25 = 379$. As seen, the estimated minimum sample size was 379 patients.

2.3. Study instrument

The most widely used generic measure of quality of life in studies of people with diabetes mellitus is the Medical Outcomes Study (MOS) Short-Form General Health Survey, which has several forms (SF-36, SF-20, and SF-12). The MOS instrument includes physical, social and role functioning scales to capture behavioral dysfunc-

2.4. Dependent variables

We measured both the worse PCS-12 and worse MCS-12 as a score of <50%, and the better PCS and MCS as the scores of ≥50%. Our outcome (dependent) variables were worse PCS-12 and worse MCS-12.

The choice of 50% cut off is based on the fact that the scores that are summarized above or equal to 50% are categorized as better health status and those below 50% are categorized to have a worse health status.34–37

2.5. Independent variables

Our independent sociodemographic variables were; age, gender, marital status and level of education. We also measured weight and height to determine the Body Mass Index (BMI). Glycemic control was determined by extracting results of within past three months of HbA1c from Integrated Patients Management System (IPMS) and defined as good (<7%) and poor (≥7%). We also calculated the average blood pressure in the last 3 visits, and documented the HIV status as recorded either in the
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