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Perspectives on barriers and facilitators to self-care in Lebanese cardiac patients: A qualitative descriptive study

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ABSTRACT

Background: Cardiovascular disease is the leading cause of mortality worldwide. Cardiac self-care practices are essential for managing cardiac illness and improving quality of life. However, these practices may be affected by factors that may hinder or facilitate self-care especially in countries that experience political and economic instabilities.
Objectives: The purpose of this study was to explore self-care practices among Lebanese cardiac patients. Another aim was to reveal factors that might influence these self-care practices.
Design: This is a qualitative descriptive study.
Setting: Participants were recruited from a referral medical center in Beirut, Lebanon and interviews took place in their homes.
Participants: Purposive sample of 15 adult participants, seven females and eight males, diagnosed with coronary artery disease at least a year ago and not in critical condition recruited from the cardiology clinics of the medical center.
Methods: Data were collected through semi-structured audio-recorded interviews that took place in their places of residents.
Results: Three themes emerged from the data: I. The behaviors of cardiac patients demonstrated selected self-care practices; II. Patients identified barriers to self-care reflective of the Lebanese political and socio-economic situation; and, III. Patients described facilitators to self-care consistent with the Lebanese socio-cultural values and norms. The most common self-care practices included taking medications and eating properly. Participants emphasized avoiding stress and being upset as a self-protective measure for cardiac health. Health care costs, family responsibilities, psychological factors and the country's political situation impeded self-care practices whereas family support facilitated them.
Conclusion: Lebanese patients reported select self-care practices in dealing with their cardiac illness. Barriers and facilitators to their self-care behaviors reflected the Lebanese context and culture. Thus health care providers must assess their patients' practices within their sociocultural context so that interventions to promote self-care are tailored accordingly.

What is already known about the topic?

- Self-care is a key component in the management of chronic conditions.
- Patients' personal characteristics and the health care system may influence self-care practices.

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- Socioeconomic status, culture, and political context were less studied as factors that may influence self-care.

What this paper adds

- Family responsibility, healthcare costs, and political conflict and unrest affected self-care practices of cardiac patients.
- Psychosocial factors such as *Za'al* affected cardiac patients actions toward self-care.
- Support from family, mainly wives and children facilitate cardiac self-care.

1. Introduction

Cardiovascular diseases remain the leading cause of mortality worldwide (Ward et al., 2010) and are identified as the primary source of death in most developing countries (Ferrante et al., 2013), thus constituting the main burden of diseases (Dickson et al., 2013). In Lebanon, deaths for all age groups and both sexes from non-communicable diseases account for 85% of total deaths; of those 47% are from cardiovascular diseases (World Health Organization, 2014).

A key element for managing chronic conditions including cardiovascular diseases is self-care (SC) supported by patient and family education (Dickson et al., 2013). Self-care is defined as: "activities that individuals, families, and communities undertake with the intention of enhancing health, preventing disease, limiting illness and restoring health" (WHO, 2011, p. 65–66). Health outcomes are improved when patients take more responsibility for their health behaviors, thus leading to improvement in health-related quality of life (Ludt et al., 2011) and reduction in health care costs (Reeves et al., 2014).

Although SC is a key component in the management of chronic conditions, its implementation is limited by the support provided by the country's chronic disease management programs (Elisson et al., 2013). Hirmas Adauy et al. (2013) reported that the barriers and facilitators to health care access were mainly a reflection of social inequities among countries. Specifically, barriers related mostly to access and acceptability, whereas facilitators reflected personal, social and health service related factors.

In a "Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines, and the American College of Physicians, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons" guidelines for the treatment of stable coronary artery disease (pages e393–e395) made recommendations for patient education and self-care (Fihn et al., 2012). Hence raising patients' SC abilities is a vital goal of health care professionals, and can be achieved by developing effective interventions that are theory based and culturally sensitive (Jang and Hyera, 2012). However, there is a need to explore cardiac patients' perceptions of SC practices in order to design effective interventions tailored to their beliefs. Therefore, this study was designed to explore SC practices among Lebanese cardiac patients and related factors.

Self-care is a dynamic process that occurs each time individuals engage in actions to take care of themselves. Moreover, SC is a learned behavior (Orem, 1985), and so its actions are determined by knowledge and resources. Yet knowledge might not always translate into SC behaviors (Bahjati, 2014). Thus the active role of patients is crucial in acquiring and performing SC activities. Influential factors that might affect SC practices should be addressed, including the socio-cultural context, patients' perceptions and beliefs, their ability for SC behaviors, and the role of the family. For instance, Stewart et al. (2013) maintained that religious faith is vital to patients as a coping mechanism in that the spiritual interaction between patients and God provides them with comfort, increase in their treatment adherence and consequently a better quality of life.

Studies of SC practices and related factors are limited in developing countries specifically in coronary artery disease patients. A study of cardiac patients, family members and health care providers in Iran showed that several cultural factors influenced the success of patient education and health behavior. Those factors were: beliefs of patients and families about disease and treatment; concealment of diagnosis from the patient; ineffective communication; and patients' lifestyle (Farahani et al., 2008). Many studies on factors related to SC were done in the heart failure population as noted in a recent meta-synthesis of investigations of barriers and facilitators to SC in chronic heart failure (Siabani et al., 2013). The authors noted that most of the factors studied related to the symptoms, patients' personal characteristics, and the health care system, but socioeconomic status, culture, and political context were less studied as factors that may influence SC. The authors recommended further research on barriers and facilitators to SC in patients with chronic heart failure so that appropriate intervention strategies are designed to improve SC.

Few studies have considered the cultural influence on SC practices in cardiac patients; however, studies in non-cardiac populations can inform cardiac SC. In Sweden, SC among diabetic men from multicultural origins was found to be influenced by their dissimilar beliefs about health and diabetes, thus the authors recommended considering the cultural background in diabetes care (Hjelm et al., 2005). In Costa Rica and Mexico, denial of the presence of the disease, lack of knowledge about symptoms, vertical communication amid providers and patients, and difficulty in adherence to treatment were identified as barriers to SC in patients with diabetes type 2 and hypertension. The identified facilitators included: family and community support, a relative's positive experience with health care, accessible health care services and health provider's guidance (Fort et al., 2013).

The above accounts of SC are based on non-Arab viewpoints; it is not known how these notions would be interpreted in other cultures like the Lebanese. The Lebanese culture is Arab affected by westernization. In a study exploring perception of SC in a Lebanese sample, it was found that "self-care as a concept is not clear in the culture" and family members were heavily involved in the