



Phenomenological Insights into Rural Patients' Experiences of Nutrition Education in Type 2 Diabetes Management

Chrysentia Clarissa Clorinda ^{1*}, Yanti Krismayanti ²

¹Universitas Padjadjaran, Indonesia

²Universitas Islam Nusantara, Indonesia

chrysentia210011@mail.unpad.ac.id *, krismayanti20051@gmail.com

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ABSTRACT

Type 2 diabetes remains a major global health challenge with cultural and social dimensions, especially in rural communities. While nutrition education programs aim to promote healthier behaviors, little is known about how rural patients interpret and internalize these initiatives. This study addresses the gap in understanding how patients negotiate lifestyle changes and construct meaning around community-based diabetes education in resource-limited settings. Using an interpretative phenomenological approach, data were gathered through semi-structured interviews with rural patients diagnosed with type 2 diabetes. Analysis revealed three key themes: cultural resistance to dietary changes, the dual role of social networks as support and barrier, and the redefinition of health practices as acts of resilience and family care. These findings emphasize that patients' engagement with nutrition education is shaped by cultural identity and social context. The study highlights the need for culturally sensitive, community-grounded strategies that empower patients to translate medical advice into meaningful daily practices.



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INTRODUCTION

Chronic diseases, particularly type 2 diabetes, represent a major global health concern that extends beyond biomedical dimensions and into the daily lives of individuals and communities (Wight et al., 2025). Diabetes is not only a physiological condition but also a social and cultural experience, deeply intertwined with lifestyle, dietary habits, and collective health practices (Mukhlis, 2025a). In many rural settings, traditional beliefs about food, entrenched cultural norms, and limited access to health services shape how individuals perceive and manage their condition (Rodgers et al., 2025). Such dynamics underscore the necessity of examining diabetes as more than a clinical diagnosis, highlighting the relevance of community-based initiatives that attempt to bridge medical guidance with social realities.

The relevance of this phenomenon lies in its profound impact on human experience. Living with diabetes requires continuous negotiation of health behaviors, dietary changes, and engagement with health education programs, which often challenge long-held cultural values and everyday routines (Munch et al., 2025). For individuals in rural communities, the experience is further shaped by social support systems, stigma, and collective identity (Mukhlis, 2025b). The subjective dimension of this journey how patients perceive, resist, adapt, and find meaning in these transitions represents a vital component of understanding health behavior that quantitative measurements alone cannot capture.

Given this context, the exploration of lived experiences becomes essential. A phenomenological approach offers a lens to uncover the meanings embedded in patients' narratives, revealing how individuals make sense of their condition within their cultural and social environments. This perspective allows for deeper insights into the human aspects of diabetes management, which

can inform the design of more contextually responsive health education interventions (Ellicott et al., 2025). Understanding these subjective experiences not only enriches the academic discourse on health education and community health but also provides a foundation for interventions that are culturally sensitive, socially grounded, and meaningful to those most affected.

Research that seeks to understand the lived experiences of individuals in relation to chronic illnesses has increasingly gained prominence in the health sciences (Abou Hashish et al., 2025). Within this domain, phenomenological inquiry has emerged as a valuable approach for exploring the subjective dimensions of illness, particularly in contexts where social, cultural, and personal meanings are central to health behavior (Mukhlis, Suradi, et al., 2023). Studies have demonstrated that patients' interpretations of their conditions often determine the extent to which medical advice is integrated into daily life, especially in chronic diseases such as diabetes where long-term lifestyle modification is required.

Despite its importance, exploring lived experiences presents methodological challenges (Abdul Rahman et al., 2025). Conventional quantitative research has provided significant insights into clinical outcomes such as glycemic control, body mass index, or dietary adherence but these metrics fail to capture the complexity of patients' subjective realities (Mukhlis & Saidah, 2025). Likewise, some qualitative studies remain limited by surface-level descriptions that do not fully engage with the interpretive depth necessary to uncover the essence of experience (Sattar & Yusoff, 2025). The reliance on standardized measures or generalized survey data often constrains understanding, neglecting the nuanced and contextually bound meanings participants attribute to their illness and its management.

These limitations highlight the need for approaches capable of moving beyond numerical indicators or superficial accounts toward a more profound exploration of lived meaning (Rakha & Woudsma, 2025). Interpretative phenomenological analysis, in particular, offers a way to reveal how individuals construct significance from their condition, negotiate cultural and social barriers, and redefine their sense of agency in managing health (Mukhlis & Abdullah, 2025). Such depth is especially crucial in rural communities, where local traditions, social dynamics, and resource constraints profoundly shape the ways patients experience and respond to health education programs (Haxhija & Geliş, 2025). Understanding these dimensions requires a methodology that can bring forward the voices of participants authentically and with sensitivity to their cultural and social environments.

Current strategies for addressing type 2 diabetes in rural communities have primarily emphasized practical solutions such as structured nutrition education programs, dietary guidelines, and community-based health initiatives (Mukhlis, Janwari, et al., 2023). While these approaches have demonstrated measurable effects on clinical outcomes, they remain limited in their ability to capture the subjective dimensions of patients' experiences (Shah et al., 2025). As a result, the understanding of how individuals perceive, internalize, and negotiate the recommended lifestyle changes remains incomplete.

Much of the existing research has relied on quantitative measures or descriptive accounts that offer only surface-level insights into participants' engagement with health interventions (Zhang & Wu, 2025). Such methods often fail to address the cultural, emotional, and social meanings that patients attach to their experiences of living with diabetes in resource-constrained, tradition-bound environments (Dinika, 2025). Consequently, the voices of patients—particularly those navigating the complex intersection of medical advice and cultural practice—are insufficiently represented in the literature.

This limitation creates a significant gap in knowledge. What remains underexplored is the essence of patients' lived experiences, including the ways they make sense of dietary changes, manage cultural resistance, and construct meaning from participation in community health programs (Bonello et al., 2025). Phenomenology offers a methodological pathway to address this gap by uncovering the interpretive layers of experience that traditional methods overlook (Mukhlis et al., 2024). By focusing on lived meaning rather than clinical indicators alone, a phenomenological

approach can provide a more holistic understanding of diabetes management in rural contexts, offering insights that are both academically significant and practically valuable for the design of culturally grounded interventions.

Previous studies have explored the experiences of patients with type 2 diabetes in different cultural and social contexts, highlighting the importance of understanding how individuals interpret and adapt to lifestyle changes (Vellinga-Dings et al., 2025). Research has shown that cultural practices, social support, and stigma strongly influence the way patients engage with health education programs (Jones et al., 2025). Theoretical perspectives in phenomenology emphasize the need to focus on the lived meaning of these experiences, rather than limiting inquiry to clinical outcomes (Mukhlis, Maryam, et al., 2023). Prior methodological approaches, however, often lacked depth in capturing the essence of patients' voices. This creates an opportunity to revisit the phenomenon using a more interpretive lens.

The present study applies an interpretative phenomenological approach to explore the lived experiences of rural patients with type 2 diabetes who participate in community-based nutrition education programs (Kim et al., 2025). This method was chosen because it enables a deeper examination of how individuals negotiate lifestyle adjustments within the boundaries of cultural expectations and social realities (Mukhlis, Arifin, Ridwan, & Zulbaidah, 2025). By adopting phenomenology, the study responds directly to the identified knowledge gap, which calls for a holistic understanding of meaning-making processes in diabetes management (Setiyawati et al., 2025). This approach allows participants' narratives to be central in uncovering new insights. The study, therefore, seeks to enrich both theoretical and practical perspectives in health education.

The structure of this article is designed to guide readers systematically through the study. The introduction provides an overview of the phenomenon and identifies the knowledge gap (Crockett et al., 2025). The methodological section describes the interpretative phenomenological approach, data collection procedures, and analytic steps (Mukhlis, Arifin, Ridwan, Zulbaidah, et al., 2025). The results section presents themes that capture the essence of participants' experiences, supported by narrative accounts and quotations (Briggs et al., 2025). Finally, the discussion and conclusion interpret these findings in relation to existing literature and highlight their contributions to theory and practice.

RESEARCH METHODS

Study Design

This study employed a phenomenological design with an interpretative orientation, which emphasizes the exploration of subjective lived experiences and the meanings participants assign to them. Phenomenology was chosen as the most appropriate approach because it provides a structured means of uncovering the essence of experiences related to community-based nutrition education for individuals with type 2 diabetes in rural areas. The interpretative phenomenological approach was specifically applied to capture not only descriptions of experiences but also the deeper layers of meaning that emerge from participants' narratives. This design allowed for an in-depth understanding of how participants negotiated lifestyle changes, confronted cultural challenges, and constructed meaning from their participation in the program.

Participants

Participants consisted of adults diagnosed with type 2 diabetes who had been actively involved in community-based nutrition education programs in rural settings. A purposive sampling strategy was applied to ensure that those included possessed direct and relevant experience with the phenomenon under study. Inclusion criteria required participants to be at least 18 years of age, formally diagnosed with type 2 diabetes, and actively engaged in the community health education program for a minimum of three months. Individuals with cognitive impairments or conditions that prevented them from providing informed accounts of their experiences were excluded. The sample included both male and female participants, with ages ranging from early adulthood to late adulthood, reflecting the diverse demographic composition of the rural communities.

Data Collection

Data were collected through semi-structured, in-depth interviews guided by an interview protocol developed to elicit detailed personal accounts of participants' experiences. Interviews were conducted face-to-face in community health centers or in participants' homes, depending on their preference, to ensure comfort and confidentiality. Each interview lasted between 45 and 90 minutes and was audio-recorded with permission. Open-ended questions encouraged participants to reflect on their perceptions, feelings, and challenges regarding lifestyle adjustments and community engagement. Observational notes were also recorded to capture contextual details that complemented verbal accounts. The interview guide was informed by previous phenomenological research in health education but adapted to the specific cultural and community context of this study.

Data Analysis

Data were analyzed using interpretative phenomenological analysis (IPA), which involves a systematic process of identifying themes that capture the essence of participants' lived experiences. Interview transcripts were first read repeatedly to achieve immersion in the data. Meaning units were then identified and coded, with codes subsequently grouped into emergent themes that reflected shared experiences. Thematic clustering was employed to develop superordinate themes that represented the underlying structures of meaning across participants. Throughout this process, reflexivity and sensitivity to context were maintained to preserve the authenticity of participants' voices. Qualitative data analysis software (NVivo) was utilized to support the organization and retrieval of data during coding but was not central to the interpretive process.

RESULTS

Negotiating Change Amid Cultural Resistance

This theme captures participants' struggles in reconciling biomedical recommendations with culturally embedded dietary practices. A systematic analysis revealed three recurrent patterns: (1) the symbolic value of rice as a staple and identity marker, (2) the emotional resistance to altering long-standing habits, and (3) the perceived conflict between health advice and familial expectations.

Many participants described the difficulty of adjusting their dietary habits due to deeply ingrained cultural practices. Rice consumption, in particular, was repeatedly mentioned as central to their sense of identity and daily energy needs. Attempts to modify these habits were perceived as conflicting with cultural norms and family traditions.

"I have eaten rice three times a day since childhood. When the nurse told me to reduce it, I felt like I would have no strength. It's not easy to change what has always been part of my life." (Participant 3)

Collectively, these accounts highlight a pattern of cultural resistance intertwined with emotional attachment, suggesting that educational interventions must integrate cultural symbolism into behavior change strategies.

The Role of Social Support and Community Belonging

Systematic coding identified two subthemes: (a) supportive social influence that reinforces adherence, and (b) social discouragement that undermines motivation.

Participants emphasized the significance of social networks, including family members, neighbors, and community health workers, in motivating them to adhere to nutritional advice. In some cases, family encouragement facilitated dietary adjustments, while in others, lack of support or even ridicule from peers hindered their efforts.

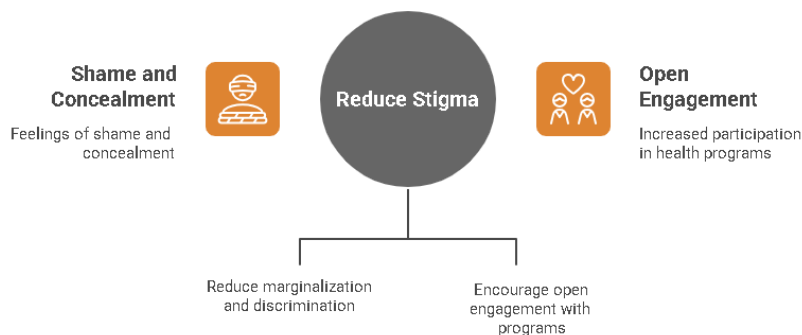
"When my daughter cooks with less oil and sugar, I feel supported. But my friends often laugh, saying my food is tasteless. That makes it hard to continue." (Participant 7)

These contrasting experiences underscore the dual function of social interactions—as both enablers and barriers to behavioral change—reflecting how belonging to a community simultaneously provides motivation and social pressure.

Stigma and Feelings of Isolation

This theme emerged from participants’ shared expressions of shame and concealment, categorized into two analytical dimensions: (1) social stigma that reinforces marginalization, and (2) self-stigma that limits open engagement with health programs.

Overcoming Stigma in Health Programs



Some participants disclosed feelings of shame or stigma related to their condition, particularly when dietary practices set them apart from others in the community. Attending health programs sometimes intensified their awareness of difference, leading to reluctance in openly discussing their condition.

“People in the village think I am weak because I don’t eat like them anymore. Sometimes I hide my food choices so they won’t notice.” (Participant 4)

These insights reveal that stigma functions as a social barrier to participation and an internal constraint on self-efficacy, reducing patients’ willingness to sustain long-term behavior change.

Discovering Meaning and Personal Agency

The final theme reflects participants’ transformative learning processes, characterized by (1) recognition of positive outcomes, (2) redefinition of self through resilience, and (3) internalization of motivation linked to family well-being.

Despite challenges, participants reported moments of empowerment when they experienced tangible improvements in health outcomes or when they were able to reinterpret their struggles as steps toward resilience. These experiences fostered a renewed sense of agency and purpose in managing diabetes.

“At first, I felt forced to follow the program. But now, when I see my blood sugar is better, I realize I am not only doing this for myself but also for my family’s future.” (Participant 2)

Through iterative interpretation, this theme illustrates how agency evolves from compliance to self-determination, showing that community-based education can serve as a catalyst for sustained empowerment.

DISCUSSION

This study revealed that patients with type 2 diabetes in rural communities experienced diabetes management as a complex negotiation shaped by cultural traditions, social dynamics, stigma, and emerging personal agency (Warmoth et al., 2025). These findings address the central research question by highlighting the meanings patients construct while participating in community-based nutrition education programs.

Contribution of Findings to the Research Question

The results demonstrate that the lived experiences of participants go beyond simple behavioral compliance with dietary advice. Instead, patients actively interpret and reconstruct health practices in light of their cultural identities and social interactions. The discovery of cultural resistance to dietary changes, the ambivalent role of social support, and the presence of stigma illuminate the barriers that often prevent sustained lifestyle modifications (Hansen, 2025). At the same time, the emergence of personal agency shows that patients can find empowering meanings within the process, transforming prescribed health practices into purposeful acts tied to family well-being and community belonging (Sarma & Hu, 2025). This phenomenological contribution offers a nuanced understanding that clinical metrics alone cannot capture, thereby directly responding to the knowledge gap identified in the introduction.

Relationship with Previous Literature and Theory

The findings align with earlier studies that emphasized the influence of cultural and social contexts on diabetes self-management (Hanshaw, 2025). Similar to Alrahbi (2020), the present study shows that cultural values can significantly affect patients' ability to integrate new dietary practices into daily life. However, this study extends prior research by illustrating how stigma and social pressure can simultaneously hinder and reshape the meaning of dietary adherence, a dimension less explored in rural contexts. The emergence of personal agency resonates with interpretative phenomenological theory, which suggests that individuals are not passive recipients of health instructions but active meaning-makers who embed their choices within broader cultural and relational frameworks (Almeida et al., 2025). By situating these findings within phenomenological theory, the study highlights how health education programs must move beyond standardized messages and engage with the interpretive worlds of patients.

Implications of the Findings

The findings of this study carry significant implications for health education and community health practice. The cultural resistance observed among participants demonstrates that dietary recommendations cannot be divorced from the cultural meanings attached to food. Programs that fail to consider these deeply rooted traditions risk alienating patients rather than supporting them. Moreover, the ambivalent role of social support suggests that interventions must address both positive reinforcement and potential social barriers that arise in community contexts (Anderson et al., 2025). By highlighting the transformative role of personal agency, the study suggests that education programs should not only provide information but also foster environments in which patients can reinterpret health practices as meaningful acts aligned with their values and family commitments (Sin et al., 2025). These implications extend beyond the immediate context of rural diabetes care, pointing to broader applications in designing culturally sensitive and socially grounded health education initiatives.

Limitations of the Study

Several limitations must be acknowledged when interpreting the findings. The use of purposive sampling in a specific rural context may limit the extent to which the results can be transferred to other populations or urban settings. While the interpretative phenomenological approach provided depth, the focus on a relatively small number of participants means that the study cannot claim broad generalizability (Barry & Shahbaz, 2025). Additionally, the reliance on self-reported narratives introduces the possibility of recall bias or selective disclosure. These limitations are consistent with phenomenological inquiry, which prioritizes depth over breadth, but they nonetheless highlight areas where future research may expand or triangulate findings with complementary methods.

Prospective Directions for Future Research

The study opens several avenues for further inquiry into the lived experiences of patients managing chronic illness within cultural and community contexts (Maldonado et al., 2025). Future research could explore how community health workers and family members experience their roles in supporting patients, offering a more holistic picture of the social networks involved in health behavior change. Comparative studies between rural and urban populations may also reveal important

differences in cultural negotiation and social dynamics (Du Toit, 2025). Furthermore, integrating phenomenological findings with participatory approaches could inform the co-design of health education programs that are more responsive to local traditions and patient perspectives (Rodela et al., 2025). Such research would deepen theoretical understanding and enhance the practical relevance of health education interventions across diverse settings.

CONCLUSION

This study examined how rural patients with type 2 diabetes experience and interpret community-based nutrition education, revealing that cultural resistance, social ambivalence, stigma, and emerging personal agency shape their engagement with lifestyle change. Beyond reiterating descriptive patterns, these findings contribute to broader theoretical discussions on health behavior as a culturally mediated process of meaning-making rather than a purely biomedical adjustment. Theoretically, the study advances phenomenological understandings of chronic illness by emphasizing agency as a dynamic construct formed through social interaction and cultural negotiation. This extends existing models of health literacy and self-management, positioning them within the lived realities of marginalized communities.

From a policy perspective, the findings underscore the need for integrated health education frameworks that bridge clinical objectives with sociocultural realities. Policymakers and practitioners should incorporate participatory and context-sensitive approaches that engage local traditions, family systems, and community actors as co-educators rather than passive recipients. Future research should test the transferability of these insights across different cultural settings and explore hybrid models that combine phenomenological inquiry with community-based participatory methodologies. Such approaches can inform more inclusive, culturally resonant public health strategies capable of sustaining long-term behavioral change in resource-limited contexts.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest regarding the publication of this article.

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