

Understanding Treatment Gaps in Type 2 Diabetes: A Qualitative Study on Why Patients Stop and Restart Care

Afreen Jabin^{1,2}, Alex Guthrie^{1*}

¹Usher Institute, Medical School, University of Edinburgh, Edinburgh, UK.

²University of St Andrews North Haugh, St Andrews, UK.

*E-mail ✉ afreenjabin542@gmail.com

Abstract

Treatment interruptions and resumptions are common among individuals with type 2 diabetes mellitus (T2D); however, the factors that trigger resumption based on the reasons for interruption are not well understood. This study explored the patterns underlying treatment interruption and subsequent resumption. Semi-structured interviews were conducted with 13 T2D patients who had previously interrupted treatment. Their narratives were analyzed to identify recurring themes and patterns. Four distinct patterns emerged: Economic rationality – Financial constraints led to treatment interruption, while resumption occurred through affordable check-ups and patients' revised strategies for managing medical expenses within limited household budgets; Proactive information seeking – Doubts about treatment efficacy prompted interruptions, which were followed by resumption through patients' active reassessment of health risks and self-directed information gathering; Health professional–patient relationship – Conflicts with healthcare providers caused interruptions, but trust-building encounters encouraged patients to resume treatment; Sustained community health partnerships – Personal challenges led to treatment gaps, yet supportive, non-coercive relationships with community health professionals promoted resumption through reinforced patient commitment. These findings underscore the importance of personalized medical support and the development of local policies that account for patients' subjective experiences of treatment interruption and resumption. Understanding these patterns can inform resource allocation and enhance community-based diabetes care interventions.

Keywords: Treatment cessation, Patient dropouts, Commitment, Thematic analysis, Public health nurse, Secondary prevention

Introduction

Diabetes affects around 540 million people worldwide, with type 2 diabetes mellitus (T2D) accounting for about 90% of cases [1]. T2D can reduce physical functioning, lower quality of life, increase mortality, and raise healthcare costs [2-4]. By 2050, it is estimated that 9.5% of the global population will have T2D [5]. Managing blood sugar continuously is essential to prevent T2D from worsening. Interrupting treatment can

lead to serious consequences. Studies show that stopping treatment raises HbA1C levels [6], which increases the risk of complications like heart disease, nerve damage, eye and kidney problems [7], and life-threatening events such as stroke or heart attack [8]. Treatment gaps are also linked to weaker physical function [9], emotional distress from low confidence in managing the disease [10], and social isolation [11]. Economically, interruptions can result in more hospital visits and lower work productivity [6, 12].

Factors that help patients stick to treatment include good health knowledge [13], accepting the disease [14], trusting doctors [15], and seeing long-term value in treatment [16]. On the other hand, nonadherence often comes from financial problems [17], complicated treatment plans [18], or distance from clinics [19]. Even when patients stop treatment temporarily, many return to care. Resumption can happen when patients

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notice their health worsening [20] or receive encouragement from healthcare providers, family, or friends [21].

Despite this, little is known about how the reasons for stopping treatment influence the reasons for restarting it. Studying these patterns could reveal critical turning points in patients' lives that encourage them to resume treatment. This knowledge could guide healthcare support and help develop programs tailored to T2D patients.

This study aimed to explore why patients with T2D stop and later restart treatment using qualitative methods.

Materials and Methods

Study setting and participants

This cross-sectional study used data aligned with previous research [16, 22]. In 2018, 110 people aged 40 or older were identified in Koriyama City, Fukushima, Japan. At that time, the city had 329,903 residents, with 28.2% aged 65 or older, similar to Japan's national average of 28.9%. Participants were selected proportionally from different areas and all had a T2D diagnosis in the Fukushima National Health Insurance database.

Four people were excluded because their self-reports conflicted with medical records or their T2D diagnosis was unclear. Among the remaining 106, 89 continued treatment without interruption. The final analysis focused on 13 patients who had stopped treatment at some point but later resumed it.

This study relied on patients' own accounts of stopping and resuming treatment. Some may have received medications but not taken them; these cases would appear as continuous treatment in records but were considered interruptions for this study.

Procedure and measurement

Between October and November 2018, public health nurses from Koriyama City Health Centre conducted one-on-one interviews with participants at locations chosen by the participants. Before starting the interviews, the first author, an expert in qualitative psychology research, trained the nurses on interview techniques and refined the questions. The interviews followed a guide developed by the first author and were supervised by the fifth and sixth authors, both medical doctors specializing in diabetes care.

The semi-structured interviews focused on confirming each participant's history of treatment interruption and resumption. Key questions included: "When were you first diagnosed with diabetes?"; "Can you describe the circumstances of your diagnosis?"; "How did you feel at diagnosis?"; "Have you ever gone six months or more without visiting a hospital or taking medication for diabetes?"; and "What led you to stop and then restart treatment?" Follow-up questions were asked to clarify reasons, such as "If reason X had not occurred, what might have happened?" or "Was this the main factor?" This approach helped reveal participants' thought processes and narratives leading to treatment resumption. Participants also reported the duration of interruption, time since resuming treatment, current treatment type, and recent blood sugar levels. Consistent with prior research [23-25], a period of six months without medication or hospital visits was defined as treatment interruption. Each participant was interviewed once, with interviews averaging 29.4 minutes. All sessions were recorded with permission, transcribed verbatim by a professional, and analyzed by the authors.

Qualitative analysis

Before coding, transcripts were read thoroughly to identify four key domains along a time course: "T2D diagnosis", "initial reactions to diagnosis", "reasons for treatment interruption", and "reasons for treatment resumption". In cases where the narrative structure was unclear, the surrounding dialogue or the full interview flow was reviewed. Sometimes participants recalled relevant experiences later in the conversation rather than immediately, making this approach essential for nuanced analysis.

Transcripts were coded inductively using hybrid thematic analysis [26]. Statements with similar meanings were grouped into broader themes. For example, repeated expressions such as "I have no money", "I only have my pension", and "I'm struggling financially" were categorized under economic barriers, representing reasons for treatment interruption.

Next, participants' reasons for stopping and restarting treatment were combined to identify patterns. Four main patterns emerged: economic rationality, proactive information seeking, health professional-patient relationships, and sustained partnerships with community health professionals.

To validate the patterns, narratives were examined within their social and cultural contexts. For instance, the

economic rationality pattern reflected difficulties in affording care due to reliance on pensions after retirement, a common feature of Japan's labor system [27]. Changes in employment and reduced income before retirement contributed to interruptions in treatment. Other patterns were similarly contextualized to ensure their relevance and accuracy within participants' life experiences.

Trustworthiness, validity, and reliability

To strengthen the trustworthiness and reliability of this qualitative study, we used peer debriefing. An experienced qualitative researcher from the same department as the first author, but not directly involved in the study, reviewed the methodology, transcripts, and findings. This process helped identify vague statements, potential bias, over- or underemphasis, and readability issues. Involving external researchers was ethically challenging, so this internal peer review minimized conflicts of interest while maintaining rigor.

We also created an audit trail to document the research process transparently, particularly the analytical steps. The audit trail followed Carcary's structured approach [28], covering both physical and intellectual dimensions. The physical audit trail included: research problem identification, proposal development, literature review, framework definition, sample selection, data collection, data management and analysis, and artifact creation. The intellectual audit trail included: clarification of philosophical stance, consideration of alternative approaches to data collection and analysis, and interpretation of evidence.

All qualitative analysis was performed manually using Microsoft Excel (2019 MSO, version 16.0).

Saturation

Saturation was assessed using the concept of information power [29], which considers study aim, sample specificity, theory use, quality of dialogue, and analysis strategy to determine adequacy of sample size. Our study aimed to explore the combined reasons for treatment interruption and resumption, representing a relatively narrow focus. Sample specificity was high because only a small proportion (~10%) of T2D patients experience treatment interruptions [30]. No pre-existing theory guided our analysis, reflecting an exploratory approach. The dialogue quality was strong, as interviews were conducted in private settings by trained public health nurses with established patient trust. Finally, the analysis strategy focused on in-depth, case-oriented exploration rather than cross-case comparison.

Considering these factors, a small sample of 13 participants was sufficient to achieve meaningful insights. No further recruitment was necessary.

Ethical considerations

This study was approved by the Ethics Committee of Fukushima Medical University (Application No. 30196). All procedures followed the Helsinki Declaration (1964) and subsequent amendments. Participants provided written informed consent for participation and publication.

Results and Discussion

Table 1 summarizes participant characteristics. The study included 11 men and 2 women. The median age at the time of the interview was 68 years (IQR: 66–70), while the median age at T2D diagnosis was 51 years (IQR: 50–60), with a median disease duration of 15 years (IQR: 10–20).

Table 1. Interviewee profiles

Participant	Gender	Age at Interview/Diagnosis (years)	Condition Duration (years)	Longest Treatment Break	Treatment Resumption	Treatment Approach	Blood Glucose Levels
A	Male	70/50	20	17 years	3 years ago	Oral drugs	100–150 mg/dL
B	Female	59/57	2	6 months	1 year ago	Oral drugs, diet, exercise	6.0 mmol/L
C	Male	60/50	10	Unknown	Several years ago	Oral drugs	6.1 mmol/L
D	Female	70/60	10	Several years	3–4 years ago	Oral drugs	6.0 mmol/L
E	Male	71/60	11	1.5 years	1 year ago	Oral drugs, diet, exercise	7.7 mmol/L
F	Male	68/51	17	Several years	Several years ago	Oral drugs, diet	5.8 mmol/L

G	Male	66/52	14	1 year	1 year ago	Oral drugs, diet, exercise	Normal
H	Male	63/33	30	13 years	17 years ago	Oral drugs, diet	6.7 mmol/L
I	Male	68/66	2	2 years	This year	Oral drugs, diet	100–180 mg/dL
J	Male	69/67	2	6 months	6 months ago	Oral drugs, exercise	7.0 mmol/L
K	Male	68/50	18	14 years	4 years ago	Oral drugs	<5.6 mmol/L
L	Male	71/51	20	Several years	Several years ago	Oral drugs	130 mg/dL
M	Male	68/48	20	19 years	1 year ago	Oral drugs, diet	6.5 mmol/L

Age at diagnosis, disease duration as at time of interview, maximum duration of treatment interruption, and timing of treatment restart were estimated from the interviewees' reports.

^aThe blood sugar levels were approximate values based on patient self-reports, and unless otherwise noted, they were measured by HbA1C.

^bThe blood sugar levels were measured by fasting blood sugar.

^cThe patient forgot the exact value but reported that their blood sugar level was within the normal range.

Qualitative analysis results

The participants' narratives were systematically analyzed and gradually condensed. For the domain "diagnosis of T2D", the initial 13 labels were summarized into 3 overarching themes. Similarly, "responses at diagnosis" were reduced from 13 labels to 4 themes. The domains "reasons for interrupting treatment" and "reasons for resuming treatment" were each condensed from 13 labels to 4 themes.

In **Table 2**, the "reasons for interrupting treatment" and "reasons for resuming treatment" domains reflect participants' subjective explanations of the circumstances, conditions, or factors that influenced their treatment behaviors.

The combined patterns linking reasons for treatment interruption and resumption are presented in **Table 3**, illustrating how different factors interacted to shape patients' decisions to stop and later restart treatment.

Table 2. Theme by domain and explanation

Domain	Theme	Explanation
Reasons for interrupting treatment	Economic barriers	Difficulties in paying for medical expenses due to financial reasons such as having only a pension or losing a job.
	Doubts on the effectiveness of the treatment	The lack of areal sense of the impact of taking medication or different therapies on improving T2D, or excessive belief in the benefits of unconventional (non-standard) therapies including supplements.
	Conflict with healthcare professionals	Dissonance in the relationship with the healthcare professionals, resulting from experiences such as being accused of skipping hospital visits or being distracted from treatment due to the professional's excessively permissive nature.
	Hassles, laziness, and busy schedules	Abandoning regular hospital visits due to personal such as atendency to avoid hassles and laziness, as well as abusy work schedule.
Reasons for resuming treatment	Low-cost/free health check-up and review of healthcare cost	Rethinking the importance of T2D management and the household financial allocation of medical costs triggered by providing low-cost or free health screening opportunities that compensate for economic deprivation.
	Active opportunity to objectively assess the health crisis related to T2D	Awareness of the T2D condition at acritical level, based on the patient's initiative to understand the significance of the objective test results.
	Health professional-patient relationships that create adesire to seek care	Encountering ahealthcare professional, such as adoctor, who encourages the patient and brings asense of security and hope.

Respectful healthcare advice within asustained partnership	Relationships with healthcare professionals who are enthusiastic reassure the patient about the need for treatment and increase the patient's commitment to treatment.
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Table 3. Patterns of reasons for treatment interruption and resumption with narrative examples

Pattern	Cause of Treatment Pause	Trigger for Treatment Restart	Participants	Narrative Examples
Financial Decision-Making	Financial Limitations	Access to Affordable or Free Health Screenings	A, B	Pause: "My pension is quite limited, so financial issues affected my treatment. There was a time I couldn't afford hospital visits for nearly a month." (Participant A) Restart: "I received a notice from Koriyama City's Public Health Centre about a free health screening. Since it was free, I decided to attend. The check-up showed my blood sugar levels had risen significantly, making me realize I urgently needed treatment. I'm still tight on money, but I've reorganized my budget to prioritize my health." (Participant A)
Self-Directed Health Research	Uncertainty About Treatment Benefits	Proactive Recognition of T2D Health Crisis	C, D, E, F	Pause: "I stopped hospital treatment after finding a supplement touted as effective for diabetes. It seemed to improve my condition daily, so I thought hospital visits and expensive medications weren't necessary." (Participant E) Restart: "Regular check-ups kept me informed about my blood sugar levels; my HbA1c was in double digits. I read an online article warning, 'You won't live past 70,' backed by solid medical evidence. This made me realize the severity of my condition, so I booked a hospital appointment and resumed treatment." (Participant E)
Provider-Patient Dynamics	Tensions with Healthcare Providers	Supportive Relationships with Healthcare Professionals	G, H	Pause: "I struggled with mobility due to back pain, which disrupted my diabetes treatment. When my back improved and I visited the doctor, they scolded me for missing appointments, which made me uncomfortable. I stopped going to the hospital after that." (Participant G) Restart: "I had stopped visiting a large hospital for reasons I mentioned. Later, when I visited a new clinic for another issue, I also resumed my diabetes care. My current doctor is supportive and motivates me to stay committed to my treatment." (Participant G)
Ongoing Community Health Support	Personal Inconvenience and Time Constraints	Collaborative Guidance from Community Health Professionals	I, J, K, L, M	Pause: "When I was diagnosed with T2D, my work schedule was overwhelming. I knew I should've kept up with hospital visits, but I lacked the time and, honestly, the motivation to make the effort." (Participant K) Restart: "Ms. X, a public health nurse, persistently encouraged me to return to the hospital. After several invitations, I finally agreed to go. Keeping my promise, I attended my appointments and restarted treatment." (Participant K)

Notes:

- The column headers were rephrased for clarity (e.g., "Reason for interruption" to "Cause of Treatment Pause").
- Patterns were reworded to reflect intent (e.g., "Economic rationality" to "Financial Decision-Making").
- Narrative examples were paraphrased to maintain meaning while improving flow and readability, preserving the original quotes' essence.
- The term "T2D" was retained for specificity, and minor grammatical adjustments were made for consistency.

The “economic rationality” pattern

This group included people who had stopped their treatment because they couldn't afford it. However, when they were offered free or very cheap health check-ups, they decided to attend. The results often showed their condition had worsened, which pushed them to restart treatment. Afterward, they tried to manage medical expenses by adjusting their household budgets.

Example:

"Koriyama City sent me a notice about a free check-up, so I thought, why not go? The test showed my blood sugar was worse than before, and that scared me. Even though I'm still short on money, I've started reviewing how I spend at home so I can stay on treatment." (Interviewee A, 9th November 2018)

The “proactive information seeking” pattern

Participants in this category quit treatment because they doubted its value, questioning the need for regular hospital visits and medication. What led them back was facing clear, objective evidence about the risks of type 2 diabetes, often from online sources.

Example:

"My health check-ups always showed high blood sugar, and my HbA1c was in the double digits. Out of worry, I looked up the risks online and found an article saying, 'You won't live to be 70.' Since it included medical data, it hit me hard. I knew I was in real danger, so I booked an appointment and returned to treatment." (Interviewee E, 31st October 2018)

The “health professional–patient relationship” pattern

Here, the decision to continue treatment was strongly tied to the quality of interactions with healthcare providers. Some patients stopped care after feeling blamed or misunderstood by doctors. Later, meeting a supportive and encouraging professional gave them the motivation to restart.

Example:

"I used to visit a large hospital but quit because of the issues I had there. Eventually, I went to another clinic for a different problem and restarted my diabetes care as well. The doctor I see now is understanding and motivating, which makes me determined to stick with treatment." (Interviewee G, 7th November 2018)

The “sustained partnership with community health professionals” pattern

This pattern was seen in people who had put treatment on hold because of personal habits or busy lives. Persistent yet gentle encouragement from community nurses or health workers helped them feel accountable, and this pushed them back into care.

Example:

"Ms. X, a public health nurse, kept urging me to return to the hospital. She asked me several times, and eventually I promised her I'd go. Keeping that promise got me back into the hospital and back on treatment." (Interviewee K, 24th October 2018)

This study set out to examine the combined reasons why individuals with type 2 diabetes (T2D) interrupt and later resume treatment, using a qualitative approach. Four main patterns were identified. In the *economic rationality* pattern, patients restarted treatment after attending free or low-cost check-ups, which encouraged them to reconsider their household budgets despite earlier financial barriers. In the *proactive information seeking* pattern, individuals returned to treatment after confronting objective evidence about their condition, having initially quit because they doubted the effectiveness of standard care. The *health professional–patient relationship* pattern showed that resumption often followed encounters with supportive healthcare providers, whereas interruptions stemmed from conflicts or distrust. Finally, the *sustained partnership with community health professionals* pattern demonstrated that continuous, non-coercive encouragement from local health workers helped patients re-engage with care after stopping for personal or lifestyle-related reasons. Together, these findings provide insights for community-level health support and resource allocation for people with T2D.

Detailed discussion of patterns and comparison with previous studies

The *economic rationality* pattern emphasized that financial constraints, particularly the cost of medical care, were a major factor behind treatment discontinuation. This aligns with earlier research on T2D treatment gaps [17]. However, our findings extend the discussion by showing that free or affordable health check-ups can act as a critical trigger for patients to re-engage with care. As seen in interviewee A's case, such opportunities pushed patients to think more practically about funding their treatment through household budget adjustments. Previous work has shown that these check-

ups improve self-management and overall health outcomes [31, 32]. Our results suggest that the mechanism may lie in a shift in mindset—patients begin to prioritize treatment financially after confronting their health status. Beyond expanding access to free or low-cost check-ups, providing tailored advice on household financial planning for diabetes management may further reduce treatment dropouts linked to economic hardship. Local governments could incorporate such support into their public health programs.

The *proactive information seeking* pattern revealed that doubts about treatment effectiveness, often coupled with reliance on alternative products such as supplements, led some patients to stop therapy. This finding echoes past research that connected perceptions of ineffectiveness with treatment interruption [14, 33]. What our results add is a clearer picture of what kind of information encourages treatment resumption. Interviewee E's narrative illustrates how exposure to objective, personalized risk information—such as life expectancy tied to blood sugar levels—can prompt patients to return to care. While family members often play a role in supporting treatment adherence [34, 35], conversations about life-threatening risks may be too sensitive for relatives to address directly. In contrast, the internet has become a widely used tool for patients to learn about blood sugar management, complications, and the underlying biology of diabetes [36]. It also offers a space for confronting difficult topics like death. However, the challenge is that unreliable or misleading diabetes information is also common online [37-39]. To counter this, local governments and public health agencies should strengthen their role as trusted sources of evidence-based information.

The *health professional–patient relationship* pattern highlighted the importance of the quality of interactions between patients and healthcare providers. Treatment was often interrupted when patients felt criticized, distrusted, or unfairly judged, as in the case of interviewee G, who stopped attending after being accused of non-adherence. Meeting a new, supportive doctor later helped him resume treatment. Previous research has already shown that a trusting relationship with providers supports continuous engagement with care [15]. Our findings add that trust and encouragement are equally crucial for patients who are re-entering care after a break. Positive communication not only builds a sense of safety and hope but also plays a direct role in motivating patients to resume treatment [40]. For this

reason, healthcare professionals should avoid blame and instead focus on encouragement, especially when working with patients who have a history of treatment interruption.

The “sustained partnership with community health professionals” pattern

This pattern illustrates how ongoing, supportive relationships with community health workers can encourage patients to restart treatment, while individual traits and lifestyle demands often act as barriers. Interviewee K's case showed that encouragement from a public health nurse—delivered with persistence but without pressure—was key in motivating a return to care. Notably, the patient described how his decision to go back to the hospital was tied to a promise he had made to the nurse. This reflects the concept of *commitment* in behavioural economics, where individuals strive to remain consistent with prior commitments [41, 42]. Such mechanisms appear to play an important role in resuming treatment. Previous research has shown that community-based health professionals, including public health nurses, improve patients' knowledge, physical outcomes, and self-care behaviours in T2D [43]. Beyond these well-documented benefits, our findings suggest they also foster a sense of accountability that supports treatment resumption. For instance, scheduling appointments together may create a shared commitment, strengthening patients' resolve to attend. While commitment is ultimately an internal process, its activation can be externally facilitated through long-term supportive partnerships with healthcare providers.

Strengths of the present study

This study offers new insights into the psychological mechanisms underlying treatment resumption. Unlike earlier research, which has often provided surface-level descriptions, our qualitative approach enabled a deeper exploration of patients' subjective perspectives and the interplay of factors driving both interruption and re-engagement.

A key challenge in studying these behaviours is *social desirability bias*, where respondents tend to underreport behaviours perceived as negative [44]. In this context, individuals with T2D may avoid admitting to past treatment interruptions, leading to underestimation of how widespread this issue is. Such underreporting can blur the true impact of policies designed to enhance treatment continuity. For example, interventions like free

or low-cost health check-ups (*economic rationality* pattern) or supportive community health partnerships (*sustained partnership* pattern) represent effective forms of secondary prevention, focusing on early detection and timely intervention. However, their success may be overlooked if the prevalence of treatment interruption is underestimated.

By providing detailed accounts of individuals who stopped and later resumed treatment, this study contributes foundational evidence for tailoring community-level diabetes policies and allocating healthcare resources more effectively. Moreover, the representativeness of our sample strengthens the transferability of findings: characteristics such as mean age and disease duration closely align with national statistics for Japanese patients with T2D [45], underscoring the broader applicability of our results.

Limitations and directions for future research

This study has several limitations that should be acknowledged. First, the sample size was small, with only 13 interviewees, which limits the generalizability of the findings. Future research may reveal additional patterns of treatment interruption and resumption among people with T2D that were not captured here. The limited number of participants also indicates a lack of data saturation, which is an inherent weakness of this study.

Second, our participants were exclusively individuals who had already resumed treatment following an interruption. Patients who remained disengaged from care were not included. To fully understand the determinants of treatment resumption, future studies should adopt a comparative design that incorporates both groups. While our focus was on providing descriptive, qualitative insights into the experiences of those who returned to treatment, building on these findings will require broader comparative approaches.

Third, the mechanisms underlying the four identified patterns remain only partially understood. For example, within the *economic rationality* pattern, it is not yet clear which factors—such as financial support, cost-benefit thinking, or budgeting strategies—play the most decisive role in restarting treatment. Similar questions remain for the *proactive information seeking*, *health professional–patient relationship*, and *sustained partnership with community health professionals* patterns. In addition, contextual influences such as healthcare system characteristics, socio-economic status, and cultural factors should be examined, as they are likely to shape

how treatment interruption and resumption unfold. Future research that integrates these contextual dimensions could generate more comprehensive strategies for supporting patients with T2D.

Conclusion

This study identified four distinct pathways through which patients with T2D interrupted and later resumed treatment.

- In the *economic rationality* pattern, low-cost or free health check-ups acted as a turning point, prompting patients with financial difficulties to reconsider their household budgets and prioritize medical expenses.
- In the *proactive information seeking* pattern, exposure to concrete, often life-threatening information (e.g., shortened life expectancy) motivated patients who actively searched for health information to return to treatment. Since family members may hesitate to deliver such sensitive information, public institutions should ensure accurate and accessible information is available through reliable channels, including the internet.
- The *health professional–patient relationship* pattern demonstrated that supportive and encouraging communication can help patients resume treatment after a period of interruption, not only sustain continuous engagement as earlier studies have shown. Positive interactions with health professionals appear to provide reassurance and hope, encouraging treatment re-engagement.
- The *sustained partnership with community health professionals* pattern emphasized the role of public health nurses in fostering patient commitment. Gentle but persistent encouragement, such as assisting with hospital appointment scheduling, can strengthen patients' sense of accountability and support autonomous treatment resumption.

Overall, these findings deepen understanding of the psychological and behavioural processes that shape the transition from interruption to resumption of treatment in T2D. The evidence contributes to strategies for enhancing adherence, improving quality of life, and reducing healthcare costs by informing healthcare professionals and policymakers about effective, community-level interventions. The use of qualitative methods allowed us to capture the often-overlooked experiences of patients who interrupt treatment, offering a valuable perspective for future policy and practice.

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