Implementing diabetes courses for Arabic speaking citizens in municipal health care centres: A qualitative study of health education ideals and practices

Sundhedsfremme, Magt og Velfærd

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Disposition

1. PhD focus areas
2. Context
3. Method and setting
4. Findings: ideals and practice
5. Summary of findings and concluding remarks
1 The PhD project

Three focus areas

1. What are the health education ideals and practices of health care professionals conducting diabetes courses for Arabic speaking citizens in municipal health care centres?

2. How do Arabic speaking citizens experience and translate diabetes courses in municipal health care centres?

1. How do Arabic speaking minorities experience and manage type 2 diabetes as part of daily practice?
2 Context

- Type 2 diabetes growing globally and in Denmark
- Ethnic minorities particularly vulnerable:
  - Up to 7 times higher prevalence
  - More frequent use of hospital and GP – taking less medicine
  - Challenged socially, structurally, culturally, language wise

- Limited health education interventions targeted at ethnic minorities
- Municipalities: new arena for such initiatives since municipal reform
- Limited documentation of how these operationalized including health pedagogical approach
3 Methods and setting

- Qualitative, explorative study
- Collective case study: Nørrebro, Vollsmose, Århus Vest health care centres
- Participant observation of diabetes classes in Arabic (19) and Danish (1) and in introductory interviews (4)
- Interviews with heads (5) and health care professionals (9)

The first health care centres to undertake diabetes courses targeting ethnic minorities
4 Findings
Health education ideals

Described by heads and health care professionals as

• participatory
• non-directive
• empathy, understanding
• open health concept
“it is essentially about believing in the individual human being. Empathy and compassion - that is what characterizes the approach in its totality.”
(interview head of health care centre)


**Perceived purpose of the course: time and care**

"For many, it’s the first time they feel they are heard. Both in the health care system and in the municipal system. Here, there is *time.*" (Interview, health care professional)

"It should also feel good to come here. Not official, like in the hospitals". (Interview, health care professional)

→ Sense of purpose defined and confirmed through creating boundaries to hospitals and GPs
Perceived challenges delivering diabetes courses

Health care professionals focused on the target group’s:
- belief in authorities
- lack of ‘student discipline’
- lack of physiological knowledge
- collective orientation frame – preventing

→ Indicating the need of fact-based, paternalistic, professional-centred approach
Practice (1): Health educator or interpreter

Health educator:
- mediating socially, culturally and conceptually
- directly engaging
- spontaneous discussions, internal dialogues course participants
- space on course participants’ terms

Interpreter:
- verbal translation
- being ‘invisible’
- hcp had control with topics and stuck to agenda
- main focus on hcp as the expert
Practice (2): Inclusive or authoritative

Inclusive approach
- Hcp inviting to share experiences
- Active listening
- Open-ended questions

Authoritative approach
- Delivering messages
- Paternalistic communication
- Right and wrong answers, predefined frame for sharing experiences
Practice (3): Holistic or biomedical health concept

Holistic
- Recognizing course participants’ medical models: diabetes as consequence of chock
- habits entry point
- talking about social context and social relations

Biomedical
- focus on the M triangle: food, medicine, excercise (Mad, Motion, Medicin)
- objective measurements reference frame – ‘you should only trust the blood sugar level’
- focus on risks and negative consequences of lack of treatment (e.g. using scary visuals)
Observations during diabetes course

C: I tell my doctor that I have unstable blood sugar. And then, all she says is that I should exercise!
H: But this is not bad. This is within the normal area.
C: Well, but it was 7,9. And then it’s 8,4!
H: Yes, but of course, because you ate.
C: But it takes much longer time for me
H: But we are all different
C: But, its because... I’m scared of it. Because everybody in my family has it. My mum and dad died from it.
H: It is fine! We will talk more about it. If it gets higher, then you might have to start taking tablets.
5 Summary of findings

→ Health pedagogical ideals and sense of purpose: aligned with recent literature on action-comptence, participatory approach

→ Practice: Co-existence of participatory and professional-centred approach
Practice seen in light of agents’ multiple navigation frames

Health care professionals’ practice (might be) oriented by

- Recent health education trends/theory
- New undefined municipal setting: need for defining purpose
- New practice field: learning by doing
- Limited resources: influence (limit?) planning, implementation, evaluation efforts
- Bio-medical background
- Perceptions (preconceptions?) of ethnic minorities
Concluding remarks

• Translating theoretical ideals into practice is a multifaceted process

• Does the coexistence of different approaches represent a contradiction?

• Need for more awareness among health care professionals on applied approaches, motivations behind and implications for target group?

• The question of resources

• Need to look into experiences, preferences, resources of the target group in this context
Tak for opmærksomheden