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Swedish and Middle-Eastern-born women's beliefs about gestational diabetes

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Summary

Objective: to compare beliefs about health and illness between women born in Sweden and the Middle East who developed gestational diabetes (GD).

Design: a qualitative, explorative study using semi-structured interviews.

Setting: in-hospital diabetes specialist clinic in Sweden.

Participants: consecutive sample of women with GD; 13 born in Sweden and 14 born in the Middle East.

Measurement and findings: all the women described health as freedom from disease, and expressed worries for the baby's health and well-being. Women from the Middle East did not know the cause of GD, discussed the influence of social factors, such as being an immigrant, and supernatural factors, tried to adapt to the disease and thought it would disappear after birth, felt they had more pregnancy-related complications but had not received any treatment. Swedish women attributed GD to inheritance, environment and hormonal change, feared developing Type 2 diabetes, found work-related stress harmful to their health, more often sought help, used medications against pregnancy-related complications, and were more often on sick-leave from work.

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Key conclusions: Swedish women initiated a battle against GD, demanded medical treatment for pregnancy-related complications because of gainful employment and viewed pregnancy as a disease. Women from the Middle East temporarily adapted to the disease and perceived pregnancy and related problems as a natural part of life.

Implications for practice: it is important to assess individual beliefs, risk awareness and to meet individual needs for information.

Introduction

Pregnancy has been described as a developmental crisis, a transition and a transformation to motherhood for the woman (Lundgren and Wahlberg, 1999), with tremendous physiological and psychosocial changes (Trad, 1991). Gestational diabetes (GD) is potentially life-threatening and associated with lifestyle changes; its diagnosis and treatment have a significant effect upon the lives of women (Lawson and Rajaram, 1994). For migrants, the acculturation process in the new country acts as an additional stressor demanding further adaptation (Berry, 1997). Stress may imply increased blood glucose and thus impaired glycaemic control accompanied by increased rates of perinatal mortality and morbidity (Persson and Hansson, 1998).

Women with GD experience a two to three-fold increased risk of perinatal mortality and congenital abnormalities (Persson and Hansson, 1998), and the risk of GD is further increased in immigrant groups (e.g. Arab, South East Asian and Indian ethnic groups; Dornhorst et al., 1992; Yue et al., 1996). The risk of perinatal mortality and congenital abnormalities can be reduced by optimised glycaemic control during pregnancy (Persson and Hansson, 1998; Jovanovic, 1998). Self-care, including knowledge about diet, exercise, medications and self-monitoring of blood glucose (SMBG) are essential in normalising the blood glucose (ADA, 2003; Gabbe and Graves, 2003), but these are demanding measures.

Although beliefs about health and illness affect self-care, health-care seeking behaviour and thus health (Hjelm et al., 1999, 2003), no studies have been published on the beliefs about health and illness in women with GD. Previous studies comparing beliefs about health and illness in people of different origin with diabetes mellitus have shown that Europeans cite various and more medically oriented causes of disease (e.g. heredity, obesity) (Dechamp-Le-Roux et al., 1990; Hjelm et al., 1999, 2003), whereas North Africans cite either stress or fate. Arab and Ex-Yugoslavian women showed a similar pattern of beliefs to North Africans, with a more fatalistic view of the disease in terms of factors lying beyond one's own control (e.g. fate and supernatural influence by the will of God or Allah – external locus of control) (Hjelm et al., 1999, 2003). Although health was described in the same way, as freedom from disease (pathogenetic perspective), in Swedes, Ex-Yugoslavians and Arab women, three different self-care behaviours were found. Swedes showed an active self-care behaviour and a healthy and controlled lifestyle. Ex-Yugoslavians emphasised enjoyment of life and a passive self-care attitude. Arabs emphasised feelings of mental well-being, adaptation to diabetes mellitus, and a number of 'musts' concerning diet, and actively searched for information and therefore had a lower threshold for seeking care (Hjelm et al., 1999, 2003). Foreign-born people seemed to have a lower degree of self-efficacy, expressed lesser perceived seriousness of the disease and had less knowledge about their body and diabetes.

Migrants from the Middle East constitute the biggest group of non-European migrants in Sweden. Many are refugees and have fled from war and persecution in their home countries (Lund and Ohlsson, 1994). The aim of the present study was to compare beliefs about health and illness in women with GD born in Sweden and in the Middle East, and to study the influence on self-care and care seeking.

Screening for and care of women with gestational diabetes

According to regional routine practice, the women in this study were screened for GD in the 28th, or, in case of heredity diabetis mellitus or previous GD, in the 12th gestational week by a midwife at a healthcare centre. If the woman tested positive, she was referred to a specialised diabetes clinic for additional investigations and further management. The staff at the diabetes clinic included a diabetologist, a diabetes specialist nurse and a dietician, who managed people with all kinds of diabetes. Antenatal care was provided according to programmes by a midwife at a healthcare centre in the case of