



ELSEVIER

Contents lists available at [ScienceDirect](http://www.sciencedirect.com)

Primary Care Diabetes

journal homepage: <http://www.elsevier.com/locate/pcd>PCDE
primary care diabetes europe

Original research

Evaluation of the “Take Five School”: An education programme for people with Type 2 Diabetes in the Western Cape, South Africa



Albertine M.B. van der Does*, Robert Mash

Division of Family Medicine and Primary Care, Stellenbosch University, Box 19063, Tygerberg 7505, South Africa

ARTICLE INFO

Article history:

Received 18 March 2013

Received in revised form

11 June 2013

Accepted 8 July 2013

Available online 8 August 2013

Keywords:

Diabetes

Primary care

Group education

Self-management skills

ABSTRACT

Aim: To evaluate the Take Five School (TFS) group education programme for patients with Type 2 Diabetes in South Africa.

Methods: Questionnaires, administered before and after 4 sessions of an hour each of group education, measured the effect on self-care activities in 84 patients from 6 different clinics. Individual interviews with health care workers (HCWs) and focus group interviews (FGI's) with patients explored attitudes.

Results: A significant improvement in adherence to a diabetic diet, physical activity, foot care and the perceived ability to teach others was seen. There was no significant change in smoking or adherence to medication. Qualitative data revealed that comprehensive education was appreciated, that the group process was deemed supportive, that HCWs doubt the effect of education in general and that a combination of group and individual sessions was seen as an option worth exploring. Strengths, weaknesses, opportunities and threats to the TFS are identified. Recommendations are made to improve the programme and its environment.

Conclusion: Significant self-reported improvements in self-care activities after a group-education programme support the view that introducing structured group education for Type 2 Diabetics in a South African public sector primary care context holds promise. Group education for diabetics, especially in resource limited settings, should be sustained and further research should focus on clinical outcomes.

© 2013 Primary Care Diabetes Europe. Published by Elsevier Ltd. All rights reserved.

1. Introduction

In 2011 the prevalence of diabetes in South Africa was estimated to be 6.5% in the age group 20–79 years [1]. Diabetes is currently the fourth most common diagnosis in primary care [2] and contributes significantly to the burden of disease in South Africa [3,4].

The management of this growing number of patients falls mostly on primary care and guidelines recommend medical management as well as patient education [5,6]. Patients need ongoing support and motivation [7], as well as “a minimum threshold of diabetic knowledge” for successful self-management and life style change [8].

Education, motivation and support are seen as key components of a structured education programme [5,6,9,10].

* Corresponding author. Tel.: +27 798456497; fax: +27 219389704.

E-mail addresses: albertinedoes@gmail.com, albertinedoes@hotmail.com (A.M.B. van der Does).

1751-9918/\$ – see front matter © 2013 Primary Care Diabetes Europe. Published by Elsevier Ltd. All rights reserved.

<http://dx.doi.org/10.1016/j.pcd.2013.07.002>

Table 1 – Before–after scores for self-care activities.^a

Self-care activity	Mean before (95% confidence interval)	Mean after (95% confidence interval)	p-Value
1. Diet, general	4.8 (4.4–5.1)	5.9 (5.6–6.1)	<0.001
2. Diet, specific	4.6 (4.3–4.9)	5.1 (4.8–5.4)	0.01
3. Physical activity	3.0 (2.6–3.5)	4.5 (4.0–4.9)	<0.001
4. Foot care	4.5 (4.0–5.0)	5.8 (5.4–6.2)	<0.001
5. Medication adherence	6.3 (5.9–6.7)	6.5 (6.1–6.8)	0.33
6. Ability to teach others	5.4 (4.6–6.1)	8.8 (8.4–9.2)	<0.001

^a Items 1–5 were scored on a scale of 1–7 (days of the week). Item 6 was scored on a scale of 1–10. General diet referred to adherence to an overall eating plan, whilst specific diet referred to adherence to recommendations for fruit, vegetables and fat.

The international call to integrate structured education programmes into comprehensive diabetes care is not only evidence based [7], but increasingly rights-based [11,12].

Reviews by both Deakin [13] and Steinbekke [14] conclude cautiously that group based education could be effective in improvements in clinical, lifestyle and psychosocial outcomes. Rickheim et al. [15] concluded that group education is equal or better, depending on the outcome selected, to individual education and might be more cost effective. The NICE guideline states that diabetes education has a low cost, and therefore even minimal improvements will result in a cost-effective intervention [9].

The goals of educational programmes should be adapted to local needs, but are generally aimed at metabolic control, preventing complications and improving quality of life, whilst keeping costs acceptable [8]. Topics to be addressed are basic pathophysiology of diabetes, treatment options, self monitoring and injection, acute and chronic complications, foot care, substance use, family planning and pregnancy, stress management, nutrition and physical activity whilst also including the family [5]. Trento states that “lifestyle intervention requires delivery of continuing patient education and care without increasing clinical workload and with measurable outcomes” [16]. She concludes that “routinely delivered group care is a feasible and cost-effective approach to improve metabolic control and quality of life in type 2 diabetes” [16]. This could be true also in the setting of low or middle income countries, where 80% of the world’s diabetics live [1].

How should this structured education be offered in the South African public, primary health care setting, where individual, ad hoc counselling is the norm? [17] The “Take Five School” programme was introduced in the Eden District of the Western Cape by a small group of HCWs aiming to provide effective small group diabetes education over four sessions of an hour each. It was never formally evaluated and it is questioned whether this programme can serve as a model for managing Type 2 Diabetes or other chronic diseases.

This study aimed to evaluate the TFS and was intended to measure the short term effects on self-care activities and to explore the opinions and experiences of patients and HCWs who had been involved in the programme.

2. Methods

2.1. Study design

Mixed methods were used: Qualitative methods involved individual in-depth interviews with HCWs and FGI’s with patients.

Quantitative methods measured the effect on self-care activities in a “before-and-after” study with 84 patients from 6 different clinics.

2.2. Setting

The primary care services in the public sector in South Africa serve uninsured people from low socio-economic groups. The TFS was offered in six primary care clinics in the vicinity of George, a rural town in the Western Cape.

Its aims were to increase self-care amongst patients and to encourage them to act as educators in their own communities. Groups of 10–15 patients were formed at each of the clinics. They were offered one hour long “classes”, once a week, for four weeks. In several clinics this process was repeated. Topics addressed were: knowledge about the illness, the complications and treatment, a healthy lifestyle and how to apply the new knowledge in your day-to-day life. The teaching-style promoted an appreciative, interactive and evocative group process, sharing information that built on patient’s prior knowledge and experience.

The classes were facilitated by a dietician, a health promoter and a doctor, depending on the clinic. Venues used included libraries, community halls and clinics. The sessions were in English and Afrikaans, and a translator for Xhosa was used. After the last class, participants received a certificate.

2.3. Sampling and selection

A sample size calculation concluded that data on 84 patients before and after the programme would achieve 80% power to detect an odds ratio of 3.0 using a two-sided McNemar test with a significance level of 0.05 for a change in smoking behaviour. The odds ratio is equivalent to a difference between two paired proportions of 0.2.

Patients were recruited until 84 before and after questionnaires were completed. All patients that started also finished and attended all sessions. Six FGI’s were conducted. Patients were invited to attend the FGI directly after their last session. Purposeful sampling of HCWs used the snowball method to identify HCWs involved with the TFS. Eleven HCWs were interviewed in ten interviews, and included a doctor and dietician, three local managers, two nursing managers, a pharmacist and three health promotion officers.

2.4. Data collection

An internationally validated diabetes self-care activities questionnaire [18] used in a similar study in South Africa

Download English Version:

<https://daneshyari.com/en/article/2678980>

Download Persian Version:

<https://daneshyari.com/article/2678980>

[Daneshyari.com](https://daneshyari.com)