



Patient Perception, Preference and Participation

Explanatory models of coronary heart disease among South Asian immigrants

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ABSTRACT

Objective: This study investigated South Asians' explanatory models (EM) of CHD and compared them to the biomedical model as part of an effort to inform the development of culturally targeted CHD prevention messages.

Methods: We conducted in-depth, semi-structured interviews in English, Hindi and Urdu with 75 respondents from a federally qualified health center and at a community center for South Asian immigrants in Chicago, Illinois.

Results: While EMs of CHD included risk factors from the biomedical model, they also included psychosocial and spiritual risk factors. Respondents emphasized that stress causes CHD and suggested that CHD was caused by sudden or inexplicable factors. Few respondents discussed cholesterol, blood pressure, or diabetes as part of CHD prevention. Women and those with lower education had low perceptions of being at-risk for CHD.

Conclusion: South Asians' EMs of CHD encompassed the biomedical model; however, EMs also included psychosocial and spiritual factors.

Practice implications: Clinicians and health educators should be aware that South Asian individual's EM of CHD may include psychosocial and spiritual factors which can affect CHD prevention behaviors.

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1. Introduction

Coronary heart disease (CHD) is the leading cause of death among Asian Indians and Pakistanis (South Asians) in the United States [1,2]. Growing evidence suggests that South Asians may be more susceptible to CHD than other US racial/ethnic groups because of a combination of traditional, novel, and genetic risk factors [3–6]. Among U.S. Asian groups, South Asians have higher rates of overweight/obesity [7] and report the least physical activity [8]. Other factors may also be involved, such as higher lipoprotein(a) levels [1,9], tissue-type plasminogen activator [10], and a high prevalence of the metabolic syndrome and type-2 diabetes mellitus [6,11,12]. Despite increasing calls for CHD prevention efforts to be targeted to minorities [13], few CHD prevention efforts in the US are directly targeting the high risk South Asian group.

A recent statement on CHD disparities highlighted the importance of addressing cultural beliefs and practices when designing CHD prevention interventions because of their effect on patients' preferences, behaviors, and health care utilization [13]. One way to address cultural beliefs and practices for health interventions is to develop targeted messages, which are designed to reach a defined population sub-group, generally based on demographic characteristics. Targeted messages differ from tailored messages, which are created for individuals [14]. Successful development of targeted messages requires understanding the health beliefs or explanatory models (EM) of the community of interest [15]. The EM is used to understand for eliciting individual or family views about the illness experience including etiology, time and mode of onset, pathophysiology, prognosis and treatment [16]. The type of EM held by patients influences receptivity to health promotion messages [17,18], health behaviors [19], and what course of treatment an individual follows [20]. Studies that have explored variations in EMs have found that EMs of illness and disease are influenced by people's social and cultural contexts and prior experiences [21–23]. While the literature can provide some guidance, it is critical to identify current EMs of the target population before developing and

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disseminating a message. Studies in other immigrant populations have shown that there is a lack of knowledge about CHD, especially about risk factors and prevention [24], and that culturally targeted interventions for specific ethnic populations might be the best way to communicate health information [25–27].

Even though South Asians in the US are at very high risk for CHD [1,2], little is known about how they conceptualize CHD etiology and prevention and if these concepts differ from a biomedical model. CHD prevention guidelines and messages in the U.S. are based on a biomedical model and focus on several major modifiable risk factors: smoking, high cholesterol, high blood pressure, diabetes, high fat diet, physical inactivity, and obesity [28]. It is unclear to what extent South Asians, the majority of whom are immigrants, have incorporated current biomedical thinking into their beliefs about the causes of CHD, and if they are aware of the major modifiable risk factors. Studies from the United Kingdom have shown low levels of knowledge in South Asians about what causes heart disease, especially among individuals from Pakistan and Bangladesh [29,30]. In this study, semi-structured qualitative interviews were used to elicit South Asians' EMs of CHD, determine their perceptions about being at-risk for CHD, and identify common themes that can inform CHD prevention efforts targeted at South Asians. This study provides a foundation and framework for the design of culturally targeted CHD education messages and a community-based CHD prevention intervention for South Asians in the US.

2. Methods

2.1. Research setting & Recruitment Strategy

Seventy-five participants were recruited from a federally qualified health center (FQHC; $n = 48$) and a community center ($n = 27$) that provides non-health care related services for immigrants. The FQHC and one of the community centers are located in the West Ridge and Rogers Park neighborhoods of Chicago, Illinois, a densely populated residential area which encompass Devon Avenue, one of the two largest South Asian business districts in North America. Compared to the general South Asian population in the U.S., the South Asians in West Ridge/Rogers Park are more recent immigrants, have lower socio-economic status (SES), and lower English proficiency [31]. Flyers informing patients about the study were distributed in the FQHC and community organizations; staff at both sites referred South Asian clients to the interviewer who was stationed at the sites. The interviewer also approached patients in the waiting areas about the study and distributed flyers to them. Respondents were encouraged to inform their friends and family members about the study and schedule an interview directly with the interviewer. Interviews were conducted on-site, in a private room.

2.2. Participants

According to local census data [31], Hindi and Urdu are the most common languages spoken by South Asian residents in this neighborhood of Chicago. Therefore, this study was limited to adults (20–75 years of age) who self-identified as Asian Indian or Pakistani and who spoke Hindi, Urdu or English.

2.3. The interview

In a semi-structured interview, respondents were first asked about concepts of health and disease in general (described in Ref. [32]) and then were asked more specifically about concepts of CHD etiology and prevention. The prompts use the term “heart disease” and “heart attack” to denote CHD. We chose “heart disease” and

“heart attack”, rather than “coronary heart disease” or “coronary artery disease” because pilot interviews suggested that the former were better understood and could be translated into Hindi and Urdu in an equivalent way. Interviews lasted between 30 and 45 min and were conducted by the interviewer who is fluent in Hindi, Urdu, and English. Hindi and Urdu interviews were later transcribed verbatim and translated into English by the interviewer who conducted the interviews.

Regardless of recruitment method, the interviewer first asked the participants their age, country of origin and preferred language for the interview to determine eligibility for participation in the study. All other demographic questions, included marital status, education, occupation, religion and insurance status were asked at the end of the interview. Weight and height were also measured.

2.4. Coding scheme and data analysis

Ten pilot interviews were used to create a comprehensive coding scheme using an open coding method common to grounded theory methodology [33,34]. This means that themes were coded whenever they occurred in the transcript and not only in response to the prompts. We developed an initial coding scheme which was modified by the research team as needed during the interview and coding process. The coding scheme for the EM of CHD included four main domains: physiologic (i.e., high blood pressure, cholesterol, diabetes), psychosocial (i.e., stress, depression) behavioral (i.e., high fat diet, not exercising, smoking), and spiritual (i.e. God, fate). Seventy-five (non-pilot) interviews were conducted to ensure that we would have adequate cell sizes across gender, age, and language. All 75 interviews were coded by the first author using NVivo 7 qualitative data analysis software [35]. Twenty percent of the interviews were randomly selected to code by NK to verify coding consensus and establish inter-coder reliability. Coding discrepancies were resolved by discussion and codes were modified to reflect the resolution. Reliability coefficient was found to be 99% agreement between coders after discussion of discrepancies.

In addition to qualitative data analysis, descriptive statistics were calculated for the socio-demographic characteristics of the participants and to determine if there were any differences in perceptions of being at risk for CHD by socio-demographic characteristics. First, we describe how respondents defined heart disease and what they perceived to be the major health issues in their community. Second, we describe the common themes that emerged about CHD etiology and prevention for the group as a whole. Lastly, we present respondents' perceptions of being at-risk for CHD and use χ^2 statistics to examine how perceptions of being at-risk differed by socio-demographic characteristics. Quantitative data analysis was performed using Stata 9.1 [36]. Two-tailed tests were used for all analyses, and a final p -value of 0.05 was used to determine statistical significance.

3. Results

3.1. Respondent characteristics

Our sample was similar in age, education, years in the US, gender, and country of origin to the South Asian community profile of the North side Chicago neighborhood drawn from the 2000 Census data [31]. There were equal numbers of men and women in the sample (Table 1). The sample included equal numbers of participants in the 20–39 and 40–59 age groups; despite attempts to recruit older adults (60+) there were fewer participants were in this age group. In general, education levels were high with 57% of respondents ($n = 43$) having completed college or more. Twenty percent ($n = 16$) of the sample had less than a high school

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