RESEARCH

CONVERSATION MAP ON DIABETES: EDUCATION STRATEGY IN VIEW OF HEALTH PROFESSIONALS

MAPA DE CONVERSAÇÃO EM DIABETES: ESTRATÉGIA EDUCATIVA NA VISÃO DOS PROFISSIONAIS DA SAÚDE

MAPA DE CONVERSACIONES SOBRE DIABETES: ESTRATEGIA EDUCATIVA EN LA OPINIÓN DE LOS PROFESIONALES DE LA SALUD

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ABSTRACT

The present study aimed to assess how health professionals view the Diabetes Conversation Map as an educational strategy. It is a qualitative, exploratory and descriptive research conducted with 14 health professionals from Primary Health Care Units located in the eastern district of the city of Belo Horizonte, Minas Gerais (Brazil). Data were collected using a semi-structured interview, guided by the following questions: "Which educational practices are being used in primary care?"; "How are they being used?"; and "What are their foundations?". Focus groups were then carried out with the following guiding questions: "What do you think it is like to be diagnosed with diabetes?"; "What do you think it is like to have to follow health plan of daily care?"; and "What is your view of the Diabetes Conversation Map?". Data were analyzed following Bardin's content analysis framework, from which two categories emerged: a) the Conversation Map as a participative learning strategy; b) factors that affect the educational practice of self-care. The use of the Diabetes Conversation Map has allowed us to know how professionals view this new strategy for diabetes self-care, thus establishing the map as a suitable tool for educational practices.
Keywords: Diabetes Mellitus; Self Care; Health Education; Health Personnel.

RESUMO

O objetivo do presente estudo foi verificar a visão dos profissionais da saúde sobre o Mapa de Conversação em Diabetes como estratégia educativa. Trata-se de pesquisa qualitativa, exploratória e descritiva, realizado com 14 profissionais da saúde inseridos em unidades básicas de saúde da regional leste do município de Belo Horizonte, Minas Gerais (Brasil). Para a coleta de dados, utilizou-se a entrevista semiestruturada guiada pelas seguintes questões: "quais as práticas educativas que vêm sendo utilizadas na atenção primária?"; "de que modo vêm sendo utilizadas?"; e "quais os seus fundamentos?" Em seguida, foram realizados grupos focais por meio das questões norteadoras: "como você acha que é ter o diagnóstico de diabetes?"; "como você acha que é ter que seguir um plano de cuidados diários para a saúde?"; e "qual é a sua visão do Mapa de Conversação em Diabetes?" Os dados foram analisados com base no referencial de análise de conteúdo de Bardin, do qual emergiram duas categorias: a) o Mapa de Conversação como uma estratégia de aprendizagem participativa; b) fatores que interferem na prática educativa para o autocuidado. A utilização do Mapa de Conversação em Diabetes permitiu verificar a visão dos profissionais sobre uma nova estratégia para a construção do autocuidado em diabetes, reconhecendo-o, assim, como uma ferramenta apropriada para a condução das práticas educativas.
Palavras-chave: *Diabetes Mellitus; Autocuidado; Educação em Saúde; Profissionais de Saúde.*

RESUMEN

El objetivo de este estudio ha sido evaluar la opinión de los profesionales de la salud del mapa de conversaciones sobre diabetes como estrategia educativa. Se trata de una investigación cualitativa, exploratoria y descriptiva realizada con 14 profesionales de la salud de las unidades básicas de salud de la regional este de la ciudad de Belo Horizonte, Minas Gerais (Brasil). Para la recogida de datos se utilizó una entrevista semiestructurada guiada por las siguientes preguntas: ¿Cuáles son las prácticas educativas que se utilizan en la atención primaria? ¿Cómo se utilizan? y ¿Cuáles son sus fundamentos? Luego se organizaron grupos focales a través de las preguntas orientadoras: ¿Cómo crees que es ser diabética? ¿Cómo crees que es tener que seguir un plan de cuidados diarios para la salud? y ¿Cuál es tu visión del mapa de conversaciones sobre diabetes? Los datos fueron analizados en base a las técnicas de análisis de contenido de Bardin, del que emergieron dos categorías: 1) mapa de conversaciones como estrategia de aprendizaje participativo y 2) factores que interfieren en la práctica educativa para el autocuidado. El uso del mapa de conversaciones sobre

diabetes ha confirmado que los profesionales reconocen que esta nueva estrategia para la construcción del autocuidado en diabetes es una herramienta adecuada para la conducción de las prácticas educativas.

***Palabras clave**: Diabetes Mellitus; Autocuidado; Educación en Salud; Personal de Salud.*

INTRODUCTION

The Diabetes Conversation Map is an educational strategy created by the International Diabetes Federation with playful and interactive illustrations, containing metaphors about the chronic condition of diabetes and the everyday situations health service users encounter. It can be used for sharing personal experiences and feelings, fostering support networks and healthy practices for life.[1-4]

The Map's applicability has been proven in studies conducted in different countries and it is considered an effective and inexpensive tool to enable interaction between health professionals and users for self-care education.[5-8]

Because diabetes care needs to be improved in Brazil, the School of Nursing at the Federal University of Minas Gerais, in partnership with the Primary Health Care Units, sought to teach health professionals how to use the Conversation Map. The objective was to use it in the discussion of educational practices and within the context of the lives of users of health services diagnosed with diabetes, in order to explore this strategy for health care and disease control.

The scope of the present study was to assess the health professionals' view of the Diabetes Conversation Map as an educational strategy.

MATERIALS AND METHODS

Qualitative, exploratory and descriptive research provides an overview of a certain fact and allows one to check the understanding of individual experiences, especially when that fact is largely unexplored.[9] This study was conducted with 14 health professionals from Primary Health Care Units in the eastern district of the city of Belo Horizonte, Minas Gerais (Brazil). The subjects were selected by convenience, being health professionals working in educational practices for diabetes in primary health care and in Primary Health Care Units.

Subjects who wanted to participate, after being briefed about the study objectives, were interviewed individually in a private room in their Primary Health Care Units. The interviews were scheduled in advance and carried out in October 2012. Data was collected through semi-structured interviews, guided by the following questions: "Which educational practices are being used in primary care?"; "How are they being used?"; and "What are their foundations?". Interviews lasted for one hour in average and were recorded for transcription.

We used a structured questionnaire to collect the participants' demographic data, with questions such as: identification with initials, sex, age, experience in primary care, training and level of professional expertise.

To define the limit of interviews, we applied the criterion of data saturation, according to the similarity and repetition of the responses. After that, we started the second phase of data collection, through focus groups.

The technique of focus groups aims at collecting data through a collective approach, seeking to investigate a given topic through moments of interaction between the research subjects.[10,11] With three groups and an average duration of four hours per group, subjects were encouraged to talk about their views on the psychosocial aspects of being diagnosed with diabetes and were presented with the educational tool Diabetes Conversation Map, and the guiding questions: "What do you think it is like to be diagnosed with diabetes?"; "What do you think it is like to have to follow health plan of daily care?"; and "What are your views on the Diabetes Conversation Map?"

For the group sessions, thematic guides were devised: healthy eating, physical activity, medication, and social support. Such guides worked as screenplays to guide and motivate discussions.

The group met on a room inside their own Primary Health Care Units, with chairs set on a circle, in order to promote more interaction among participants. The moderator and observer occupied strategic places and did not have positions of command or hierarchy.

All material was recorded and subsequently transcribed, in order to compose the database. We followed Bardin's content analysis framework to interpret the data.[12] To ensure anonymity, subjects were identified by the letter "P" for professional, and a number from one to 14.

From the pre-analysis and exploration of the material, two categories emerged:

- the Conversation Map as a participative learning strategy;
- factors that affect the educational practice of self-care.

Finally, we should make it clear that prior to data collection all participants signed the consent form and were informed about the objectives of the study, which was approved by the Ethics Committee of Federal University of Minas Gerais, under Report # 0024.0.410.203-09A, having fulfilled all the requirements established by Resolution # 466/12 of the National Health Council.

RESULTS AND DISCUSSION

Among the 14 professionals who participated in the study were: a doctor, five nurses, two dietitians, two physical therapists, two psychologists, a physical educator and a pharmacist. Of these, 100% were female, were aged 26-61 years, all had specialized courses in Public Health, and a year of experience in diabetes education.

From the analysis of the interviews, we observed the professionals' dissatisfaction with their role as health educator. There was also the desire to try different approaches and innovative educational practices, but they often feel overwhelmed by the work process. This can be seen in the following excerpts:

> *[...] I admit, my performance is not good, for not knowing about the disease... [this is why] I'm interested in the training to see the difference [...] (P1).*

> *[...] I feel like I've failed in my educational activities regarding diabetes and other diseases as well, because what we call "group" is really just a place we go to meet the users, exchange prescriptions, and take their blood pressure and sugar [...] (P4).*

The following stage was dedicated to the training through the Conversation Map and the focus groups. Two categories emerged from the analysis of the participants' view of the tool.

The Conversation Map as a participative learning strategy

This first analytical category shows the professionals' views on using the Conversation Map in educational interventions. The map was considered a facilitating tool for conducting practices, and qualified as a playful material, encouraging reflections on self-care and the uncertainties provoked by the disease.

The use of new educational approaches such as the Conversation Map, has assumed an important role in attention to diabetes, making it possible to improve the knowledge and skills of professionals regarding self-care practices, in addition to helping individuals understand how their actions can influence their health.[5]

Through the map, professionals pay attention to the importance of dialogue and qualified listening in the process of overcoming barriers in user self-care. Thus, communication is a simple resource that can be used in any educational approach, especially diabetes, a chronic condition surrounded with doubts, difficulties and feelings.[13] This can be seen from the following excerpts:

> *[...] Sometimes the professional does not speak in plain language. They use technical terms and this makes it difficult for the user to understand how to take care of themselves [...] (P6).*

> *[...] User participation is very important, it is only after their participation that they expose their experience and this becomes clearer, more concrete [...] (P10).*

It is important to point out that by initiating dialogue, the professional must make sure that the user understands the content, by considering their level of education and cognitive level, because otherwise, this can compromise their health, because a communication failed to be established.[14,15] Additionally, the Conversation Map fosters creative and contextualized communication, allowing the use of simpler language, thus ensuring the wider understanding.[16]

Furthermore, the educational strategy presented in this study considers nuances in the population's profile caused by their low socioeconomic and cultural levels, taking into consideration the reality of developing countries.[7]

The professionals also reflected on changing their approaches in the following ways: adapt the information to the user's reality; add dynamic and illustrative figures to encourage active participation; organize the discussion of the map by themes, such as pathophysiology of the disease, healthy eating and physical activity.

In this context, the professionals came to realize the necessity to raise the above issues to develop new educational practices, both individual and collective. Regardless of the approach, individual or group, educational practice shows positive results in controlling diabetes.[17-20]

Factors that influence the educational practice for self-care

In this category, we identified the health professionals' perspective on the challenges they face in self-care education. The realities caused by different socioeconomic levels, such as illiteracy and cognitive impairment, were the factors hindering the achievement of educational practices and user autonomy.

Professionals also cited users' poor knowledge of diabetes as one of the main factors interfering in the process of self-care, as well as erroneous beliefs related to the treatment. Another issue was the users' mutable feelings, that is, changing from the moment of diagnosis to the stage of acceptance.

> *[...] There is a lack of understanding of users about the disease [...] when they understand and comply with treatment, we see an improvement. They report some improvement, but when they don't comply, they come back with the same complaints [...] (P7).*

> *[...] Their lack of understanding about the disease is like this big knot. They act as if [having to take] insulin [meant] a death sentence [...] (P12).*

On the other hand, a study[21] argues that, even though knowledge is a prerequisite for self-care, it is not the only nor the main factor involved in the educational process. In other words, the educational process must be combined with issues related to the user, such as their attitude, their view on aspects that can hinder self-care and their own motivations.

Another issue raised by the professionals was the fact that the diagnosis of diabetes can be loaded with feelings and that usually users go through five distinct phases, from the initial grief to a final acceptance of the disease.[22,23]

> *[...] They all have these feelings, in the following order: first it is diagnosed, there is the stage of denial: "the doctor said that I have diabetes, but I feel nothing." Then angry begins [...] [as they learn there are certain things they can't eat]. Until they reach the stage they [finally] accept the condition and collaborate [...] (P9).*

Moreover, how each user faces the disease is influenced by personal experiences, directly related to beliefs and values formed throughout their lives. According to the literature, beliefs are convictions not rationally founded which shape everyday conduct. Thus, personal beliefs on nutrition, particularly in relation to the existence of harmful or forbidden foods, are hard to change and can be a factor that may interfere with the self-care of disease.[15]

Regarding the attitude of users, professionals note their resistance to administer self-care and that they usually expect solutions to come from the family and professionals. Studies emphasize the role of the health professional as a partner in the construction of self-care and not just someone to guide their actions. At the same time, the establishment of self-care goals must be in accordance with the user's priorities, thereby promoting their autonomy and their power of choice, even though that means it will be a long process of transformation.[24]

FINAL CONSIDERATIONS

Using the Diabetes Conversation Map has allowed us to know the professionals' views on a new strategy for diabetes self-care, thus establishing the map as a suitable tool for educational practices. The study also made it possible to identify the professionals' view on the challenges faced by users in learning self-care.

One of the study's limitations was the small number of participants. We believe, however, that the results can contribute to health education, given the scarcity of studies, discussions and reflections on this particular theme. We suggest that further research is carried out to assess the educational practices in diabetes conducted by health professionals using the Diabetes Conversation Map.

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