

Diabetes Literacy: Making a case for partnerships between health promotion and adult L&N

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Workshop aims

1. To introduce the concept of 'diabetes literacy'
 2. To demonstrate through a case study how adult L&N teachers can work effectively with health professionals
 3. To make the case for health literacy partnerships in Australia on a much larger scale
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The current picture on health literacy partnerships

- ❑ Australia is ...'without formal alliances, shared agenda, unifying framework or national approach' (Green et al. 2007, p. 30) linking the literacy and numeracy field with the health sector
 - ❑ Local health literacy partnerships are largely ad hoc and based on short term funding
 - ❑ Many health literacy partnerships are 'under the radar'
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The health literacy survey (ABS 2008): A catalyst for action?

- ❑ Overseas examples of health literacy surveys (USA – Kutner et al 2006; Canada - Canadian Council on Learning 2007)
 - ❑ *Health Literacy, Australia* (ABS 2008) reports that 59% of adults in Australia have poor or very poor health literacy skills (below level 3 ALLS)
 - ❑ Health literacy in the ALLS is defined as: 'the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy'.
 - ❑ The survey results show generally that those people more likely to have poorer health literacy skills are: older, lacking formal education, unemployed or whose first language is not English.
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What is diabetes literacy?

- 'The skills and competences to comprehend, evaluate and use information to make informed choices about the risks, prevention and management of diabetes' (Black, Innes & Chopra 2008: 4)
 - The focus in this workshop is on risks and prevention, not management, of type 2 diabetes
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A partnership approach to educating CALD people about the risks and prevention of type 2 diabetes

The main features of the case study:

- ☐ Commonwealth Innovative Literacy Funds
 - ☐ 6 courses (x 7 weeks x 2 hrs) in local community sites
 - ☐ Groups: Chinese, Iranian, Armenian, Afghan
 - ☐ Use of community 'brokers'
 - ☐ Use of community interpreters
 - ☐ Team teaching by qualified Nutritionists and L&N teachers
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Program structure

Weeks 1&2: Introduction, what is diabetes, body functions, type 1 and type 2 diabetes

Weeks 3&4: Focus on diet – types of food and nutritional content

Weeks 5&6: Focus on the importance of exercise

Week 7: Course recap, discussions, treatment referral details, communal lunch

Co-presenting with an integrated concept of L&N

The primary focus of the course was on education for the risks and prevention of type 2 diabetes. It was NOT to improve literacy and numeracy skills as such. The nutritionist was there to provide the health content. The L&N teacher was there to provide a pedagogical role, to improve the learning of the participants.

One L&N teacher stated how her working relationship with the nutritionist worked:

'She (nutritionist) said these are the goals we want to meet. I want students to go away with this, this and this. How do we get there? Then let me do the how do we get there bit'

Some role conflicts to work through

Role misconceptions - 'Well I don't want to take over because it's literacy' (nutritionist)

Sensitivities about professional boundaries – the L&N teacher who was seen to be too prescriptive – the nutritionist who was seen to present information too quickly, covering too many concepts in one go

The need for planning and communication – (L&N teacher said about nutritionist) 'when she turned up, she said sort of, now, do you want to get started now? I was surprised because I presumed that she was going to be leading ...'

Learning from each other

- 'so she's like, the knowledge, and I kind of structure the class ... like I would normally in a classroom'
 - 'The whole aspect of using worksheets in a way that gets them to do things in a written way ... I wasn't aware of any of that' (nutritionist)
 - 'I think she did a fantastic job ... with little understanding of diabetes and a wealth of resources on the net, some of which aren't what we use in Australia' (nutritionist)
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Complementary skills

Dialogue showing how co-presenters perceived the course outcomes in terms of participants consulting a doctor:

(Dietitian) That's what I'd like ... (my) personal role ... is that they will leave this with an increased awareness of the issues around diabetes, eating, exercise, care of the feet, and where to go for more help, and to be a bit more empowered in asking their doctor

(Literacy teacher) And they know what these words mean, they know concepts, what insulin is and what it does

(D) Take more control over their own health

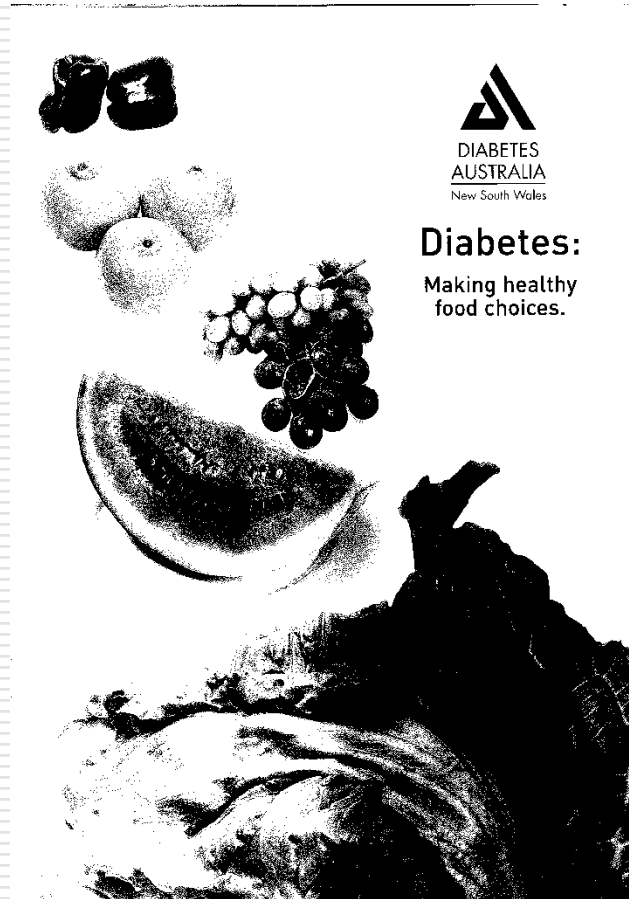
(L) And they've already got that schema before they go in there ... they know the words

'Hands-on' activities used by the presenters

Many of the following activities featured in the courses:

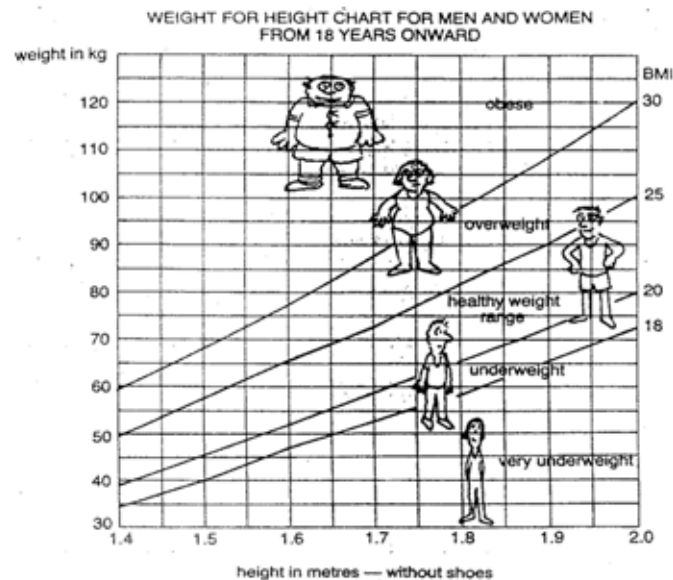
- ☐ Diabetes quiz and surveys – 'Are you at risk'
 - ☐ Calculate your BMI (Body Mass Index)
 - ☐ Record how many steps –using pedometer
 - ☐ Excursion to the supermarket
 - ☐ Examine food packages for nutritional content
 - ☐ Food measures – spoons, scales
 - ☐ Recipes for analysis
 - ☐ Keep a food diary for one day or week
 - ☐ Tai Chi, Yoga
 - ☐ Visit local community centres/walking groups
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Resources – Diabetes Australia



Hands-on exercises – measuring Body Mass Index

You can see which range you are in by reading the chart below:



You can calculate your
BMI (Body Mass Index)
by following this formula:

$$\text{BMI} = \frac{\text{weight (in kg)}}{(\text{height (in m)})^2}$$

e.g. weight 85kg / height 1.75m

$$\begin{aligned}\text{BMI} &= 85 \div (1.75)^2 \\ &= 85 \div 3.063 \\ &= 27.75 \text{ kg/m}^2 \\ \text{BMI} &\approx 28\end{aligned}$$

A dialogic approach

- ❑ A negotiated approach: 'I'm not a 'gatekeeper of nutrition' (nutritionist)
 - ❑ Group work – what food do they eat?
 - ❑ Cultural factors – e.g. rice types – low/high GI vs costs. 'if you want to eat your ordinary rice, that's ok, just have a small serve and lots of vegies'
 - ❑ The concept of 'a piece of fruit'
 - ❑ Bonding, bridging, linking ties
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A critical literacy approach

A dialogic approach encourages questions:

1. Why do some group have a higher prevalence rate of type 2 diabetes?
 2. Why are low GI foods more expensive?
 3. Why are we bombarded in the popular media with messages advertising fast food/processed food?
 4. Why are food labels so complex to understand?
 5. Why aren't we getting the alternative healthy food and exercise messages?
 6. Why is type 2 diabetes more prevalent in Western Sydney than the Eastern suburbs?
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Course effectiveness – qualitative perspectives and findings

- ❑ A surprising lack of knowledge about type 2 diabetes among participants before the course: 'I learn everything from here' (Armenian man already diagnosed with type 2 diabetes); 'he had no idea about diet' (his wife's comments)
 - ❑ 'Now I understand about low GI'
 - ❑ One Chinese woman had been recommended by her doctor to drink red wine (which she didn't like), not knowing that similar benefits were obtained from green tea (which she did like) and lots of vegetables
 - ❑ 'Before I seen the label, says energy and other stuff. I didn't know what that means ...'
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Social capital – spreading the message via networks

The benefits extended beyond the participants:

‘My husband’s glucose was high, ten point something ... he’s now 4.5’

‘I speak to her on telephone ... everything here, I post for her’ (Iranian woman talking about her Mother in Iran)

Children and grandchildren – given fewer ‘treats’, and use of course pamphlets for validation: ‘hey, the department of health tells you this is what you should be eating’

The role of community ‘brokers’ and interpreters – spread the message in the community

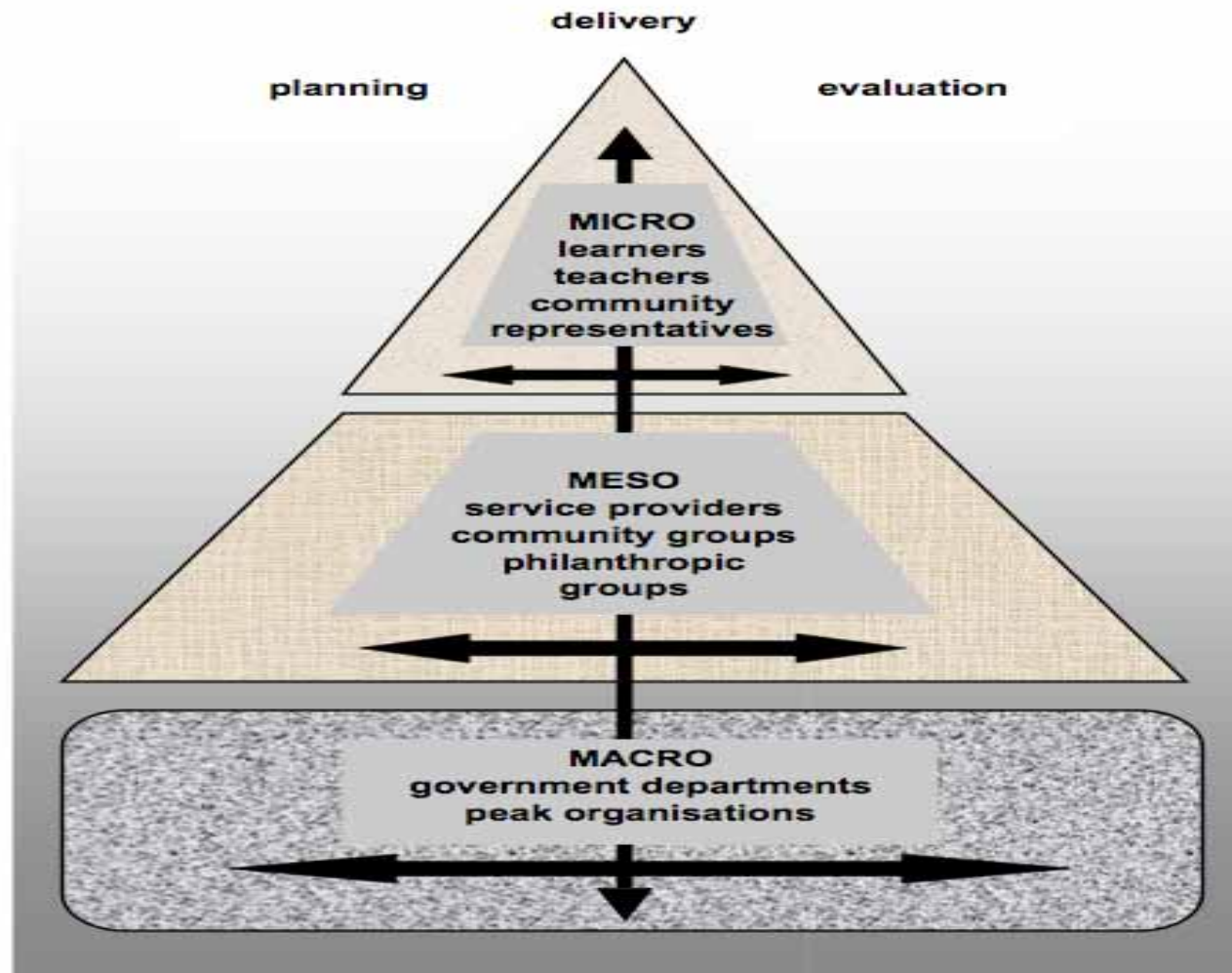
Even strangers received good advice: an Iranian woman met a Turkish woman and said, ‘I study diabetes, sugar, ok, you have to eat like this, you have to exercise’

What needs to happen: Some policy and partnerships processes

- ❑ A prominent promoter of health literacy (e.g. Financial literacy is promoted strongly by Paul Clitheroe)
 - ❑ Governments need to recognise its significance (e.g. COAG agenda) – policy development – national strategy – national taskforce – funding (e.g. as with mental health)
 - ❑ Dialogue within and between peak organisations in health and adult literacy
 - ❑ Develop horizontal and vertical partnership links at the macro, meso and micro levels
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Partnership structures

(Balatti, Black & Falk 2009, NCVER)



References

- ❑ Australian Bureau of Statistics 2008, *Health literacy survey*, ABS, Canberra.
 - ❑ Balatti, J, Black, S & Falk, I forthcoming, *A new social capital paradigm for adult literacy: Partnerships, policy and pedagogy*, NCVER, Adelaide.
 - ❑ Black, S, Innes, C & Chopra, M. (2008), *Diabetes literacy: A partnership approach to educating culturally and linguistically diverse people about the risks and prevention of type 2 diabetes*, http://icvet.tafensw.edu.au/ezone/year_2009/feb/diabetes-literacy-report.pdf
 - ❑ Canadian Council on Learning 2007, *Health literacy in Canada: Initial results from the international adult literacy and skills survey*, Canadian Council on Learning, Ottawa.
 - ❑ Green, J, Lo Bianco, J & Wyn, J 2007, 'Discourses in interaction: The intersection of literacy and health research internationally', *Literacy & Numeracy Studies*, vol.15, no.2 pp19-37.
 - ❑ Kutner, M, Greenberg, E, Yin, J, Paulsen, C & White, S 2006, *The health literacy of America's adults: Results from the 2003 national assessment of adult literacy*, US Department of Education, Washington DC.
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