

COMMUNITY AWARENESS ON CORONARY HEART DISEASE IN NORTHERN AREAS OF PAKISTAN (PROCESS EVALUATION OF HEALTHY HEART PROGRAM)

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ABSTRACT

This document presents data from qualitative research using a series of focus groups which were conducted for the community from 15th April to 30th April 2007. The focus groups were conducted to ascertain the awareness of degree of Coronary Heart Disease (CVD); the quality of the training program, and if behavior has changed as a result of the awareness program, in Northern areas of Pakistan. There were nine focus groups conducted and each group consisted of 6 to 8 participants. All participants in general, reported that they were happy with the awareness program but mentioned that some of the material for health education was not culturally appropriate. Further, all participants were talked about their health behavior and beliefs. The findings suggest that there is a need to focus more on the processes of planning to develop awareness of coronary heart disease (CHD), organize more innovative health education and interventions that aim to empower community to become more informed and active consumers of health care.

KEY WORDS

Coronary heart disease, Awareness programs, CVD

INTRODUCTION

At the beginning of the 20th century, CVD was responsible for fewer than 10% of all deaths worldwide. Today, that figure is about 30%, with 80% of the burden now occurring in developing countries. (Rodgers, 2002). Pakistan is one of the developing countries, with the highest rates of coronary heart disease (CHD). According to the official estimates, CVD results in more than 100,000 deaths every year (samad, 2003) however, the actual figure may possibly be much higher than that. One in four middle-aged adults in Pakistan presents with CVD, risks are uniformly high in the young and in women (Tazeen, 2007). Therefore, improving general awareness about CVD and its risk factors can influence the actual morbidity and mortality in a community by decreasing the risk of developing heart disease. As a result Aga Khan Health service Pakistan (AKHS'P) initiated heart awareness program for the community. After a year of program intervention AKHS'P wanted to know the awareness developed in community and what is their views and perception regarding the program. As a result AKHSP proposed to conduct a process evaluation in three districts of Northern areas; namely Gilgit, Gupis and Yasin.

AIMS

The aim of this study is to examine the potential awareness and the perceptions of heart disease in beneficiaries in the Northern areas Pakistan.

OBJECTIVE

To assess the attitudes and practices of heart health program on the target population of Gupis, Alyabad, Danyore and Gilgit (Northern Areas).

METHODOLOGY

Ethical approval was sought and approved, through strategy planning committee of, Aga Khan Health service' Pakistan. The purposive sampling was used in this study. A total of 9 focus groups were conducted. Six to eight participants were invited in each

group. The field officer identified the, beneficiaries for the focus groups. The selected beneficiaries were contacted by health care providers at home 2 days prior to focus group. Surprisingly, very few beneficiaries refused to participate in the focus group; otherwise all were very happy to be a part of this study. After explaining the purpose of the focus group, verbal consent was taken. Whilst each group was led by a moderator and a note taker, the discussions were conducted in the native language of the group participants, with the field officer acting as interpreter in the case of two beneficiary groups. The focus group lasted for 1.5 to 2 hours. Jane Ritchie's thematic framework model was used for the analysis of the transcribed data. After focus group sessions, all 10 cassettes were given to a professional transcriptionist to translate and transcript data from Urdu to English.

FINDINGS

AWARENESS OF HEART HEALTH

On asking question regarding heart health awareness to community it was said "we were taught about not using salt, big meat (beef) and ghee." Further it was said "They also taught us not to use dalda and banaspati ghee, use oil so we are trying not to use dalda. further they talked about sugar they said not to use more sugar here we use salt but they said you can use everything but in limits". On other hand it was said "It is not all about diet but people who smoke they also get heart attack so they said not to use cigarettes but here our people take alcohol as well they make wine at home and usually in winter people who do farming they stay at home for six months because in snow they can't work so they are at home and drinks and we can't stop our man and whenever AKHS'P arrange awareness program our man never attends". Further it was also identified that they were taught about diet, smoking and exercise as well.

COMMUNITY PERCEPTION /BELIEF

In northern areas people have very different perceptions and belief on illness and its treatment as it was said "in our area and most of the northern area belief on evil spirit (jin) and they go to traditional healer or spiritual healer (pari) so she prays and then she rubs her hands and a paper comes in her hand and then she gives to a person and ask

her/him that pour in glass of water and people get relief I have gone to her but I also go to doctor as well.”Further it was added “Yes most of the people here they don’t prefer to go to doctor they prefer to go to pari (spiritual healer) because we have very few doctors here we have nurses in centers though they are very nice and they diagnose and give medicine but besides medicine people go to traditional healer.”It was shared by one of the participant “One man, aged 40 was sitting and watching TV and all of the sudden his right side stopped working he couldn’t talk his wife called neighbors and they all said he must have a shadow of evil and he should be taken to traditional healer then he was taken to healer and he did some magic and give some thing for him to eat and slowly after 15 days of healing process he became much better and now he is doing good”On other hand it was said “in our session we are told that if any of us have chest pain we don’t wait immediately go to doctor. But I don’t agree with that whenever I have headache or backache and go to doctor he just gives me pain killer then after few days I again get same problem, then I got to traditional healer and he gave me one paper and told me to read and put in water and drink it and I felt ok so why one should go to doctor if we have chest pain.”

COMMUNITY BEHAVIOR

The community also talked about their health behaviors which has been used for many years it was said ‘It was identified that people of northern areas use salt in tea as it was said “They said that we should not use salt because that can raise our blood pressure but we people use tea with salt and we are using this for last many years I am 49 my mother and father are more than 70 years they are also using salt they never had heart disease of high blood pressure.”Furthermore they talked about smoking. It was said “Here at night men goes out and they do smoke and drink and we as a women we can’t control them as We were also taught about the substance use, alcohol use and smoking they said people who use that can get heart attack. Our people also use naswar(a kind of drug).”Most of the women showed their concern that they want to implement what they have learnt about heart health such as about diet and want to use oil but due to reluctant behavior of their husband they can’t do anything. One another woman said “I shared with my family and I told to my mother in law as she is very old she said I am eating ghee for last many years and I didn’t get any disease then why you people will get, she made fun of mine but still I try not to use more ghee”. One of the community person added “I think anything in large quantity is poison for example Dalda should never be used I myself forbade. Secondly it is salt. In past apricot juice was used at large and no salt. However in past there was excursion and less diet. Now a day’s people rest all the time. In past an old man and women worked himself there was no machine, At that time if they would have eaten stone, it would digested. But now machine do all the work and we only eat, so I mean now we have less work and eat more”. It was further added “I want to say that long time back we used to do a lot of work and now there is no hard work, we do not get tired even we don’t sweat, few years back I used to have basket of two mounds of manure and used to walk in the field for two to three months and then I used to get tired. That tiredness was helpful to cure all the diseases. Now this hard work or lifting heavy burden is finished. As my brother said machines do all the work. Now we don’t get tired therefore we suffer from diseases”.

VIEWS ON HEART HEALTH AWARENESS SESSION

Participants shared very positive views on heart health program. It was told “I think this kind of session should be for males rather than women because we understand and we try to follow the guidance given to us but man they don’t listen.”These sessions were conducted by the health care providers and all the providers were female so there was a view shared by one women “I think this type of awareness program should be conducted by doctors so there would be more participants, when nurse takes session many people ignores but if there would be a doctor people will listen more to them.”One of the participant said “I also want to tell you about the training programme

that there are so many educated people here as well in our community so the facilitators should be more confident whatever they are saying so participants take positive note from that. To be very honest we take everything lightly and when we think that the facilitator is also doubtful about the information then we just take as a message we don’t implement. For example in one slide there was a boy wearing shorts and was running this is not acceptable in our community”. Moreover, it was said “One thing which was lacking in the session was that they didn’t allow us to share our experience regarding heart disease. We were given very little time to speak because the presentation was very lengthy and time was short. As they taught us many things in one day they took almost 3 hours to complete.”It was suggested by many community people that these types of sessions should not continue more than an hour as participants cannot manage to take in volumes of information. The community also identified weaknesses regarding heart health awareness session it was said “the main weakness which I found was that the facilitator used English and Urdu language. In our community most of them are illiterate so they don’t understand what has been said so this type of programs should be arranged in our local language as well. And one more thing which I want to add is that akhsp should arrange separate sessions for different people such as, youth, educated people, uneducated people and old aged people because all have different mentality and level of understanding.”It was further added “I am illiterate and I can’t understand big words of Urdu so I just saw the pictures on transparency but I was not able to participate in the program so facilitator should have command on multiple languages at least on our own language.”Moreover it was said “in this session we are also taught about diet like what to eat and what not so some of the pictures of food were not appropriate which is not according to our culture as in some of the pictures they showed us burgers and pizza which is not being used in our area even people don’t know what is that.”

GENDER BIFURCATION

Gender discrimination is one of the key findings of the focus group. According to women their community is male dominant society it was said “females always listen but man doesn’t they are very strong they don’t listen to their wife’s or mothers.”On other hand participants shared their concern that when the health sessions are arranged, health care providers should always be informed on the same day so women can share this information with their husbands/partners so they too can attend the sessions. Therefore, it was suggested that the community should share this information 3 days prior to the awareness. On contrary it was said “In my opinion this type of training should be given to the females only as they look after house they cook so they can take care of their family diet so it will be more useful for us.”It was also said “I have observed that heart related disease is mostly in males than females. So it is quite necessary to include males in session. Secondly females are bound to cook the items which are brought by males at home.”

DISCUSSION

CULTURAL AND GENDER INFLUENCES

Culture and gender is one of the areas which need to be discussed as an essential part of an analysis of focus group. From many perspectives women in South Asia find themselves in subordinate positions to men and are socially, culturally, and economically dependent on them. (Agarwal, 1994). Women are largely excluded from making decisions, have limited access to and control over resources, are restricted in their mobility, and are often under threat of violence from male relatives. (Jejeebhoy, 2001) Although, women’s right to health has been reiterated many times, there are social and cultural barriers in developing countries that hinder their empowerment. Women’s low status, deprivation of education and lack of control over their own lives and bodies have a negative impact on their health status and that of their families. (Qureshi, 2007) The finding on gender disparity was not only identified through focus

group but could be observed as the participants of the focus group were mostly females. It was identified that men think of themselves to be healthier than women. However, the health of the male population is a substantial contributor to the health of the nation. In general, men have a poorer health status and lower utilization of health services than women. They have a lower life expectancy and are more likely to die from avoidable deaths than women. Men's health is increasingly being recognized as a specialty area of health promotion and of clinical practice. (Johnson, 2008) In Pakistan, public health policies and programs for women are quite difficult to implement. Women's social and geographic mobility is minimal, especially in rural villages, due to gender norms within the Islamic religion preventing them from talking to men freely and even prohibiting them from going out without their husband's permission at times. (Mine, 2007) The finding shows that women and older respondents tended to agree more with current scientific knowledge about heart disease mortality than did men and younger respondents. The findings suggest that sex and age, in particular, require consideration in the development of community cardiovascular disease intervention programs. (Pace, 2008)

HEALTH SEEKING BEHAVIOR

One of the key areas which were identified in all nine groups was health seeking behavior. As it is an important factor in health management, but this is often ignored while considering plans for providing health facilities to people. As a result, new schemes for providing health care do not get the desired acceptance of the community, and are therefore rendered unsuccessful. The decision makers in the health sector are recognizing the need for understanding the health seeking behavior of the community and its acceptance and usage of traditional and modern methods, as also the perception of the community regarding the service delivery. This becomes especially relevant among traditional and tribal societies like Northern areas.

The focus group identified that people only seek medical care when they are sick. They manage and deal with their illness at home or go to traditional healer. It was observed during discussions that the reason for not utilizing health services was the faith these ethnic people have in the traditional healers like the *pari khan* (faith healers). Though the participants were well aware of the health services provided in the local area, the participant preferred to go to traditional healer or faith healers. Most of the participants said that the traditional healers are located in places where the community has easy access. This makes them popular and readily relied on by communities. (Abdool Karim, 1994). Focus groups also identified that people of Northern parts of Pakistan whether they were health professionals, believed in black magic as it was also found that they have strong belief in traditional healing. And consulting faith healers is a common practice. People in rural communities often value very highly, self-sufficiency, self-reliance and independence. Consequently, health is given a very low priority which often translates into the view that medical services and hospitals really are the last resort. Consequently, people only go to health centre in the case of a serious condition. So there is certainly a growing need to justify the significance of studying health-seeking behaviors for designing advocacy campaigns, lobbying for a policy shift and convincing donors to invest in priority areas. (Shaikh, 2007)

HEALTH BELIEFS AND HEALTH BEHAVIOR

The findings of the study show that there was lack of awareness on heart health of beneficiaries which was hindering to change community behavior. Furthermore, the health of individuals and aggregate populations within a given community is dependent on their ability to identify their risk for specific health problem(s). In addition, these individuals and groups must be willing to adhere to life style changes in order to maintain health and wellness. Therefore, the role of nurses and other health care practitioners is to assess an individual's health risk and his/her belief that engaging in specific risk reduction interventions could lead to healthier

outcomes. Moreover, it has been identified that health education and disease prevention programs which are developed with language preferences and cultural values show efficacy of a program and positive behavioral changes based on communities' current circumstances. (Dutta, 2008) During the focus group sessions, it was identified that the lifestyle of the people of Northern areas is very different from areas more exposed to current medical knowledge. The participants may understand that a diet containing more than 3kg of ghee and salt is unhealthy and may cause heart disease, yet they see no harm in continuing with these practices. Therefore intense behavior change training programs needs to get organized, to maintain a life style change. The training program can facilitate the learning process by teaching in an interactive format that provides an opportunity for learners to engage in learning about the application of health belief principles in clinical practice. Part of the teaching and learning process is to demonstrate how course content can be applied realistically to clinical practice. The finding on heart health demonstrated that the practical application of course content was absent in the training program.

SOCIAL POLICY

Pakistan's first solely public health and health promotion was launched in 2004. And The National Action Plan for Prevention and Control of Non-communicable Diseases and Health Promotion in Pakistan has gained a prominent place on the nation's health agenda. From a health promotion perspective, the action plan was unique in that it focused on the community setting through two major behavioral communication change initiatives--one through the media and the other by integrating non-communicable disease prevention into the work plan of the Lady Health Workers. (Ronis, 2007) This approach had been observed during the focus group discussion as participants shared their views on education sessions. Besides, participants also highlighted many social issues such as poverty, education, gender disparity and life style. The study has also highlighted that recent shift in public health policy towards population-based approaches to the reduction of cardiovascular disease. This shift has been accompanied by a re-examination of strategies appropriate to the goal. Often, community development approaches, designed to affect socio-environmental change, are suggested as the most appropriate strategy for affecting community-wide change. (Kerry, 2000)

CONCLUSION

CVD is seen as a preventable disease in Western countries where the population is urged to take control over their health and adopt health seeking behaviors. (Gibney, 2004). However, a global CVD epidemic is rapidly evolving, with the burden of disease shifting. Twice as many deaths due to CVD now occur in developing countries as in developed countries. (Beaglehole, 2003) To reduce the burden of CVD, it is important to make more effort to develop more health promotion program. The findings of this research show that beneficiaries had limited understanding and awareness, but tried to ascertain the effects of their teaching and learning of heart disease, before the program. After training program it has enhanced the awareness. However some of the health beliefs and behaviors need to be addressed with the help of health belief models. Indeed, this study may reflect the notion that current health promotion messages are not creating the required impact; consequently, studying new ways of delivering health education may be warranted. Consequently, interventions that aim to empower patients to become more informed and active consumers of health care should be developed and evaluated. A cultural competence training programme for practicing health care professionals and volunteers need to be amending with proper planning.

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