Developments in Community Migrant Health Promotion Workers in the Netherlands: pro's and cont's

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Long history..

- Start more than three decades ago (1980’s)
- Migrant health educators recruited from the main migrant groups at that time (labour migrants from Morocco and Turkey)
- Lay women from the communities with low education
- Only in mother language
- Trained in basic knowledge about body, health and illnesses and the Dutch health care system.
Long history …

- Group sessions.
- At familiar locations for the migrant populations.
- Voluntary or paid ‘by the hour’.

- Aimed at improving the knowledge among members of the migrant populations.
- Aimed at empowering, both the health educators and members of the community.
Since the ’90’s….

- HIV epidemic: higher prevalence among migrants of HIV endemic countries
- Migrant health educators specially trained on HIV
- Also male migrant health indicators

- Start of some research: effect evaluation on knowledge gain on HIV:
  - Increase of knowledge
  - No effect on behavior
  - Mainly small scale studies
Since the ’90’s ….

- Improvement of the labor position of migrant health educators
- The need – and development – for migrant health educators in other health care settings (primary health care)
- The need for further development of the function of migrant health educators: professionalization
- The need for better training programs (knowledge and educational skills, language)
Since the ’90’s

- But:
  - Lack of standardized training programs
  - Lack of ‘regular’ (officially acknowledged) training programs
  - Lack of structural funding

- Lack of ‘evidence’
- Lack of resources for scientific sound evaluations.
Some examples
Migrant health educators in primary health care

Introduction of migrant health educators
- Same cultural background as the target population
- Same language as target population
- Trained as health educators

In order to:
- reduce workload of primary care professionals
- improve communication
- improve quality of primary health care for migrants
Migrant health educators in primary health care

Where:
- practices of general practitioners, with a large proportion of migrant patients.

Who:
- health educators with Turkish, Moroccan, Surinamese, African background.
Migrant health educators in primary health care

What:

- individual consultation, on referral by GP;
- consultation in the presence of GP and patient;
- open consultation hours;
- group consultation or education sessions;
- home visits.
Migrant health educators in primary health care
Migrant health educators in primary health care

- *decrease* of communication problems (GP and patients);
- *increase* of duration of consultation;
- *improvement* of perceived quality of health care provided (GP and patients);
- *decrease* of perceived subjective workload (GP).

- However: structural resources became not available.
Migrant health educators in perinatal care

- Antenatal education program ‘Happy Mothers, Happy Babies’
- Aimed at Turkish women
- Aimed at improving healthy lifestyle during pregnancy (smoking), maternal infant care practices and psychosocial health.

- Non-randomized trial among Turkish pregnant women
- Data collection at 3 and 8 months of pregnancy and 2 and 6 months after birth
Migrant health educators in perinatal care

- Results:
  - No intervention effects was found for
    - smoking during pregnancy,
    - Sudden Infant Death Syndrome prevention behavior on the long term,
    - soothing behavior,
    - serious depressive symptoms,
    - parent– child attachment.

- Limitations of the Study?
  - Hesselink et. al, Midwifery 2011
Diabetes voorkómen!
A preventive intervention to reduce diabetes type 2 risk in elderly migrants in Amsterdam

F. El Fakiri, Health Service of Amsterdam; Amsterdam, 2012

Differences in diabetes prevalence in The Netherlands: Dutch (3,1%), Turkish (5,6%), Moroccan (8,0%)

Amsterdam
Population: 780,000
Nationalities: 178
Diabetes voorkómen! study aim

To investigate the effectiveness of the intervention ‘Diabetes voorkómen’ on:
- diabetes knowledge and awareness
- identification and referral of high risk individuals
- participation in physical activity

→ Intervention components
   a. educational course led by peer health educator: (4 sessions: Information on diabetes risk factors, healthy eating; diabetes screening (risk test/glucose measurement) & GP referral of high risk individuals)

   b. Physical activity sessions led by sportteacher/physiotherapeut (weekly sessions for 1 year)
Methods

- Study design: quasi experimental, without control group (pre-post design)
- Study population: active recruitment of participants from self-organisations
- Data collection:
  - structured questionnaires administered at face-to-face interviews in participants’ mother tongue
  - Measurements: glucose (finger stick), diabetes risk test (including BMI, waist circumference)
  - Registration forms (attendance to sessions)
Results: diabetes knowledge and awareness before & after intervention

diabetes knowledge ↑, in highest educated group

Diabetes knowledge scores (0-30)  
N = 84

Participants’ estimated risk

N=82
Conclusions

- Self-organizations are appropriate settings to reach (elderly) migrants (hard-to-reach individuals; at risk for diabetes)
- Intervention program is effective in identifying high risk groups for diabetes.
- As implemented, the intervention has limited additional effects on diabetes knowledge and awareness
  - program adaptation to participants’ educational level ➔ big challenge!
- High satisfaction with peer health education/educators & intervention program
- Controlled studies are needed to test the effectiveness
Prevention of cardiovascular risk general practices in deprived neighbourhoods


patients at (high CVD) risk ---- high workload of GP

Inadequate care

Solution: additional support?
(migrant health educator & Practice nurse)

“does intensification of preventive care in general practice by a structured collaboration of GP, GP assistant, practice nurse and migrant health educator leads to a reduction of cardiovascular risk?"
Methods

- Study design: randomised controlled trial (RCT)
- Setting: 3 primary healthcare centres located in deprived neighborhoods of Rotterdam & The Hague (5 general practices including 18 GP’s)
- Patients: living in deprived neighborhoods; 30-70 years; at high cardiovascular risk (≥ 1 CVD risk factors: hypertension; diabetes; hypercholesterolemia; smoking; family history CVD; history CVD)
- Primary outcomes: reduction 10 year absolute risk (Framingham)
- Secondary outcomes: reduction in CVD risk factors
The intervention according to plan

Meeting primary healthcare team

- **Practice nurse:** risk assessment, health education, co-ordination and informative task
- **Migrant health educator:** ethnic specific health education
- **GP Assistant:** logistic task (measurements, patient recall & follow-up)
- **GP:** treatment task, final responsibility
Results: change in 10-year absolute risk at 12 months
- 10-year cardiovascular risk improved after one year follow-up in intervention and control group (1)

- no additional effect of intensified preventive care above periodic measurement of the cardiovascular risk profile

- major explanation for lack of effect: low implementation rate of intervention activities (according to plan) \( \Rightarrow \) intervention group \( \approx \) control group 1

- favourable study effects \( \Rightarrow \) periodic measurements and follow up of high risk patients

- marginal role of migrant health educator in almost all practices
2013: where are we now?

- Migrant health educators have no structural basis
- In most cases – apart from perinatal care – has been ended
  - Lack of political support
  - Lack of scientific evidence
2013: where are we now?

- However, in my opinion:

  - Migrant health educators are still needed to improve the quality of care provided towards – especially first generation migrants not speaking Dutch

  - We still need sound scientific research about the effects of the inzet of migrant health educators