



Exploring migrant engagement with preventive health: a meta-ethnography

Anna Isaacs*, Dr. Nicola Burns, Dr. Sara Macdonald, Prof. Catherine O'Donnell

Department of General Practice and Primary Care, University of Glasgow.

*MRC funded doctoral student





- Increasing burden of chronic disease¹,
- Preventive interventions might contribute to increased health disparities³
- Noted inequalities in access and health outcomes amongst certain migrant and ethnic minority groups⁴
- Higher rates of stroke, obesity and type II diabetes amongst African migrants in Europe and UK⁵

¹http://www.who.int/nutrition/topics/2_background/en/

³Mackenzie et al 2011

⁴Ingleby 2012

⁵Agyemang et al 2009



- Elucidate understandings and perceptions of prevention of chronic diseases amongst African migrants and compare these perceptions to those of health professionals.
- Explore how wider influences shape these understandings of preventive health care so as to better understand how those influences affect health outcomes for migrants.
- Incorporate political economy approaches into migrant health research
- Compare approaches to migrant health service provision around the globe.



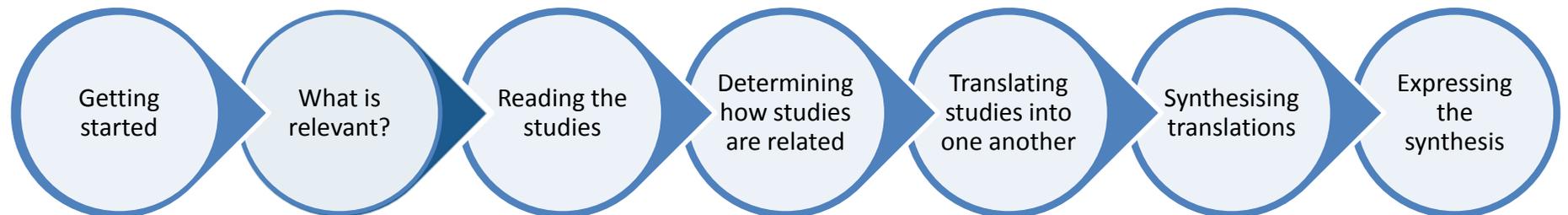
Exploring the provision and use of preventive healthcare services and perceptions around preventive health for migrants from Sub Saharan Africa in Glasgow

Meta-ethnography

- Focus groups
- 'Go-along' interviews
- Photo elicitation
- Interviews with primary care staff & public health professionals



- Method for synthesising qualitative literature
Synthesis of concepts rather than ‘facts’
- Suited to producing new theories and conceptual models
- Line of argument synthesis





Why do it?

- Limited evidence on most appropriate approaches
- Limited focus on prevention
- Few comparisons between approaches around the world
- Allow for wider inferences to be made
- Focus on in depth conceptual analysis



- How do i) migrants and ii) health professionals who work with migrants talk about preventive care and the utilisation of preventive services for CVD and type II diabetes?
- How useful is the concept of ‘candidacy’ as a framework for understanding patient and provider engagement with preventive health?



Prevent AND (*migrant* OR refugee* OR “asylum seeker*” OR “ethnic minorit*” OR BME OR underserved OR indigenous) AND (diabetes OR CHD OR CVD OR “cardiovascular disease” OR “chronic heart disease”) NOT epidemiology*

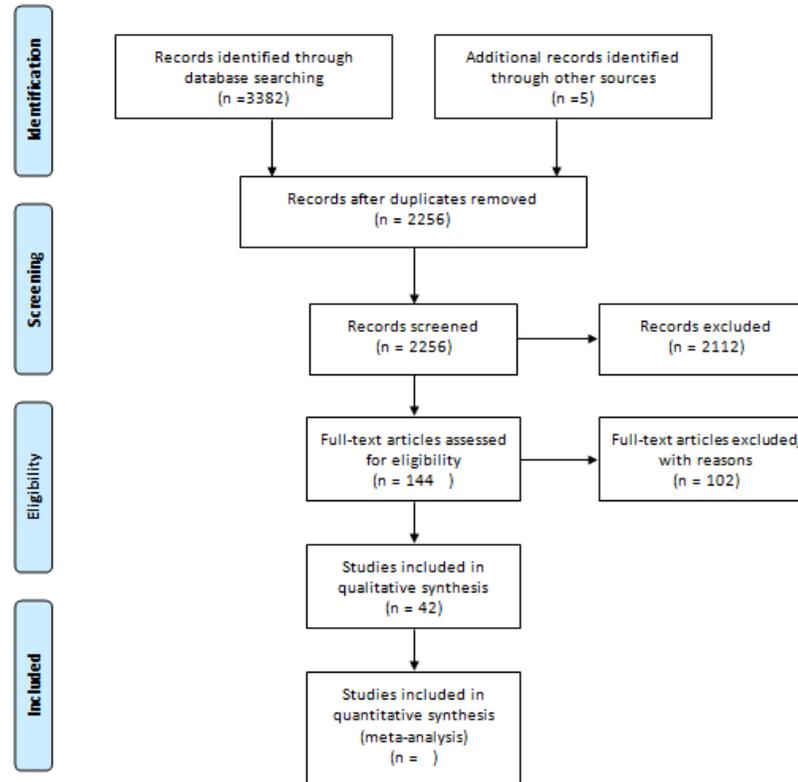
- Review registered on Prospero
- Search conducted on: Web of Science, SocIndex, Cinahl, Psychology and behavioural sciences collection, Science Direct (Social sciences) Medline, IBSS, ASSIA and PubMed plus a hand search
- Saved in endnote and transferred to distiller for screening



Progress so far.....

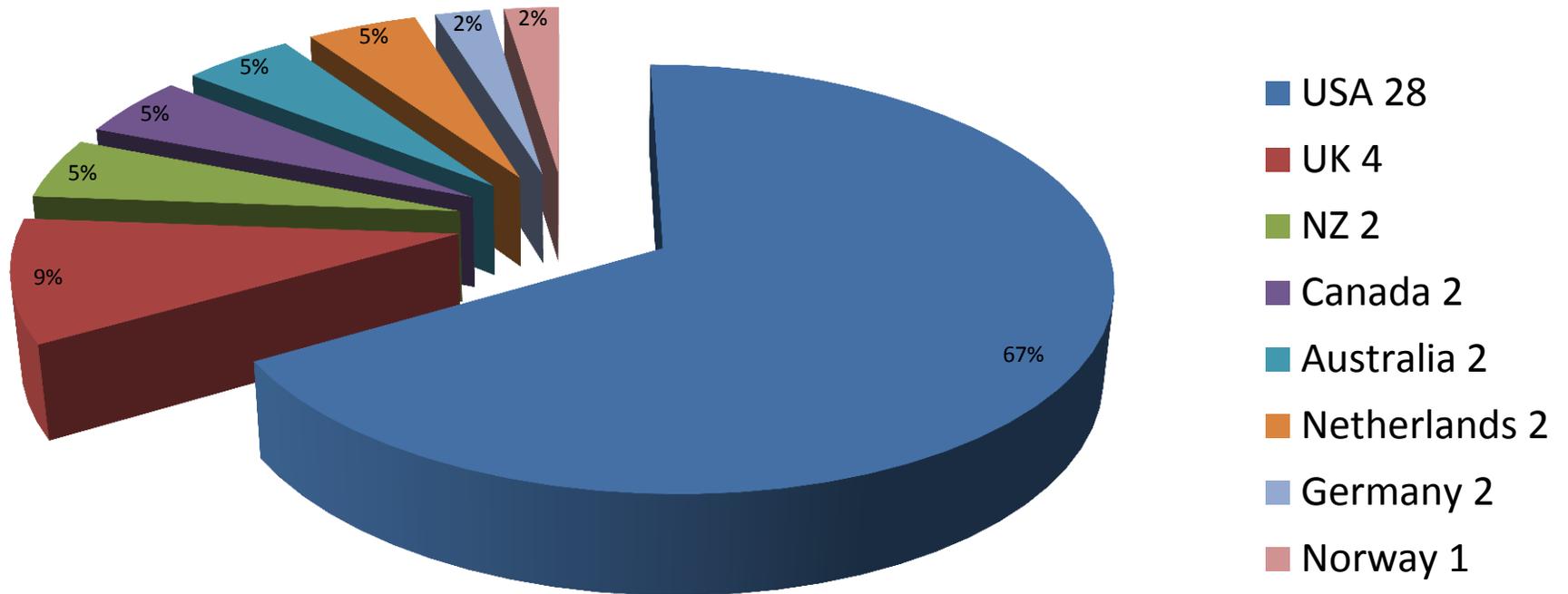


PRISMA 2009 Flow Diagram



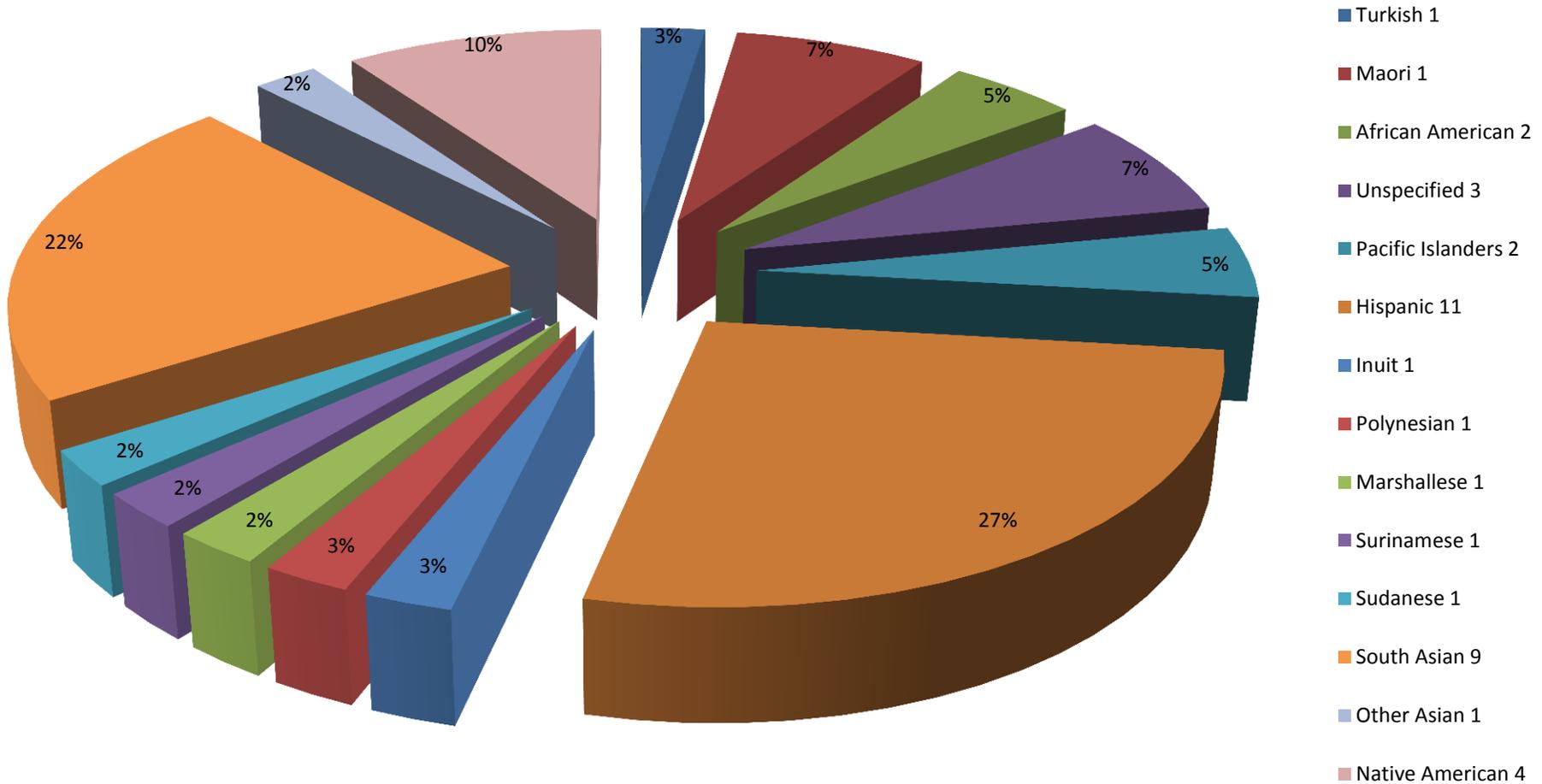


Papers by country



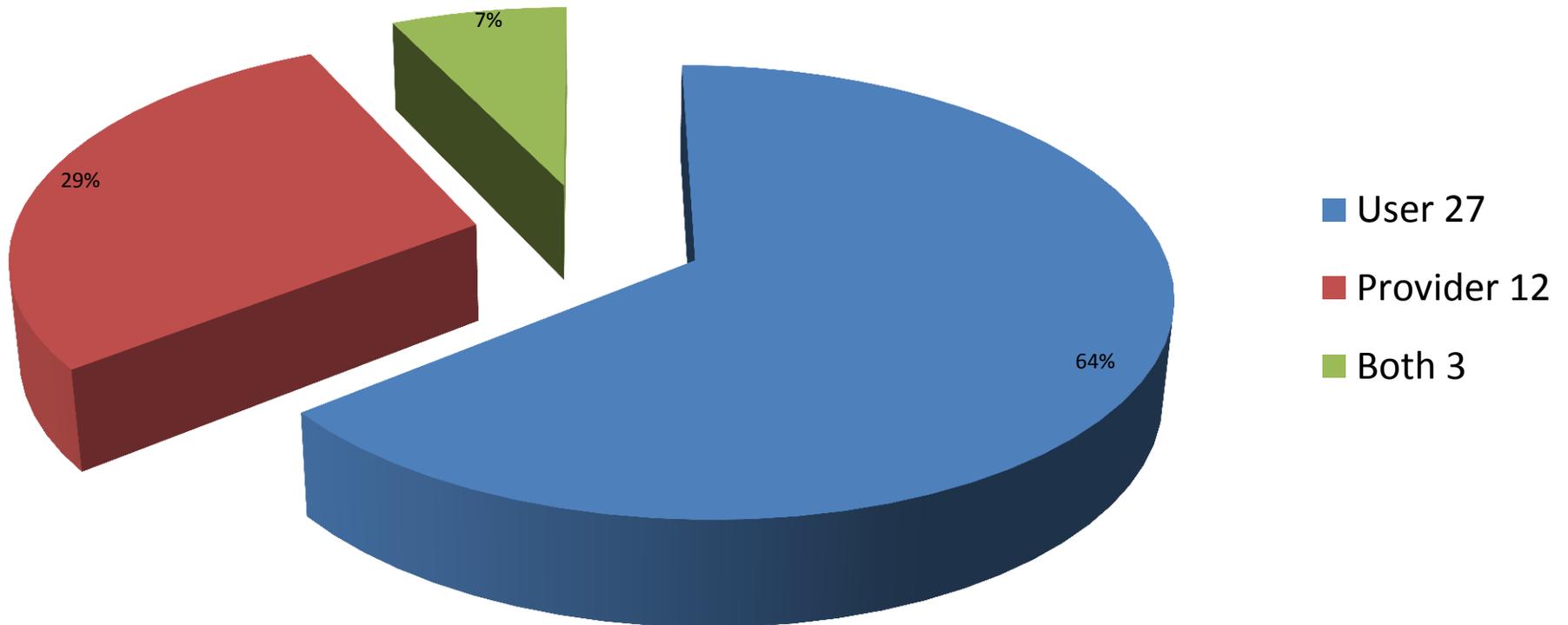


Papers by focus





Papers by perspective



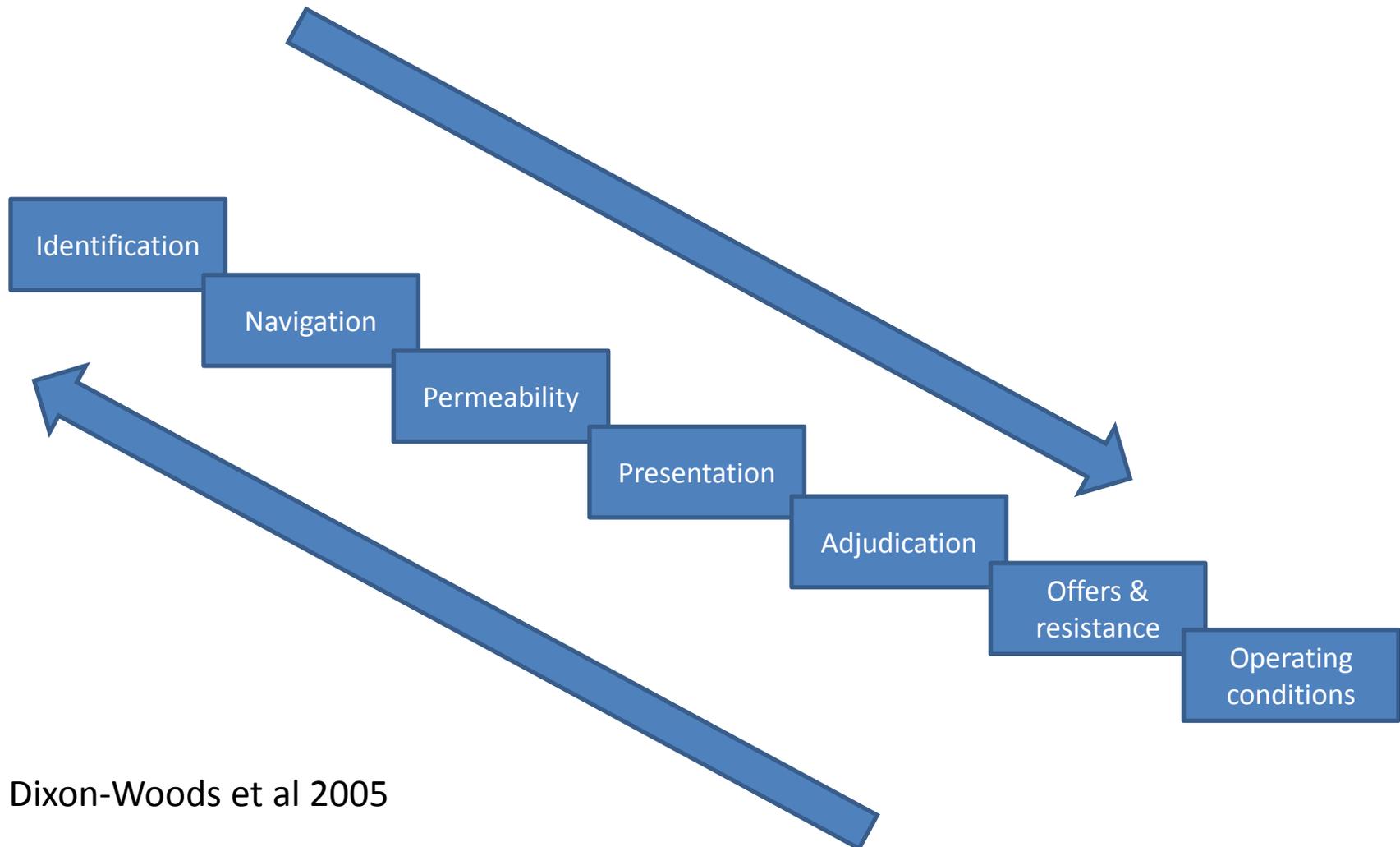


*'People's **eligibility** for healthcare is determined between themselves and health services. It is a **continually negotiated** process of individuals subject to multiple influences arising both from people and their **social contexts** and from **macro-level influences** on allocation of resources and configuration of services' Health services are continually constituting and seeking to define the appropriate objects of medical attention and intervention, while at the same time people are engaged in constituting and defining what they understand to be the appropriate objects of medical intervention'*

– Dixon Woods et al 2005



The candidacy model



From Dixon-Woods et al 2005



- How well does the candidacy model work for prevention?
- How does being a migrant affect individual's notions of candidacy and health services understandings of individual's candidacy?
- How does candidacy differ with differing health systems?
- Can the papers from provider and user perspectives be synthesised together - where are there similarities and where are there differences?
- Best way to group the papers?



References:

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