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The Ethos of Health Policies in the Grip of Lay Anticipation: The Case of Therapeutic Education for People Living with Type 2 Diabetes in Cameroon

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Abstract: Therapeutic education is an integral part of health promotion. It is an ancient and innovative approach to care, the result of a slow but steady evolution of public health practice around the world. Despite the fluctuating semantics in different paradigms, the goal of this approach is the quality of life of the person living with type 2 diabetes. To achieve this goal, a synergy of actions of all actors involved in the educational care approach and a promotion of community participation are necessary. Unfortunately, empirical evidence has shown a mismatch between the practices of expert and lay actors in the management of type 2 diabetes. The objective of this study is to analyse the therapeutic education practices of these two categories of actors. A qualitative descriptive study was conducted using documentary research, direct observation and in-depth semi-structured interviews. The target population consisted of lay actors (people living with diabetes, peer educators and family caregivers) and expert actors (health care providers, managers of diabetes care centres) according to our selection criteria. The field data was subjected to content analysis. The results showed that there were opposing pairs of actions, notably hospital-centred practices versus advanced therapeutic education practices. The medical approach versus the anthroposocialmedical approach to therapeutic education. Finally, the logic of expert actors is opposed to that of lay actors in educational care. An integration of the living environment and an effective focus on the person living with type 2 diabetes could improve community participation in the implementation of public health policies.

Keywords: Therapeutic Education, Health Policy Ethos, Type 2 Diabetes Management, People Living with Type 2 Diabetes

1. Introduction

Type 2 diabetes is a chronic disease that still attracts the attention of scientists in the 21 st century despite major advances in its management. Indeed, this pathology remains a health problem according to the WHO [17] as it is responsible for more than 3.8 million deaths and complications worldwide. Despite the innovative technology regarding screening, treatment and monitoring strategies, therapeutic education remains the best approach to promote self-care by people living with diabetes. This approach to care as a dimension of health promotion requires community participation. Community participation, a concept that emerged from the Bamako initiative and the Harare conference in 1987, seems more appropriate and an absolute necessity, given the progression of type 2 diabetes. Unfortunately, despite the decentralisation of care structures in the health districts (decree 95/013 of 7 February), it is inoperative, because people living with diabetes in the permanent quest for their well-being are not involved, and diabetes care policies do not take into account the approaches. Yet they have the potential to contribute to improving therapeutic education, and thus contribute to the construction of an efficient management policy. Therapeutic education, at the centre of this research, is understood as an approach to care that is inseparable from the management of diabetes according to d'Ivernois et Gagnayre [5].

The act of care is a way of educating and educating is caring Grimaldi [6] The international body has conceived it as a process integrated into care involving organised information, awareness and learning activities, centred on the sick person. Since its recognition by the WHO [29], it has been integrated

into care as an effective way to help people better manage their diabetes. The aim is to maintain or improve the quality of life of the patient, to reduce hospitalisations and the need for emergency care WHO [17]. As an essential component of diabetes management, it depends on the context and the actors. In the context of this research, these are expert and lay actors. The former (expert or top-level actors) are those involved in the development of diabetes management policy in general. In particular, they are involved in the organisation of diabetes management strategies. Aware that diabetes management is complex, and in view of unsatisfactory educational practices, lay actors (people living with diabetes, peer educators, their families) go beyond the medical world Baszanger [20], in search of well-being. Our priority is to analyse the therapeutic education practices of these latter actors who anticipate those of the expert actors. To achieve this objective, three articulations are addressed, namely a methodology, results and discussion.

2. Methodology

The study took place in reference sites, namely the National Obesity Centre, the National Hypertension and Diabetes Centre (CNHD) of the HCY and the Cameroonian Association of Diabetics (ACADIA). A qualitative descriptive approach and a clinical method seemed relevant to this study. Using data collection tools such as an interview guide and an observation grid, we collected data from the target population composed of expert actors involved in the management of type 2 diabetes such as the heads of department of the CNO and CNHD on the one hand and health professionals on the other. Lay actors such as people living with type 2 diabetes, peer educators and family caregivers on the other hand.

During two months, May and June 2018, in-depth interviews were conducted with ten actors meeting the inclusion criteria, including five policy actors and five lay actors. While a non-participant observation of therapeutic education practices was carried out with the lay actors. The analysis technique that allowed us to extract meaning and depth from the data was content analysis and Olivier De Sardan's development theory underpinned our analyses.

3. Results

The results are based on the therapeutic education practices of people living with diabetes of expert and lay actors.

3.1. Therapeutic Education Practices of Expert Stakeholders

The practices of the expert actors concern the organisation and strategies of therapeutic education.

The organisation is based on two approaches, curative and preventive, according to the actors. The curative approach is essentially oriented towards the disease and treatment, while the preventive approach is based on information, as one expert actor stated: 'Diabetes is a very complex chronic disease. That is why we welcome the diabetic with advice and information about his disease and treatment. This awareness is necessary for good compliance with the treatment. We classically do what is recommended, namely Information, Communication and Education (IEC) plus Behaviour Change Communication (BCC). They need to be able to observe the patient well and control the disease to avoid complications.

Curative and preventive approaches are implemented, even if their effectiveness and efficiency is to be demonstrated in this context. IEC and BCC are some components of therapeutic education. Therapeutic education requires a specific contextualised programme, learning, demonstration workshops in a negotiated context. It requires space, time and updated management models according to the International Diabetes Federation. In addition, consideration of the patient's experience, cultural values and diversified therapeutic pathways should be integrated.

The strategies of the expert actors are essentially hospital-centred and group-based. The hospital-centred strategy is to wait for the PVD2 in the hospital and when they come to the hospital, they mobilise group education. One expert actor put it this way: "We welcome patients here at the centre to give them advice on diabetes and treatment. Group education saves us time, because we deal with the classical topics".

The expert actors consider the hospital as the only appropriate space for the reception of PVD2, in order to talk to them about their disease and the treatment. Outside this space, people are left to their own devices in their homes.

3.2. Therapeutic Education Practices of Lay Actors

The socialisation of therapeutic education consists in integrating learning into the daily life of people. It is about getting people living with type 2 diabetes to integrate their practices into their daily lives by mobilising their personal and environmental resources. Tales, proverbs, songs, practical demonstrations are integrated into the therapeutic education session. The association represents this space for socialisation. A peer said: "We do specific practical education based on proverbs, stories and practical demonstrations. With the agreement of a PVD, we do foot hygiene, make meals from local ingredients. This helps to develop new ways of thinking, acting and feeling, as each patient is required to do these activities at least once within the association. The association of people living with diabetes is a space for expression, interaction, exchange and experience, which restores the person's confidence and promotes attentive listening to the sessions. It is favourable to a transfer of knowledge which is a necessary skill for the PVD2 in contextualising its knowledge. The expert actors do not integrate this approach in therapeutic education.

The advanced practice of therapeutic education by lay actors is a common practice. It consists of visiting sick people in their homes, to see how they live in their home environment. They find out what resources they have in order to use them in therapeutic education. It is about getting out of the hospital setting and into the person's social environment.

A peer educator said: "It is preferable to go out into the field as in the case of advanced vaccination strategies, as soon as we meet in the association, we agree on a programme of meetings.

At home, the density of the network of relations and the person's living conditions are taken into account. I try to understand the lifestyle in general, the family environment, the dynamics of the relationships in order to detect difficulties which form the basis of therapeutic education.

This strategy brings the carer and the patient closer together and strengthens mutual trust. The complicity that is created is very favourable to empowerment, compliance, therapeutic observance and even self-regulation of the health of people living with type 2 diabetes. All these skills are essential for anticipating the care process. Unfortunately, this approach is difficult to grasp by expert actors who find the approach tedious and costly. They require additional resources to compensate for their efforts.

The results showed that the lay actors take into account the representations of the person, his or her concerns and above all their therapeutic recourses. Concerning the social representations of the person living with diabetes, they are more taken in a pejorative sense by the expert actors, because they can negatively influence therapeutic compliance. However, it is a question of addressing themes that concern the person living with type 2 diabetes and not the global concerns of people in general. From this perspective, individual therapeutic education is essential to encourage the recounting of their journey since diagnosis.

A peer educator who is a member of the Cameroonian Association of Diabetics says: "to accompany a person living with diabetes, I take into account his social representations, his reasoning skills, his experiences, his experience of the disease, his history since the disease and I articulate with the doctor's recommendations to ensure effective accompaniment. This certainly takes time, but I feel obliged to succeed in my activity. Besides, that's what I'm here for". This strategy puts the person at the centre of the whole process and therefore helps them to understand themselves and to find their own health management strategies.

Taking into account the various therapeutic resources in the support process encourages the construction of appropriate therapeutic education messages. These recourses can constitute resources for the therapeutic education of these people. With the development of alternative medicine and information and communication technologies, the PVD2 get information from Internet sites and take products which, for the most part, stabilise their glycaemia or their weight. A peer educator said: "I have been diabetic for about ten years; I maintain myself well and I keep my complications at bay with products from naturopaths, Chinese, forever products... I consult the internet more and more to enrich myself. In any case I feel comfortable with these products and it works. I go to the hospital just to have my weight and blood sugar checked. So I have to take all that into account to educate my peers. This is a significant dimension in the care process, implemented in any case, that the expert actors seem to ignore.

4. Discussion

This section articulates the practices of expert and lay actors. Three essential aspects are highlighted in view of the results, namely hospital-centred practices versus advanced therapeutic education practices. The medical approach versus the anthroposocialmedical approach to therapeutic education, and lastly, the logics of expert actors versus the logics of lay actors.

4.1. Hospital-centred Strategy Versus Advanced Therapeutic Education Strategy

The hospital-centred strategy considers the hospital as the only place for therapeutic education. It is a question of welcoming and taking the person into a hospital environment which is often alien to the person, because it is static and has difficulty integrating the social environment of the patient 2. The environment also imposes a care schedule, specific interactions and care activities that are too standardised and not always understandable. This strips the person living with type 2 diabetes of what constitutes his or her daily way of life, of these cultural codes. Yet, according to the recommendations of the IDF [23] it is important to take into account the family environment of the person living with type 2 diabetes. In the same vein, the theme of the International Diabetes Day in 2019 emphasised the role and place of the family in supporting people living with diabetes. The family environment is in this respect crucial in the support of PVD2 Consoli et al [4].

3.2 Despite the burden of diabetes management, the chronicity of the disease imposes a permanent accompaniment of the family, and consequently education in advanced strategy is necessary, especially as Lefevre [24] reveals the complexity of TVE with regard to the uncertainties that surround it. From this perspective, getting out of the hospital to meet the person in their living environment is crucial Calafiore et al [3]. This is the advanced therapeutic education strategy mobilised by peer educators. These lay actors, in order to understand the aspects to be developed in the content of therapeutic education and to understand PVD2, immerse themselves in the environment of the person living with type 2 diabetes in order to get a feel for their needs. From this perspective, they negotiate the topics to be addressed in the therapeutic education in line with the expressed needs.

In contrast to this hospital-centred approach to therapeutic education, which takes place in an environment alien to PVD2, the advanced strategy of TVE places the person in their natural environment, which is favourable to the development of appropriate behaviours to improve the management of their diabetes. Implementing this advanced strategy means promoting rapid adaptation in a context where knowledge is complex. This approach seems to respond to Balcou-Debussche [2]'s call for the development of an integrative conceptual approach to therapeutic education. Moreover, placing the therapeutic education action in a context of the social life of the PVD2, favours the development of a relationship of proximity, of trust, which encourages the development of certain individual dispositions.

From this perspective, lay actors put PVD2 at the centre of the process and the therapeutic education relationship is symmetrical. The strategy put forward is to move out of the

formal setting into the social setting. It is a revolution in therapeutic education that can inspire expert actors. This strategy allows the person to be linked with his or her illness, with his or her environment, and finally with him or herself, in order to better understand therapeutic education. Moreover, a person who expresses himself better in the usual living environment can easily adhere to and comply with his treatment. This idea is corroborated by that of Kivits et al [25] who believe that the proper functioning of an educational intervention depends strongly on the context in which it is implemented, i.e. the social and cultural environment of the health systems in place.

4.2. Biomedical Versus Anthroposocialmedical Approach to Therapeutic Education

The medical approach to therapeutic education constructs a discourse on risk prevention, information on treatment and risk behaviour. It focuses on disease and treatment through curative and preventive activities. From this perspective, TVE is part of a prescriptive approach Nkoum [26] furnished with scientific aspects of the disease, prohibitions that converge towards instructions. This closed model favours less the participation of the sick person and more the submission of the person to recommendations, to norms. The objective of this model is to eradicate the evil, the disease. From this point of view, death is assimilated to a therapeutic failure and therapeutic education is closed. Deccache [31] suggests an educational approach consisting of four stages, namely an educational diagnosis, objectives, implementation and evaluation.

Operationalising this approach requires an anthroposocialmedical approach Ambomo [22] or an ethnological approach to therapeutic education according to Balcou-Debussche [2] Considered as an anthropological, or ethnological field, therapeutic education places the person living with type 2 diabetes at the centre. The latter cannot be considered as a sole carrier of a pathology, as he or she is above all a social being, in perpetual interaction with other individuals from the family, the world of work or the neighbourhood, in specific geographical, cultural and economic environments. Moreover, TVE, by its essentially relational character, favours encounter and presence, the meeting of individualities that clash and seek to assert themselves. From this point of view, it raises questions of identity, recognition and otherness. Balcou-Debusshe [16], speaking of health literacy, goes in the same direction as the lay actors. It is a question of using local resources, notably the local language, the experiences, the various assets of the person living with type 2 diabetes to produce adapted content. Using an account, a proverb to develop an idea is more comfortable for the PVD2 than vague information disseminated. Indeed, the PLW2 would like to feel understood and taken into account in the therapeutic education process.

As a social field, the actors involved in the field of therapeutic education of people living with diabetes mobilise different capitals. Their positions depend on the volume and structure of the capital they have at their disposal. [30] invites us to speak of economic capital (financial assets, wealth), cultural capital (diplomas, knowledge, etc.), social capital (all of one's social relations) and symbolic capital (all of the signs and codes linked to one's social space). In addition, PVDs2 use the capital they have related to self-observation, the experience of illness and the construction of meaning by the illness and the responses of others Phillips et al [8].

Combining all of the above dimensions leads to an understanding of therapeutic education as a set of actions and words that respond to values aimed at supporting, helping and accompanying people who are fragile in body and mind, and therefore temporally or permanently limited in their ability to live 'normally' or 'autonomously' in the community" Simon et al [27].

It goes beyond the "health" dimension to integrate the notions of learning, acquisition of reasoning and decision-making skills, mediation between actors and affect (emotion). Lay actors, in the process of implementing their advanced therapeutic education strategy, seek information on all aspects of the person's life, personality, demands and projects. Through interviews, the educational diagnosis is used to answer the following questions: what are the patient's plans, what are the factors apparently facilitating or limiting learning, what should the PVD2 learn to ensure a certain security (Ibid).

Indeed, while expert actors mobilise a technical language and inscribe therapeutic education in a somatic configuration, lay actors take into account all the dimensions of the person, and his interactions with the specific social environment that it is desirable to intensify by the expert actors. The articulation between the hospital and natural environments could be favourable to the development of the person living with diabetes has part of therapeutic education. This social approach to therapeutic education is an anticipation of the lay actors on the actors of the public action, because it is not thought even less integrated in the process of care. Lay actors insist that the communication of the experience of the disease by people living with diabetes themselves, the sharing among peers and relatives are in themselves acts of care and therapy.

4.3. From Individuality to Socialisation to Therapeutic Education

Individuality is understood here as isolating the person living with diabetes in the learning process. Indeed, in addition to the fact that chronic disease "de-institutionalises the life course" Boutinet [28] removing the person living with diabetes from his or her social environment disconnects him or her. Despite the forms of therapeutic education in groups, the expert actors put the person alone in front of his or her capacities of understanding and acquisition, all the more so because the pedagogy implemented is not active and is short in time. On the other hand, when the PVD2 integrates associative groups, he quickly socializes to therapeutic education, because he feels safe in this environment. The articulation between his natural environment and his associative environment favours the development of knowledge from the experiences of others. These spaces of socialisation, of demanding learning favour

new ways of thinking, acting and feeling are an expression of socialisation in TVE.

In view of the inequalities in access to modern health services and their low capacity to bear the costs of the disease, socialisation in therapeutic education seems relevant, as it values the sick person in all his or her dimensions. In particular, the cognitive (explanations), emotio-affective (narration), perceptive (body approaches, work on bodily feelings, etc.), infra-cognitive (work on automatic thought patterns, implicit reasoning, repressed emotions, lost perceptions, etc.) and meta-cognitive dimensions (understanding how to stand back from learning, representations of the care-giver-client relationship, values, meanings, intention, project, etc.) Lagger [14].

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The specific accompaniment of people living with diabetes is a necessity in view of their vulnerability. This concept has its roots in the Latin: ad-cum-panis which means towards-with-bread. It is another aspect of community risk management and self-management support by peer educators. Community risk management is linked to a collaborative network that is established within an association. It is the planned meetings of people living with diabetes to share experiences, concerns and information. This creates an interactive network between people living with diabetes and their families. The vulnerability of the person living with diabetes is a factor in this community-based risk management. The resources available to each person with diabetes are capitalised upon to benefit others. Thus, encouragement, multiple counselling, regular visits are all elements that fit in this register. All these elements can offer psychological comfort to the PVD2. To this psychological comfort, financial means can be added to resolve possible concerns related to the disease. The warmth that emerges from the associative context is a source of motivation for the PVD2. It contributes to the intelligibility of the messages; to the vigilance or the capacity to perceive, to recognise its symptoms and warning signs; in short to the anticipation of the risks.

From another point of view, support for self-management with the consideration of lay knowledge and its constructions is necessary in the TVE process. Despite the wealth of work by anthropologists on these concepts, they remain little mobilised by expert actors Balcou-Debussche et al [1] From another point of view, the socioconstructivist approach aiming at the enhancement of the person's potentialities is another way of sociabilising the PVD 2. Indeed, as a human being capable of acting on his environment, the latter is able to participate in the elaboration of the educational diagnosis from the incentive model Revillot [9].

4.5. Logics of Expert Actors Versus Logics of Lay Actors

The transactional nature of TVE induces a dynamic of actions underpinned by different logics: the paternalistic logic versus the therapeutic pragmatism logic. Logic of ponce pilatism and scapegoating versus reconciliation of social roles to the career of the sick.

4.5.1. Paternalistic Logic Versus Therapeutic Pragmatism Logic

The logic of paternalism of health professionals expresses sufficiently the asymmetry of the carer-client relationship. The expression 'actor from below' is borrowed from Ela [13] who considers the disenfranchised, the poor, the disinherited as part of the world below. This world is made up of actors who invent and reinvent everyday life through bricolage and thus develop resilience mechanisms that enable them to face the challenges they face. The lesser appreciation of the action of lay actors (actors from below) in the care process stems from the fact that the health professional holds the power through his or her knowledge which he or she uses and informs the person in order to transform him or her. This educational relationship is paternalistic in the sense that the health professional has a posture of the one who possesses knowledge and expertise, and who is therefore always right Gottlieb et al [15]. This induces a logic of information linked to the logic of teaching which consists of transmitting knowledge on which he relies and instructs the ignorant person on how to adapt. The aim is to make the person responsible, thus promoting him or her. This overly formal and unidirectional pedagogical relationship between the teacher (health professional) and the pupil (the sick person) Perrin [7] has the consequence of placing TVE in a perspective of objectives to be achieved and evaluation,

concerning the medico-technical aspects of disease management, thus obscuring the psychological dimensions and the trajectories of the disease. Moreover, the discourse of health professionals highlights the fact that it is the failings of the health system that prevent them from achieving their objectives. As a result, most of the professionals subscribe to the logic of professionalism which conceals a difficulty in adapting to the context of therapeutic education.

The word pragmatism comes from the Greek "pragma", the result of "praxis", which refers to action. When we speak of therapeutic pragmatism in this work, we are referring to the search for concrete and tangible efficiency in the choice of therapeutic routes by the PVD2.

We have observed that most VDP2, as soon as they are informed of their pathological status, adopt an attitude of recourse to alternative therapies underpinned by the logic of therapeutic pragmatism. The latter consists of a search for effectiveness in care through a combination of several therapies from sometimes contradictory etiological systems and is part of an alternative approach to care between the conventional, the non-conventional and the beyond conventional; which calls upon the domain of the invisible. This partition between the "visible" and the "invisible" had already been noted by Laplantine [12], as a cleavage between the biological and the non-biological structuring the representations of doctors regarding their territory of intervention. The therapeutic itineraries that emerge here are all characterised by a back and forth between biomedical medicine and alternative therapies.

Moreover, this logic of therapeutic pragmatism can be understood in the sense that PVD2 seeks to update the information received in order to better improve her compliance. The feeling of a lack of effectiveness of the medical treatment plunges her into confusion. Moreover, faced with the diversity of "TVE" contexts and the pluralisation of dietary injunctions, the PLW2 seek not to conform to a model of existence, but on the contrary to invent their own. It is in this sense that they multiply the therapeutic itineraries, in search of their health standard. However, developing countries 2 sometimes return to scientific medicine when alternative medicines have shown their limits. Are these multiple recourse attitudes not indications that call for the reinforcement of therapeutic education and bring the PVD2 to a rational substratum of the logic of self-normativity?

According to Barrier [11], self-normativity allows the patient, through a process of appropriation of the disease, to determine a "global health norm", which establishes a harmonious relationship between the subject, his disease, his treatment, and his life in general, in all its dimensions. The central idea is that autonormativity recognises the patient's intrinsic capacity to set a standard of health for him/herself, to the detriment of extrinsic standards from the medical authority. The logic of self-normativity allows VDP2 to define her therapeutic choices. For she creates a singular relationship with type 2 diabetes and appropriates it through a singular health standard. From this point of view, she establishes a harmonious relationship between the disease, its treatment and the recommendations of "ETP". In the context of this research, the logic of self-normativity is perceptible from the words of the actors. For example, it is common to find that many PLWHA2 readapt dietary constraints in order to achieve harmony between themselves and their treatment, their disease, their cultural values, their economic conditions and their environment. Moreover, some People Living with Type 2 Diabetes, having observed contradictions between the different therapeutic prescriptions, contradictions between the systems of care represented by traditional practitioners, naturopaths, alternative medicines and biomedicine, invent a health standard that is part of a personal logic of managing their career as a patient.

4.5.2. Logic of Ponce Pilatism and Scapegoating Versus Reconciliation of Social Roles with the Career of the Sick

La logique du bouc émissaire que nous avons évoqué au niveau des PVD2 revient au niveau des professionnels de santé. À titre de rappel, elle consiste à imputer la responsabilité de ce qui est anormal à autrui. Ce que nous désignons par la logique du *ponce pilatisme* est aussi inspiré d'un mythe juif[1]. Elle consiste en une déresponsabilisation vis-à-vis d'un malheur qui pourrait arriver à une personne.

Nous constatons que les discours des professionnels de santé ressortent le fait que ce sont les défaillances du système de santé qui les empêchent de réaliser leurs objectifs. Par conséquent, la responsabilité de l'état actuel de la pratique d'ETP ne leur incombe pas. Lorsque la faute n'est pas imputée aux professionnels de santé, elle incombe aux autres acteurs impliqués dans le processus d'ETP. Les acteurs experts estiment pour la plupart que les politiques publiques ne les accompagnent pas suffisamment. Par ailleurs, les PVD2 ne prennent pas l'éducation thérapeutique au sérieux. Cette autodisculpation les emmène à se désengager et à se déresponsabiliser vis-à-vis du statu quo de l'ETP c'est en cela que consiste la logique du *ponce pilatisme* des professionnels de santé dans le domaine de l'éducation thérapeutique de la personne vivant avec le diabète de type 2.

By reconciliation of social roles, we mean a system of normative constraints to which the actors who hold them are supposed to conform and rights correlative to these constraints Boudon et Bourricaud [10]. The chronicity of type 2 diabetes weakens the PVD2. Contrary to the representations of the expert actors, this vulnerability is an obstacle for the PVD2 to assume her social roles, could explain her unavailability to follow the TVE sessions. The meaning of this attitude can be understood from a logic of reconciliation of social roles to the role of the diabetic. The plurality of demands made on PVD2, which is linked to the multiplicity of her social roles, invites her to reconcile them with her career as a patient. However, the family position, the degree of responsibility in the family as well as in the professional and associative sphere, turns out to be a factor of commitment or not to the practice of TVE for some PVD2.

[1]Bible, Jean 19, versets 4 à 6

Being a diabetic does not remove PVD2 from these family, professional and societal responsibilities. Her attendance at TVE sessions is a function of the prioritisation of these roles. To support this logic, we met PLW2s who were divided between their professional, therapeutic and family constraints. In the majority of cases, some PVD2 prioritise the production of means of life to the detriment of TVE. In some cases, others find compromises to maintain themselves in the field of TVE while continuing to exercise their societal obligations. We can see that the management of social roles influences the management of the disease career in PVD2. From this point of view, integrating the environment of the ill person would be favourable to understanding their social roles in order to take them into account in the therapeutic education process.

5. Conclusion

Therapeutic education for people living with type 2 diabetes is an approach to care that aims at the quality of life of the latter. It involves several actors, some of whom are experts and others lay people. Unfortunately, empirical findings have shown a mismatch between the practices of expert and lay actors in the management of type 2 diabetes. The objective was to analyse the therapeutic education practices of these two categories of actors. A qualitative descriptive approach was used, favouring documentary research techniques, direct observation and in-depth semi-directive interviews. The target population was made up of lay actors (people living with diabetes, peer educators and family caregivers) and expert actors (health care providers, managers of diabetes care centres) according to our selection criteria. The field data was subject to content analysis. The practices of lay actors implement an anthroposocialmedical approach to therapeutic education comprising three essential aspects, namely, the socialisation of therapeutic education, advanced practice of TVE, specific support for community risk management and therapeutic recourse. The expert actors tend to focus on hospital-centred strategies based on prevention and cure. The following pairs of oppositions emerge: hospital-centred practices versus advanced therapeutic education practices. The medical approach versus the anthroposocial-medical approach. Finally, the logic of expert actors versus the logic of lay actors in educational care.

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