# Managing diabetes in CALD communities

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*Culturally and linguistically diverse communities have a greater prevalence of diabetes and poorer outcomes than the Australian-born population. Managing diabetes in this group of patients can be challenging due to multiple barriers involving both the patient and the healthcare professional.*

The high rate of diabetes in culturally and linguistically diverse (CALD) communities is due to genetic, environmental, lifestyle and migration related factors. Management of diabetes, which requires lifelong patient participation and engagement with healthcare professionals, can be challenging due to multiple barriers including health literacy and sociocultural issues.

A CALD background is defined as 'people born overseas where English is not the main language' and also includes people born in Australia whose main or preferred language spoken is not English. Indigenous Australians are not included in this definition.[1]

## Prevalence

Australian population data show that immigrant groups have a higher prevalence of type 2 diabetes than the Australian-born population. They also have a greater risk of developing complications of diabetes.[2]

## Key points

- **In culturally and linguistically diverse (CALD) communities there is a greater prevalence of type 2 diabetes, occurring at a younger age and with poorer outcomes.**
- **GPs should familiarise themselves with the risk factors and prevalence of diabetes and particular challenges in various ethnic groups to guide screening and management.**
- **Allocation of adequate time with the aim to address two to three key issues at each appointment is optimal in the CALD patient consultation.**
- **Cultural humility and diversity awareness is a goal for all healthcare professionals in assisting CALD patients.**
- **Involving bilingual and multicultural staff and the effective use of medical interpreters aids patient compliance.**
- **Culturally tailored programs and strategies, with acceptability to the target group, is an important step in health equity in CALD populations.**
- **The use of community leaders in diabetes education programs help enforce positive exercise and dietary behaviours and assist with de-stigmatisation.**

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Diabetes occurs five to 10 years earlier in immigrant groups, and at diagnosis more than 20% of patients are less than 50 years of age.[2] The highest prevalence of diabetes and insulin-treated diabetes occurs in people born in the Middle East, North Africa and southern Asia. Australian data show the prevalence of diabetes is three times higher in immigrants from Italy and Greece living in Melbourne.[3] The highest diabetes-related hospitalisation and mortality rates are seen in immigrants from the South Pacific Islands, the Middle East and southern Europe.[4] A disproportionately high incidence of type 2 and gestational diabetes is seen in immigrants from the Indian subcontinent and Southeast Asia.[5] Ethnicity also seems to influence the future development of impaired glucose tolerance and type 2 diabetes in women immigrants from these regions.[6]

Also, there is a significant gap in the available data for diabetes risk in specific CALD populations and little evidence about what models and methods work best for diabetes prevention.[7]

## Barriers to patient care

People from CALD communities have significant barriers to accessing and utilising healthcare services due to language and health literacy, migration-related issues, sociocultural beliefs and negative social labelling – all leading to poorer clinical outcomes.

### Language and health literacy

The chronic and insidious nature of diabetes – with little in the way of symptoms initially yet leading to considerable morbidity if untreated – is always difficult to translate, even with professional medical interpreters. Health literacy is vital for patients to engage in their health and to take an active role in health-related decisions, yet many CALD populations have low levels of literacy and numeracy in English and low levels of functional health literacy, which can lead to poorer outcomes.[8,9] They also have less awareness of the available services and have challenges in navigating the healthcare system.

### Immigration-related issues

As an immigrant tries to settle into their new way of life, their priorities are usually to fulfill basic necessities such as housing, education and employment. Financial survival usually takes precedence over health issues, and taking time off work to attend and travel to medical appointments may be difficult or prohibitive.

A change in diet is also inevitable in the new immigrant, with many abandoning the healthy aspects of their traditional diets and increasing their intake of fat and sugar. The subsequent consumption of fast foods combined with greater purchasing power has been shown to increase rates of obesity in this group.[10]

### Sociocultural beliefs

In some cultures there is conflict between a patient's cultural beliefs and Western medicine, with reliance placed on traditional medicine and the beneficial properties of certain foods. Long-term medication use is thought to cause harm and dependence, leading to low treatment adherence. A study on Chinese immigrants with type 2 diabetes demonstrated that a strong belief in traditional Chinese medicine resulted in lower medication adherence.[11]

For many immigrants born in the developing world the concept of 'exercise for health' is not fully understood nor considered a priority. Activities such as running in public and mixed-gender exercise classes are not readily accepted, especially in women of Bangladeshi background.[12] People from Middle Eastern countries and hot climates are not accustomed to brisk exercise; and in Muslim culture the need for modesty with clothing may affect physical activity in public spaces. In South Pacific Island communities, physical activity at work or home is considered sufficient and activities need to have purpose. Engaging in exercise for health benefits is not common, however, young people enjoy sports and have a particular interest in ball games and this interest could be used to encourage exercise. In traditional Chinese texts (and in popular Chinese belief) vigorous exercise and sweating is not favoured and even considered harmful (losing precious Qi – vital life energy). The health benefits of other forms of low impact exercises such as walking, tai chi and yoga are preferred.[13,14]

There is evidence to suggest that ethnic minority groups delay and underutilise health services at diagnosis of diabetes and at all stages of illness, even when they have symptoms of ill health. A Victorian study on Arabic-speaking patients showed significant barriers in accessing services even in the presence of symptoms of hyperglycaemia. These barriers were due to placing reliance on family and key community members to assist with the decision-making to access healthcare services. Some also expressed fatalistic belief and lack of confidence with hospital-based healthcare professionals and experienced fear of accountability regarding self-management, but had more confidence with Arabic-speaking GPs. In contrast, English-speaking Caucasian patients had no hesitation in early access to and uptake of medical services.[15,16]

### Poor community acceptance

In many CALD communities a diagnosis of diabetes can lead to a feeling of stigmatisation and negative social labelling, which leads to withholding the diagnosis from family and friends and avoiding medical consultations. There is resistance to dietary modification and many confuse dietary modification as abandoning traditional diet and ingredients and moving to a Western diet. Patients may find it difficult to adopt a change in lifestyle and fear being blamed for not achieving targets. There are myths and misconceptions and stories of harm from long-term medication use (particularly insulin), which is often considered a death sentence.

## Barriers to care – healthcare professionals

Barriers to care created by healthcare professionals include a lack of cultural awareness and confidence in dealing with CALD patients. This can lead to the risk of the healthcare professional being perceived as culturally insensitive, which can then lead to miscommunication and difficulty establishing rapport. Healthcare professionals working

**Resources for the CALD patient consultation**

**Diabetes Australia Position Statement: a new language for diabetes**
https://static.diabetesaustralia.com.au/s/fileassets/diabetes-australia/f4346fcb-511d-4500-9cd1-8a13068d5260.pdf

**Translating and Interpreting Service (TSI National): 131 450**
www.tisnational.gov.au/

**NDSS Multicultural Diabetes Portal**
http://multiculturalportal.ndss.com.au/

**AUSDRISK online calculator**
www.diabetesaustralia.com.au/risk-calculator

**Traffic Light Guide to Food**
www.trafficlightguide.com.au/site/pag21.php

**LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) model**
https://medicine.osu.edu/sitetool/sites/pdfs/ahecpublic/LEARN_Model.pdf

**Centre for Cultural and Ethnic Health**
www.ceh.org.au/training/

**International Diabetes Federation Guideline: Ramadan and fasting**
www.idf.org/e-library/guidelines/87-diabetes-and-ramadan-practical-25

with and treating CALD communities report low levels of confidence and that undergraduate education and continuing professional development does not adequately address understanding of different food rituals, traditional diets and cooking methods.[17]

## Management strategies

In multicultural societies such as Australia, where universally equitable medical services exist, the decision to access and utilise health services depends on the patient's own will. This is especially important in chronic diseases that do not usually cause acute symptomatology, and therein lie the challenges of cultural and language barriers.

Key strategies in managing diabetes involve ongoing patient participation in self-management, lifestyle modification and pharmacotherapy aided by establishing a trusting relationship between treating practitioners and the patient. GPs play a key role in patient engagement and are in a unique position to start this process by demonstrating a genuine interest and by trying to understand the patient's context. This in turn will help patient confidence and involvement. By exploring patient beliefs and barriers and regular interaction, GPs can develop a mutually acceptable and culturally appropriate management plan with their CALD patients.

Simple measures, such as allocation of adequate time for consultations and involving key family members with the aim to address two to three key messages at one time are helpful. Due to the unique barriers and challenges outlined above, appointment attendance by CALD patients tends to be poorer than the Australian-born population. A system of scheduling follow-up appointments after each consultation is helpful for periodic assessments, and providing appointment details in the patient's own language in written format is recommended. Following up missed appointments by sending reminders/recalls via telephone or letters is also helpful (recall templates are available with most practice software), as is utilising bilingual and multicultural staff (if available and appropriate) to encourage attendance and aid compliance.

A list of resources to assist GPs in the management of CALD communities is shown in the Box.

## Language and communication

A willingness to learn and engage by asking open-ended questions such as belief in traditional medicine, attitude to Western medication use, food rituals, celebrations and religious fasting will help the GP understand cultural nuances and allow them to acquire confidence when working with specific CALD communities. The Diabetes Australia position statement 'A new language for diabetes' promotes the use of positive and plain language and how to avoid medical jargon. It also provides practical scenarios for healthcare professionals and recommendations for verbal and written interactions.

The LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) model focuses on teaching generic skills for communication and negotiation that can be applied to all patient-practitioner encounters.[18] Another method is the teach-back technique, which involves delivering information tailored to the individual patient and then asking the patient to express what they have learnt (in their own words) back to the practitioner. The teach-back technique has been shown to improve retention and adherence to lifestyle and medication.[19] It can also be used to improve safety with parenteral medications, especially insulin.

The use of trained medical interpreters has been shown to improve clinical outcomes and patient satisfaction with care.[20] The government-funded Translating and Interpreting Service (TIS National) is a free 24-hour service available through the Doctors Priority Line for all services claimable under Medicare delivered in private practice. Medical professionals are eligible for free registration to TIS National.

## Appropriate education and resources

Incorporating culturally sensitive elements into the consultation is crucial to improving quality of care for CALD patients. Encouraging the use of a traditional diet with an emphasis on the healthier components and with particular attention to portion sizes is useful. The Traffic Light Guide to Food's 'carb counting app' is an excellent tool and is expected to soon be available in Korean, Chinese and Hindi languages with traditional food ingredients and recipes.

Culturally appropriate diabetes education resources are available in different languages and can be accessed from the NDSS Multicultural Diabetes Portal. These should be used in conjunction with

verbal advice, keeping in mind that some CALD patients may have low language proficiency, even in their own language. Inclusion of pictorial aids in addition to written and verbal modes of education can be effective.

Patient resources are listed in the Box.

## Challenges in particular CALD groups

Awareness of risk factors and prevalence of diabetes in various ethnic groups can guide effective screening programs and management strategies. AUSDRISK calculators in different languages can be used in waiting areas. The role of unplanned opportunistic methods of diabetes screening (e.g. health camps, community events, gatherings) cannot be underestimated.

Fasting during Ramadan can be a challenge for healthcare practitioners working with Muslim communities. Some background understanding of fasting and other rituals during this period will assist in providing pre-Ramadan education and adjustment of the fasting patient's treatment regimen to optimise blood sugar control and avoid hypoglycaemia. The International Diabetes Federation provide practical guidelines in this area.

In South Pacific Island communities, traditional generosity with food (where many types of carbohydrates can be consumed at one meal) and the rapid adoption of fast foods and other convenient foods and low compliance with medication in addition to poor attendance for routine follow up is an issue.

## Bilingual and ethnic healthcare professionals and staff

Involvement of bilingual and multi-ethnic health staff has proven to be an effective strategy in improving communication and health delivery.[21] Culturally tailored programs delivered by a healthcare professionals with a shared cultural and linguistic background have also been shown to improve mutual understanding in a model similar to the Aboriginal healthcare worker (which has been applied with some success).[22] With increasing diversity in the medical workforce there is greater availability of GPs and other healthcare professionals from different backgrounds and their appropriate use should be encouraged where possible.

## Diversity awareness and cultural humility

Simply resolving the language issue is insufficient unless cultural context is understood and addressed. Cultural competency starts with awareness of one's own culture, biases and prejudice and this is followed by understanding the differences between themselves and other cultural backgrounds, particularly in relation to patient needs and attitudes toward health-related issues.[23]

Recently the concept of cultural humility has been promoted over cultural competency (it is recognised that one cannot possibly know all there is to learn about each culture).[24] Cultural humility should be a goal for all healthcare professionals. It is a respectful attitude towards other cultures and involves active and ongoing commitment to the learning process in order to become a reflective practitioner.

CALD communities are diverse and heterogeneous and therefore a common strategy to assist healthcare professionals in every day clinical practice may not be appropriate. However, there is currently limited diabetes-related CALD training or educational resources or courses available for healthcare professionals. Therefore by acquiring knowledge and demonstrating a desire to learn in a respectful and sincere way from the patient, GPs can develop some understanding and confidence when dealing with particular ethnic groups. This is a lifelong process. It is also important to recognise that cultural differences can be complex and vary within the cultural groups themselves and with other factors such as age, education, socio-economic status and with acculturation over time.

## Involving community leaders and story telling

Involving multicultural health workers, community, religious leaders and pharmacists as role models in the target CALD community and using story telling in the native language is a powerful and persuasive way to inspire that community. This has been shown to be effective in the immigrant Somalian, Latino and Arabic communities.[25,26] Equipping community role models with general understanding of diabetes, common myths and challenges helps enforce positive health messages in the target communities and assists with destigmatisation.

## Multimedia and online apps

The use of media targeted at the ethnic community can be a useful tool for diabetes awareness and patient orientated culturally appropriate messages can be delivered through free social media applications. In an exploratory study in to the Chinese population in Sydney there was improved patient adherence, satisfaction and psychological wellbeing with online diabetes programs delivered through preferred social media platforms.[27] Different platforms are more acceptable and appear to be widely used by certain ethnic groups (e.g. Wechat for Chinese populations and Kakao Talk for Korean populations). These have the potential to provide both opportunistic and purposive opportunities for culturally sensitive diabetes education.

## Conclusion

In an increasingly multicultural Australia most GPs will encounter patients from CALD communities. Therefore GPs should familiarise themselves with the risk factors and prevalence of diabetes and the particular challenges in various ethnic groups to guide screening and management. Managing diabetes in these groups comes with additional challenges, in which GPs play a key role. Culturally tailored programs and strategies, with acceptability to the target group, is an important step in health equity in the CALD population. **ET**

### References

A list of references is included in the online version of this article (www.endocrinologytoday.com.au).

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