Can we ever really tackle diabetes in ethnic minorities?

Many ethnic minorities are at dramatically increased risk of developing type 2 diabetes (T2D) and tackling the complex network of mutually reinforcing barriers to better care often proves remarkably difficult. Yet investment in culturally appropriate initiatives for T2D is often only a few pence per head a year.

Mark Greener explores why addressing T2D in ethnic minorities depends on a paradigm shift in care towards supporting self-management and fostering personal responsibility.

The UK is remarkably ethnically and culturally diverse. According to the 2011 Census, around a fifth of people in England and Wales regard themselves as belonging to an ethnic group other than white British. Almost 1-in-23 were ‘other white’, 1-in-40 were Indian, 1-in-50 Pakistani and 1-in-250 Arabic, for example. Many of these ethnic minorities are at dramatically increased risk of developing T2D.

Tackling T2D in the UK’s diverse ethnic minorities can prove remarkably difficult, underscored by the ongoing demand for culturally sensitive information. Krishna Sarda, Diabetes UK’s Engaging Communities Manager, explains that the charity receives 500–600 requests a month for translated information from members of relatively new communities in the UK, for example in Polish. Around 1300–1500 requests come from members of longer-established communities in the UK, including for information translated into Urdu and Bengali. Yet investment in culturally appropriate initiatives for T2D by clinical commissioning groups (CCGs) is, Krishna notes, often only a few pence per head a year.

A mutually reinforcing network

A complex network of mutually reinforcing barriers – including biological, cultural and socioeconomic – underlies the increased risk of T2D among ethnic minorities. South Asians show, for example, greater insulin resistance than Caucasians, after allowing for body mass indices and proportions of total body fat, as well as earlier impairments of beta-cell function. South Asians also typically show more visceral fat deposition, even as infants. The UK SABRE study showed that differences in truncal fat and visceral adipose tissue may contribute to the increased T2D risk among South Asian and African Caribbean people aged 40–69 years compared to white Europeans. The association was especially strong in women.

In addition, a typical South Asian meal contains more calories and carbohydrate than a European meal. Krishna called for increased awareness of foods that are high in salt, fats and sugars. ‘People may not appreciate how unhealthy some traditional foods are,’ he says.

Linguistic problems and a reluctance to access health care present additional barriers, remarks Debbie Hicks, a Nurse Consultant who heads an intermediate care service for Enfield Community Services, Barnet, Enfield & Haringey Mental Health Trust – an ethnically diverse part of north London. ‘We have people in my area, for example from the Turkish community, who have been in the UK for 20 or 30 years, but who don’t speak English,’ Debbie told Practical Diabetes.

‘I recently saw one lady who’d been here since the early 1960s and had no English. Her daughter attended to translate for her. We employ interpreters, of course, and many of these translate the messages very well. In some cases, there seems to be a short-lived benefit from translating health promotion and consultations, but I’m not sure that it has a lasting effect.’

Debbie added that, in her experience, many people from ethnic minorities seem to have a ‘fatalistic’ attitude towards diabetes. ‘Typically, people from ethnic minorities don’t access health care as much as white Europeans. Even if they initially see a health care professional, they often don’t attend the follow up appointments,’ she says. Krishna agrees, noting that many people from ethnic minorities don’t collect or take their prescription.

Against this background, in 2009 Debbie’s service invested £20 000, supported by a pharmaceutical company, in an attempt to improve engagement with the Turkish community. Debbie’s team set up an information stand in a major shopping area to raise awareness about diabetes. People were asked to complete a short questionnaire to determine their risk of diabetes. High-risk people were signposted into a nearby Superdrug store for a health check. ‘I don’t feel this was money well spent,’ she admits. ‘It didn’t seem to change anything.’

Another recent public health initiative aimed to reach the Turkish and Somali communities by providing culturally-sensitive educational sessions by working with community leaders. Debbie’s team held sessions at times that allowed Somali people to attend – such as after Friday prayers – and sessions specifically for Turkish people. Information was translated by Somali speaking and Turkish speaking health educators. ‘Again, it didn’t seem to work,’ she remarks. ‘We had 80 places available on the sessions. Just 11 people booked in, but only about three or four turned up. We need a different approach.’

Addressing entrenched attitudes

Fundamentally, Debbie remarks, the failure arises because tackling T2D in ethnic minorities means overturning entrenched cultural and societal traditions, attitudes and behaviours. ‘I’m generalising of course,’ she says, ‘but the Turkish community is very male dominated. Men traditionally tend to drink a lot of sweet tea and smoke. Older Turkish men, in particular, would not consider increased activity a priority. Furthermore, in a community with traditional gender roles, you need to inform the wives and daughters, who typically buy and prepare food. If you don’t, they will just continue to prepare the unhealthy food their men want.’
Towards a response

Krishna argues that determining the demographics of ethnic minorities locally is the first step to addressing these issues. 'Once you have the intelligence, once you understand the demographic pattern, you can create services that meet local needs,' he remarks.

Krishna’s team at Diabetes UK draws on several statistical sources – including census and immigration data – to gain a thorough insight into and understanding of the UK’s diverse ethnicities. From this, they develop the charity’s services tailored to specific local needs.

Such insights also help CCGs develop initiatives that change behaviour despite entrenched cultural, linguistic and other barriers. 'We recognise that managing type 2 diabetes depends on changing behaviour,' Krishna says. 'Diabetes UK’s growing number of Community Champions are already playing a positive role in shifting attitudes and helping people from ethnic minorities to manage their diabetes effectively.'

Diabetes UK’s Community Champions learn about culturally-specific risk factors, symptoms, myths and misconceptions surrounding T2D. Following training, the Champions, who are often health workers and community leaders, raise awareness in their communities by holding events, giving talks – for example, during festivals or religious services – and encouraging people at high risk to visit their GP or community pharmacist for a diabetes test. 'You can’t just provide some translated leaflets and hope behaviour changes. It just doesn’t work like that,' Krishna says. 'You need long-term targeted engagement.'

'It’s a real challenge to understand the issues,' Debbie agrees. 'You need people from inside the culture, who really understand the issues, to provide education and support on a regular basis,' she says. In response, her service has successfully provided educational sessions for Asian women in a ‘protected environment’.

‘Our Community Champions have the skills to drive cultural change,’ Krishna adds. 'They can help people from ethnic minorities develop the self-efficacy, confidence and motivation to make the changes needed to tackle their risk of developing type 2 or to help them successfully manage their condition.’

‘Many people from ethnic minorities do not appreciate the seriousness of type 2 diabetes,’ Krishna adds. 'They may not appreciate the impact their lifestyle has on their blood glucose levels. They often don’t realise that poor blood glucose control can lead to devastating complications in diabetes including blindness, kidney disease and amputation. We need to emphasise that diabetes is a serious and complex condition that, left undiagnosed or poorly treated, can lead to devastating complications.’

Unfortunately, relatively few studies assess culturally-targeted interventions. A Cochrane review reported that ‘culturally appropriate health education’ produces ‘short-to-medium-term effects on glycaemic control and on knowledge of diabetes and healthy lifestyles’. For example, glycaemic control improved after culturally appropriate health education at three and six months (mean reductions in HbA1c of 0.4% and 0.5% respectively) compared with usual care. The improvement in glycaemic control persisted, albeit at a lower extent, at 12 and 24 months (mean reductions 0.2% and 0.3% respectively). Long-term, standardised, multi-centre, randomised controlled studies need 'to compare different types and intensities of culturally appropriate health education within defined ethnic minority groups'.

‘There are plenty of successful examples and “successful failures” that haven’t made a difference, but have taught us a lot,’ Krishna remarks about the current evidence base. ‘Nevertheless, little investment has been put into collecting real world evidence of what works and what doesn’t work. But we have no option but to go with the evidence we have.’

In addition to further research, Krishna would like to see a central “knowledge hub” to help spread best practice. He notes that much of the information regarding improved care for migrants with T2D is fragmented. A single source would provide information health care professionals can use if, for example, translating a document is not cost-effective for a local health economy.

Indeed, the level of investment in initiatives to address the needs of ethnic minority patients who are at high risk of developing T2D or already living with the condition is often low. It is not always clear how much CCGs spend treating diabetes. But based on those who place a figure on the service, Krishna reports that the current investment in community interventions for T2D within ethnic minorities is between 25p and £1.75 per head. ‘One CCG has told me that there is no more money for these initiatives and we are just two months into the financial year,’ he notes.

Against this background, Diabetes UK’s demographic modelling helps CCGs allocate resources appropriately. 'You can’t have a meaningful conversation about investment until you have hard information about needs,' Krishna says. 'At Diabetes UK, we are more than happy to provide the information that health care professionals and commissioners require. I would be delighted if I was flooded with enquiries.'

A paradigm shift

‘We need to shift the paradigm,’ Krishna concludes. ‘For too long the debate focused on education and what health care professionals could do for ethnic minorities. But while these are critical elements of type 2 diabetes care, we need to do more than just provide information or prescribe drugs. We also need to encourage and support individuals to take personal responsibility and manage their condition effectively. Health care professionals should identify agents of change within each culture who can help to shift the debate to put greater focus on patients managing their condition well, and the appropriate support must be in place to help people across communities to achieve this.’

Mark Greener, BSc(Hons), MSB, Medical Correspondent

References

