

Addressing the ethnic barriers to diabetes care provision

Grace Vanterpool

Article points

1. There is an increased prevalence of diabetes in certain minority ethnic groups.
2. Once diagnosed with diabetes, people from minority ethnic groups are also more likely to face inequalities in accessing care.
3. There are certain cultural barriers to effective diabetes service delivery.
4. Some areas have employed Asian healthcare professionals or link workers to educate other healthcare professionals on the health beliefs of Asian people.
5. Another initiative is Action Diabetes, which was associated with an increase of 30% in referrals to diabetes clinics among South Asian people in Slough after 1 year.

Key words

- Cultural barriers
- Asian people
- Action Diabetes

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Communication difficulties and other barriers can make it difficult for people from minority ethnic groups to access healthcare information and services. This was highlighted in *Testing Times*, a report by the Audit Commission (2000). People from minority ethnic groups were twice as likely to report gaps in their understanding of care, for instance. In this article, Grace Vanterpool focuses on diabetes care provision for Asian people, based on her experience gained while working in Slough.

The Diabetes Population Prevalence Model (Yorkshire & Humber Public Health Observatory, 2005) yielded some important results on the prevalence of diabetes.

The model was used to estimate that in 2001 over 2.1 million people in England had type 1 or type 2 diabetes, representing 4.4% of the population. These figures include undiagnosed diabetes. Breakdowns by region were also calculated (see *Table 1*).

As well as estimating prevalence for 2001, the model was used to predict diabetes prevalence for the year 2010. Taking into consideration the combined effects of an ageing population and predicted increases in obesity levels, the figures suggest an increase of just under 16% from 2001 levels, taking overall prevalence to just over 5%.

Age

The Diabetes Population Prevalence Model was used to provide clear estimates on the increasing prevalence of diabetes seen as people get older (shown in *Table 2*).

Ethnicity and type 2 diabetes

The prevalence of type 2 diabetes varies across different ethnic groups, as exemplified in *Table 3*. The exact reasons for the increased prevalence in Black and South Asian people are not known, but it is conceivable that several factors – such as genetic variation, disparities in the way the body stores fat, and cultural differences – may play a part. Once diagnosed with diabetes, people from minority ethnic groups are also more likely to face inequalities in accessing care (Diabetes UK, 2006).

Barriers associated with diabetes care in Asian communities

In Britain, the term 'Asian' suggests a single cohesive group, but in reality the communities are from different countries, speak different languages, follow different religions, belong to different social classes and hold different traditions. Diversity in language, religion, cultural norms and expectations can, in the author's experience, prevent effective communication. There are several barriers which can stand in the way of the delivery of a high

Table 1. Estimated diabetes prevalence in 2001 by English region.

| Region | Prevalence |
|--------------------|------------|
| North East | 4.73 % |
| West Midlands | 4.65 % |
| London | 4.59 % |
| North West | 4.58 % |
| Yorkshire & Humber | 4.55 % |
| South West | 4.37 % |
| East Midlands | 4.33 % |
| East | 3.97 % |
| South East | 3.86 % |

quality of care to this group. These barriers may also prevent healthcare professionals delivering effective educational programmes to Asian people and their families.

One such barrier is that of cultural beliefs. Culture is a complex concept and a multifaceted social phenomenon that has powerful influences on all aspects of life. The author has found that Asian health beliefs often differ significantly from Western health beliefs, and this can result in misinterpretation of diabetes management. In turn, this creates significant barriers for healthcare professionals and can be misconstrued as non-compliance to treatment.

Another potential barrier arises from anecdotal reports of Asian people stopping their medication when they visit their country of origin, because of a belief that the condition has been cured.

Some areas have employed Asian healthcare professionals or link workers to educate other healthcare professionals on the health beliefs of Asian people.

Ramadan

Ramadan is the holy month for Muslim people, falling in the ninth lunar month in the Islamic calendar year. Ramadan is a period of worship, self-discipline, austerity and charity. This time of year can be particularly challenging for people with diabetes and healthcare professionals alike, especially if they are not aware of the meaning and importance of Ramadan to Muslim people. Fasting is obligatory for most healthy Muslim people. Exemption is granted to certain groups, including the under-12s, the

sick, older people, pregnant and breast-feeding women, and travellers. People with diabetes can also be exempt from fasting, particularly those individuals whose diabetes is treated with insulin (Diabetes UK, 2003).

Integrated care

Integrated care models for diabetes care are being considered by most diabetes clinical networks and diabetes teams nationwide. These integrated care models will be developed according to local demographics and local need. The National Service Framework for diabetes (Department of Health, 2001) set out the priorities of diabetes networks. One aim should be to provide seamless care for people living with diabetes from the various minority ethnic groups within a community.

The author has observed that more and more integrated diabetes services are including support from interpreters, health trainers and family members. It is common for people with diabetes to give 'ownership' of their condition (including responsibility for insulin adjustment and diet) to their families, perhaps because of reluctance to take personal responsibility.

People with diabetes who have undertaken the Expert Patients Programme or a similar course may also be encouraged to get involved.

Slough and Action Diabetes

Slough has a large population of non-White people, and the majority are from South Asia. The prevalence of diabetes in the area is believed to be as high as 7%, this being predominantly type 2 diabetes (NHS, 2004). In order to raise awareness, to prevent diabetes and to diagnose the condition early among South Asian people, a project called 'Action Diabetes' was put in place, which provided sessions in temples and mosques and offered structured education in Punjabi.

Table 2. Estimated diabetes prevalence in 2001 by age (years).

| Age | Prevalence |
|-------|------------|
| <30 | 0.3 % |
| 30–59 | 3.3 % |
| ≥60 | 13.8 % |

Page points

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Table 3. Estimated prevalence in males of type 2 diabetes in 2001 by ethnic group for two age ranges (years).

| Age range | South Asian | Black | Other |
|-----------|-------------|-------|-------|
| 40–49 | 11.2 % | 5.1 % | 2.5 % |
| 50–59 | 18.5 % | 6.9 % | 3.6 % |

| Table 4. Objectives for Action Diabetes. | |
|---|---|
| <p>General aims</p> <ul style="list-style-type: none"> To tackle health inequalities (the poorer health outcomes and higher rates of diabetes and circulatory problems seen in hard-to-reach communities). To raise awareness of diabetes in hard-to-reach communities. To find undiagnosed people with diabetes in Slough, through increased screening. <p>Wider applicability</p> <ul style="list-style-type: none"> To serve as a model of engagement that can be exported across the NHS. | <p>Communication</p> <ul style="list-style-type: none"> To develop a communications toolkit. To use communication cost-effectively in order to reduce the time and cost of managing diabetes. <p>Mapping</p> <ul style="list-style-type: none"> To develop an approach to assessing demand based on the use of a health needs mapping tool To plot the geographical areas of Slough where there is the greatest risk of diabetes. To use the findings to enable effective promotion of health in the area. |

A double-decker bus was used to increase diabetes awareness locally (Figure 1). The project was developed together with Dr Foster, and it received funding from the Department of Health and the pharmaceutical industry.

There were a number of objectives for this project, which are detailed in Table 4. Several groups were set up to focus on the task in hand through ‘lunch and learn’ sessions. These took place in various settings in the community, as well as various NHS localities.

What was learnt?

Some of the feedback that came from the people of Slough follow.

- ‘Surely all it takes is for one family member to understand diabetes, to ensure everyone else understands it.’

- ‘Our Asian community needs to be told what to do.’
- ‘Employers need support to implement new menus and encourage employees.’
- ‘We need celebrities and doctors to be vocal about the dangers.’

The outcome

Action Diabetes was launched in October 2004 by John Hutton (Minister of State for Health at the time), the Mayor of Slough, religious leaders and healthcare professionals. After a year, referrals to diabetes education clinics from the South Asian population were up by 30%. A formal evaluation of this project will be available early next year. ■

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Figure 1. Left: The double-decker bus used to promote diabetes awareness, with people involved in Action Diabetes standing in front. Right: The author performing a blood glucose test inside the bus.

