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Patients requests and needs for culturally and individually adapted supportive care in type 2 diabetes patients
A comparative study between Nordic and non-Nordic patients in a social economical vulnerable area of Linköping, Sweden

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ABSTRACT

Aims: This study sought to determine and compare the metabolic control of type 2 diabetes mellitus (T2DM) in non-Nordic immigrants and native Nordics. The aim was also to describe and compare the request of supportive care between these two groups.
Methods: One hundred and eighty-four patients (n = 184) coming to a routine check-up in a primary healthcare setting (PHC), were consecutively enrolled to the study during a period of one year. Data on therapeutic interventions, clinical measurements, healthcare consumption, and adherence to standard diabetes healthcare program were extracted from the patients' medical record. Structured interviews on supportive care were conducted by diabetes trained nurses. If needed, a qualified interpreter was used. Comparisons were made between Nordic patients (n = 151) and non-Nordic patients (n = 33).
Results: Among T2DM patients in a setting of PHC, there was a difference in meeting the metabolic target HbA1c, between native Nordics and non-Nordic immigrants. There was also a difference in request on supportive care. The non-Nordic group significantly requested more and different supportive care. They also attended the standard diabetes program to a lesser degree.
Conclusions: Culturally/individually adapted prevention is not only medically warranted but also requested by the patients themselves.
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1. Introduction

Type 2 diabetes mellitus (T2DM) is the major contributor to the epidemic rise in diabetes and accounts for >90% of diabetes [1–4]. The prevalence is continuously increasing worldwide and it is affecting 382 million people worldwide, corresponding to 8.3% of all adults. In Sweden the overall prevalence of diabetes increased about 30% from 2005–2006 to 2012–2013 [3].

Once T2DM is developed it can usually be successfully managed with lifestyle modifications and pharmacological interventions [5]. To prevent future complications adequate treatment is of great importance [2] as well as preventive measures in the terms of patient education [6] and lifestyle changes [5].

Migration is a known risk factor for T2DM [7] and prevalence of diabetes has been shown to be higher in immigrants than among natives [8,9]. A Swedish study report a doubled prevalence of diabetes among immigrants from Middle East compared to native Swedes and that diabetes onset in immigrants from Iraq to Sweden occur on average six years earlier compared to onset time among Swedes [9]. Patient with early T2DM onset progress to diabetes complication at a faster pace and have a shorter life expectancy [10]. In addition, studies in different cultural settings have shown worse metabolic control in immigrants as compared with non-immigrants [11,12]. Immigrants and refugees in US are less likely to adhere to diabetes care recommendations than US-born patients with diabetes [13]. It has also been reported that immigrants from non-westernized countries to Sweden receive worse preventive health care. Further, they retrieve prescribed preventive medication to a lower extent [14]. Culturally adapted intensive prevention strategies targeting the high risk group of people with Middle Eastern ethnicity may therefore be warranted in Sweden [9].

Health literacy, the degree to which individuals have the capacity to obtain, process, understand health information, and to act upon it [15], is essential if patients are to take responsibility for their health [5]. There is an association between low health literacy and worse glycemic control in general [16], and among immigrants in particular [17]. Since self-management of diabetes often involves interpretation of quantitative information, the ability to calculate and other numeracy skills are important. Also, the level of native and non-native languages skills affect whether the information or concept is easily understood or not [5].

More than 98% of patients' diabetes care is in their own hands; and in effect, healthcare professions do not manage T2DM, patients do [5]. Centered care on the patient rather than on their "disease" is not a new concept and has been advocated for diabetes for more than a decade. Each patient presents with a unique set of needs, risks, and limitations that require an individualized strategy. Self-management of diabetes, recognized as an essential element of chronic illness care, is imperative for health outcome [5]. Thus, there is a need for healthcare professionals, and the community at large, to support patients to enable them to take a more active role in improving their health. Adults have been shown to be more likely to make and maintain behavior changes if those changes are personally meaningful, freely chosen and they are empowered to do so [5]. The demanding role of the healthcare professional in providing diabetes self-management support and education is considered essential, perhaps even critical, for success [18]. On this basis it is of importance to individualize diabetes supportive care.

This study sought to determine and compare the metabolic control of T2DM in non-Nordic immigrants and native Nordics. One aim was also to describe and compare the request of supportive care between these two groups.

Table 1 – Standard diabetes healthcare program.

Diabetes care program	Frequency
Visit to nurse	At onset and then at least once a year
Visit to physician	At onset and then at least once a year
Visit to dietician	Group tuition at onset
Visit to chiropodist	At onset and then up to five times a year by level of angiopathy/neuropathy.
Fundus retinal photography	At onset and then every second year if retinopathy already exist, or if treated with insulin. If treated with oral hypoglycemic agents every third year.
Clinical measurements	
HbA_{1c}	At least every six month
Lipid profile	At least once a year
Urine sample for albuminuria	At least once a year
Electrolytes	At least once a year
Creatinine and glomerular filtration rate	At least once a year
Blood pressure	At least every six month
Echocardiography	At least once a year
Body measurements (weight, length, BMI, waist circumference)	Every six month

2. Methods

2.1. *Diabetes health care program*

In Sweden patients receive chronic T2DM care in primary health care (PHC). All patients found to suffer from T2DM in the setting of this study are offered a standard diabetes healthcare program, congruent with the Swedish national and regional programs (Table 1). The patients undergo clinical examination, cardiovascular risk profiling and receive information. Clinical measurements are taken. Self-monitoring of blood glucose (SMBG) is not included in the routine.

The therapeutic targets were during the study; Blood pressure <130/80 mmHg, LDL <2.5 mmol/l (<96.5 mg/dl), and HbA_{1c} <47 mmol/mol (<6.5%) if treated with lifestyle intervention, HbA_{1c} <52 mmol/mol (<6.9%) if treated with oral hypoglycemic agents, and HbA_{1c} <57 mmol/mol (<7.4%) if treated with insulin.

2.2. *Participants*

Included in this study were patients with T2DM coming to a routine check-up in PHC, Linköping, Sweden. The diagnose

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