Culture and Diabetes: Who cares?

How can CDEs reach people from different cultural groups

ADEA-NSW/ACT Branch Conference

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Dr Sarah Abdo

Department of Diabetes and Endocrinology, Bankstown-Lidcombe Hospital

NSW GOVERNMENT Health
South Western Sydney Local Health District

WESTERN SYDNEY UNIVERSITY

Why “Who cares?”

- Does culture even matter in the way we deliver healthcare?
- Does the patient care whether you know anything about their culture?
- Even if it does matter, there are so many important things we need to address, cultural issues are not a priority!
- Who cares what cultural background people are from, diabetes is diabetes!

Arguably, modern medical practice’s greatest challenge may be finding a way to keep ***caregiving*** central to **health care**

Outline

There are many different cultural groups existing in Australia and each group is heterogeneous

The effects of culture and religion on diabetes care will differ significantly related to many factors **other than culture**

The breadth and diversity within our community can make it difficult to use a “one size fits all approach” to effective diabetes care

Consider Cultural humility as a framework rather than cultural competency

Glycaemic targets based on patient characteristics[1]

The general HbA_{1c} target for most people with type 2 diabetes is **≤53 mmol/mol (7.0%)**

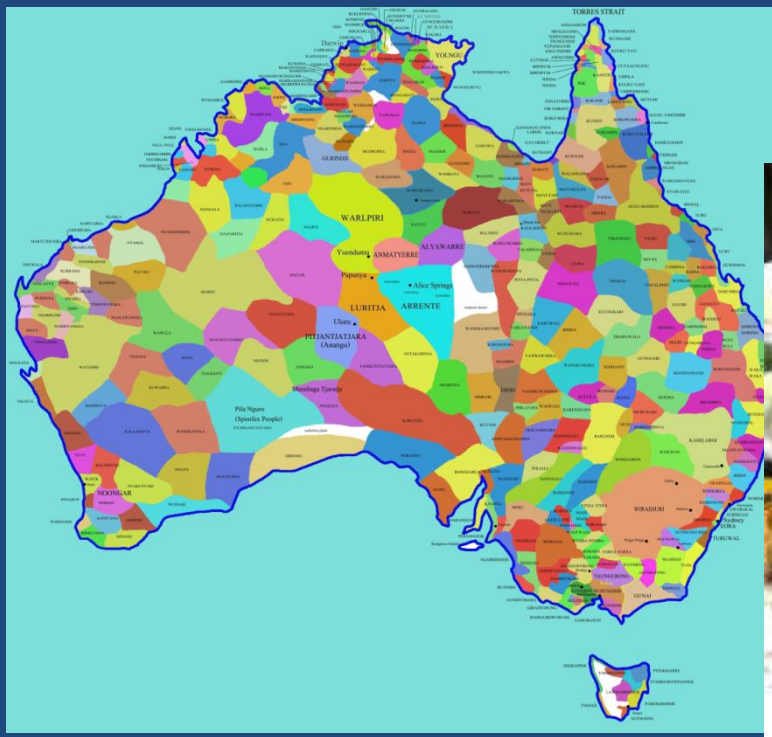
However, targets can be individualised based on patient characteristics

Patient characteristic	Glycaemic target
• No known cardiovascular disease • Short duration of diabetes • Without severe hypoglycaemia or another contraindication	≤48 mmol/mol (6.5%)
• Reduced hypoglycaemia awareness • Major comorbidities	≤64 mmol/mol (8.0%)
• Limited life expectancy	Symptom control
• Women planning pregnancy	≤42 mmol/mol (6.0%)*

*Aim for the tightest achievable control without severe hypoglycaemia before and during pregnancy

1. Gunton JE *et al.* A New Blood Glucose Management Algorithm for Type 2 Diabetes: A Position Statement of the Australian Diabetes Society. Dec 2016. Available at: www.diabetessociety.com.au.


YOU NEVER LAMB ALONE
We love our Lamb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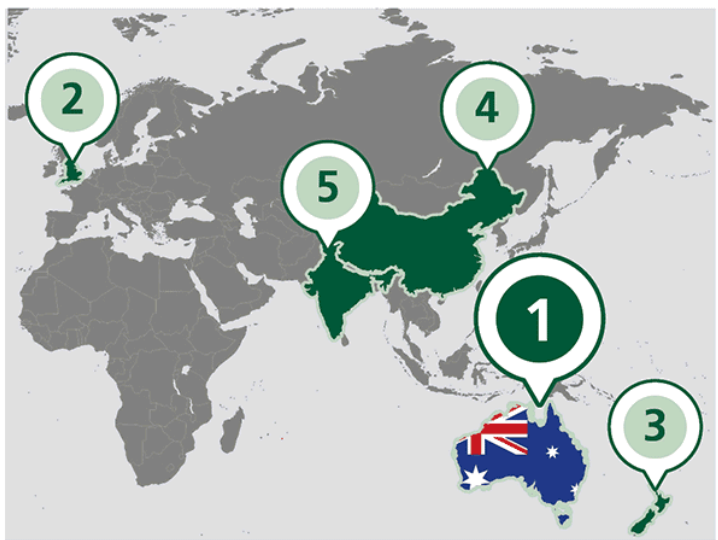
YOLNGU
WARLPIRI
ANMATYERRE
ALYAWARRE
Yuendumu
Papunya
Alice Springs
LURITJA
ARRENTE
Uluru
PITJANTJATJARA
(Anangu)
Pila Nguru
(Spinifex People)
NGONGAR
WIRADJURI
GUNAI


THIS IS
AUSTRALIA
A BuzzfeedOz Project by Anna Mendoza and Tania Safi

TOP FIVE COUNTRIES OF BIRTH AS A PROPORTION OF THE TOTAL POPULATION



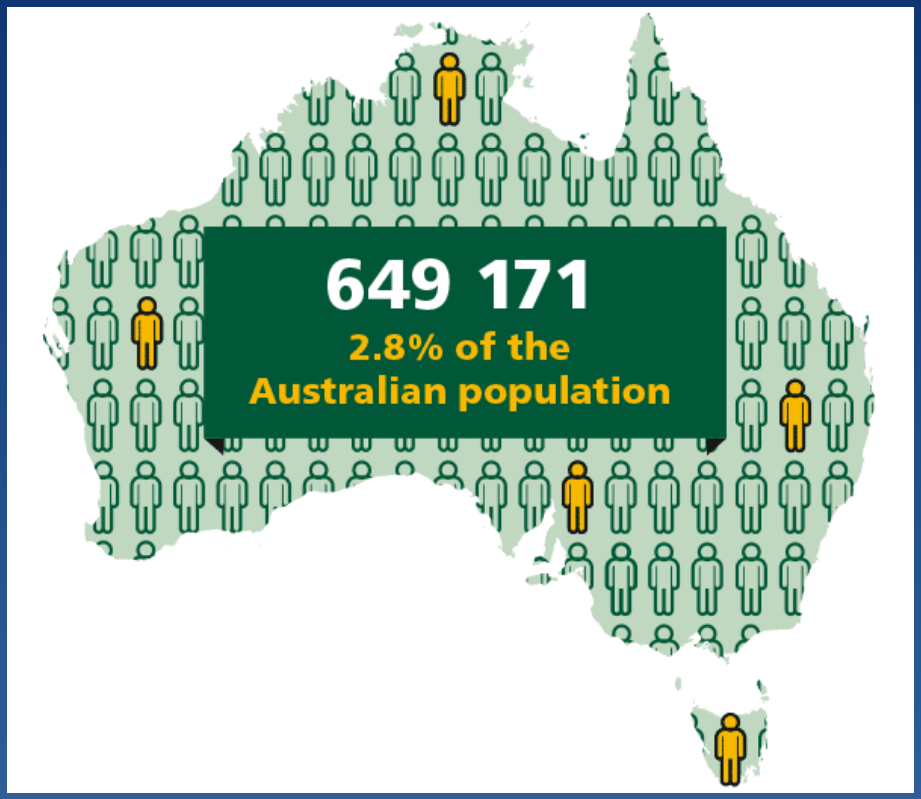
Top Five		2011	2016
Country		%	
1	Australia	69.8	▼ 66.7
2	England	4.2	▼ 3.9
3	New Zealand	2.2	2.2
4	China	1.5	▲ 2.2
5	India	1.4	▲ 1.9

http://abs.gov.au/ausstats/CulturalDiversityDataSummary

LANGUAGES

In 2016, there were over 300 separately identified languages spoken in Australian homes. More than one-fifth (21%) of Australians spoke a language other than English at home.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES



The Aboriginal and Torres Strait Islander population has increased since 2011 from 2.5% to 2.8% of the Australian population

RELIGION

In 2016, Christianity was the main religion reported in Australia (52%)

While the Islamic population made up only 2.6% of the total population, it was the second largest religion reported in the 2016 Census after Christianity. Islam was closely followed by Buddhism (2.4%)

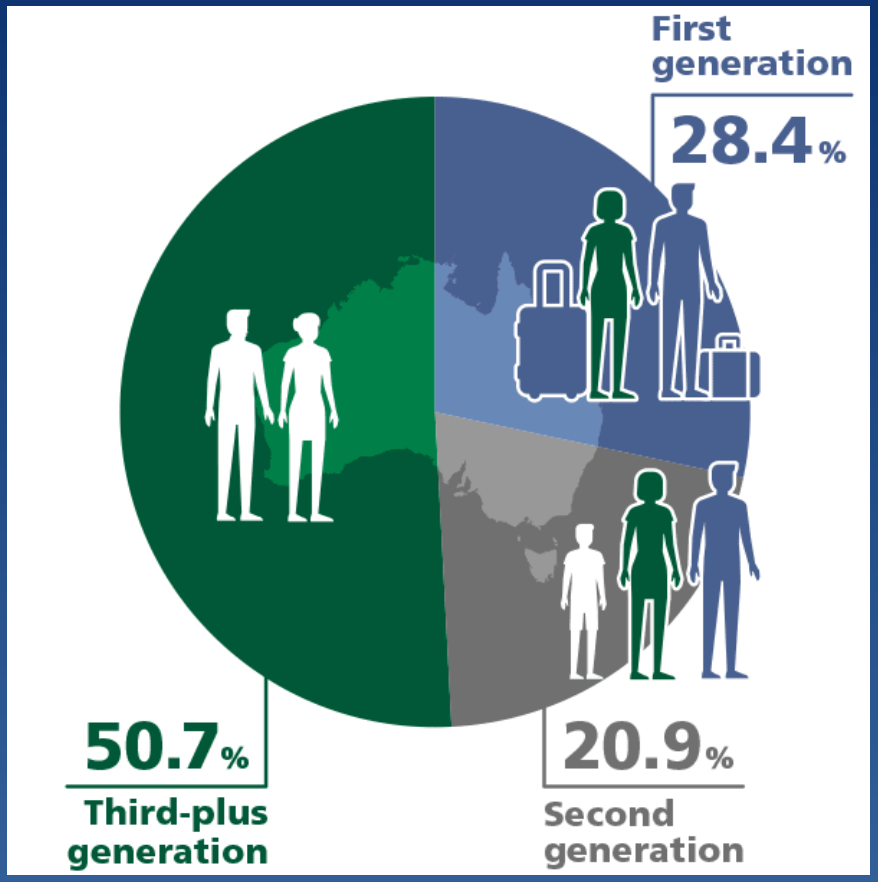
The 'No Religion' count increased to almost a third of the Australian population between 2011 and 2016 (22% to 30%)

Religious Affiliation		Population ('000)	Population (%)
Christian		**12 201.6**	**52.1**
Other Religions	Islam	604.2	2.6
	Buddhism	563.7	2.4
	Hinduism	440.3	1.9
	Sikhism	125.9	0.5
	Judaism	91.0	0.4
	Other	95.7	0.4
	Total	**1 920.8**	**8.2**
No Religion [a]		**7 040.7**	**30.1**
Australia [b]		**23 401.9**	**100.0**

a No religion includes secular and other spiritual beliefs.

b As religion was an optional question, the total for Australia will not equal the sum of the items above it.

THE GENERATIONS OF AUSTRALIANS



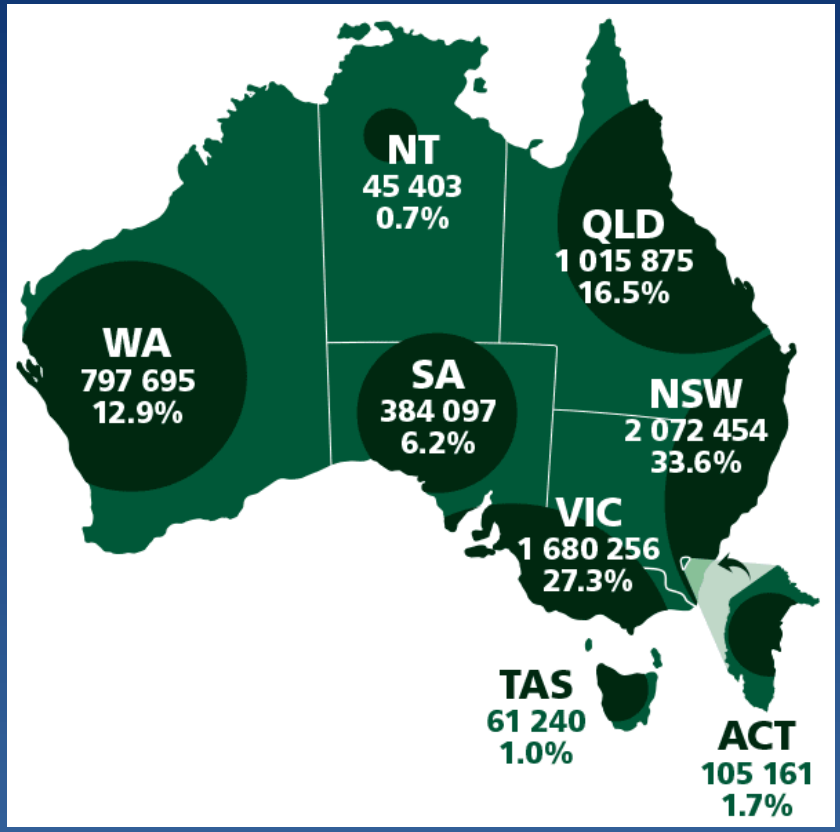
In 2016, nearly half (49%) of Australians had either been born overseas (first generation Australian) or one or both parents had been born overseas (second generation Australian)

WHERE DO MIGRANTS LIVE ?

For Australia's overseas-born population, NSW is the most popular state or territory to live (2,072,454 people or 34% of the overseas-born population)

83% of the overseas-born population lived in a capital city compared with 61% of people born in Australia

Sydney had the largest overseas-born population



Sydney urban area

Country of birth of mother, stated responses	Sydney	%	New South Wales	%	Australia	%
Australia	1,652,624	37.2	3,884,762	51.9	12,643,365	54
China (excludes SARs and Taiwan)	314,277	7.1	329,967	4.4	699,074	3
England	176,989	4	322,472	4.3	1,302,147	5.6
India	171,849	3.9	191,594	2.6	605,777	2.6
Lebanon	125,873	2.8	129,707	1.7	176,241	0.8

Religious affiliation, top responses	Sydney	%	New South Wales	%	Australia	%
Catholic	1,119,028	25.2	1,846,443	24.7	5,291,834	22.6
No Religion, so described	1,085,579	24.4	1,879,562	25.1	6,933,708	29.6
Anglican	493,580	11.1	1,161,810	15.5	3,101,185	13.3
Not stated	394,543	8.9	684,969	9.2	2,238,735	9.6
Islam	252,214	5.7	267,659	3.6	604,240	2.6

Language, top responses (other than English)	Sydney	%	New South Wales	%	Australia	%
Mandarin	227,342	5.1	239,945	3.2	596,711	2.5
Arabic	193,228	4.3	200,825	2.7	321,728	1.4
Cantonese	137,918	3.1	143,333	1.9	280,943	1.2
Vietnamese	98,904	2.2	102,896	1.4	277,400	1.2
Greek	75,289	1.7	81,683	1.1	237,588	1
English only spoken at home	2,483,363	55.8	5,126,633	68.5	17,020,417	72.7
Households where a non English language is spoken	645,774	41	735,563	26.5	1,971,011	22.2

How does diabetes vary among different cultural groups?

Table A1: Standardised prevalence ratios for self-reported diabetes by region of birth and sex, people aged 20 years and over, 2001

	Prevalence ratios	
Region of birth	**Males**	**Females**
Middle East and North Africa	3.60[(a)]*	2.43[(a)]
South-East Asia & Southern Asia	1.87[(a)]*	1.54[(a)]
Southern & Eastern Europe & Central Asia	0.85	1.46*
Australia	1.00	1.00
UK & Ireland	1.17	0.71
Northern & Western Europe	1.26[(a)]	0.55[(a)]
All other countries	1.56	0.57[(a)]

* Significantly different from 1.00 (Australian-born) at the 5% level of significance.

(a) Estimate has a relative standard error of between 25% and 50% and should be interpreted with caution.

Note: Ratios were estimated using the indirect method of standardisation and standardised to the 2001 Australian-born male and female populations.

Source: AIHW analysis of the ABS 2001 National Health Survey.

Complication rates

Table 6: Standardised separation ratios[(a)] for diabetes-related lower limb amputations by region of birth, people aged 25 years and over, 1995–2004

	1995–96 to 1998–99			2000–01 to 2003–04		
Region of birth	**Males**	**Females**	**Persons**	**Males**	**Females**	**Persons**
South Pacific	2.7*	3.1*	2.9*	2.1*	3.4*	2.5*
Southern Europe	1.1	1.3	1.2	1.1*	1.4*	1.2*
Eastern Europe & Central Asia	1.4*	1.2	1.3*	1.0	1.3*	1.1
Sub-Saharan Africa	0.4	0.6	0.5	1.3	0.9	1.2
Middle East & North Africa	0.9	1.5	1.1	1.0	1.1	1.0
Northern Europe	1.1	0.8	1.0	1.1	1.3	1.1
Australia	1.0	1.0	1.0	1.0	1.0	1.0
Western Europe	0.8	1.0	0.9	0.9*	1.2*	1.0
South Eastern Europe	0.9	1.1	1.0	0.9*	1.1	0.9
UK & Ireland	0.7*	0.6*	0.7*	0.7*	0.7*	0.7*
Southern Asia	0.7	0.7	0.7	0.8*	0.6*	0.7*
South & Central America & Caribbean	0.8	0.3	0.6	0.5*	0.9	0.6*
New Zealand	0.5*	0.6	0.5*	0.8*	0.4*	0.7*
Northern America	0.7	1.0	0.7	0.5*	1.0	0.7*
North-East Asia	0.3*	0.5	0.4*	0.2*	0.3*	0.3*
South-East Asia	0.3*	0.5	0.4*	0.3*	0.4*	0.4*

* Significantly different from 1.0 (Australian-born) at the 5% level of significance.

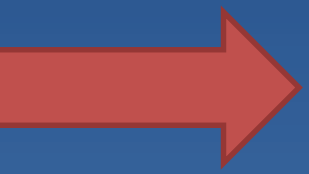
(a) Indirectly age-standardised to the Australian-born male and female populations in 1995–96 to 1998–99 and 2000–01 to 2003–04. The standardised separation ratio is the ratio of the observed number of hospital separations to the number expected if overseas-born Australians experienced the same age-sex-specific hospital separation rates as the Australian born population.

Source: AIHW National Hospital Morbidity Database.

Diabetes Care is the same for all

Key components of diabetes management

- Healthy meal plan
- Exercise
- Ongoing care and follow up
- Adherence to an appropriate treatment plan



Individuals everyday approach to behaviours

Factors Affecting patient Engagement

Intrinsic

- Attitudes and health beliefs
- Depression
- Self-efficacy
- Level of diabetes knowledge & technical skill
- Ethnicity and culture
- Functional health literacy
- Medication adherence

Extrinsic

- Financial capabilities
- Family influences
- Workplace environment
- Community environment
- Clinical relationships
- Access to effective diabetes healthcare delivery

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INDIVIDUAL FACTORS

So how do we reach our patients?

- What does the patient need to self-manage their disease within the diverse and changing environment of their world:
  - Desire
  - Knowledge
  - Skills
  - Ability
- Focus on the **individual** with diabetes, rather than the disease state itself
- Initial encounter : Consider questions about the patient's life and health beliefs
- Use a Patient-centred approach to establish the foundation for a trusting healthcare provider – patient relationship

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Attitudes and health beliefs

- People with diabetes often need a reason to engage in diabetes self-care
- Unfortunately diabetes is a silent condition unless there is hypoglycaemia or a complication

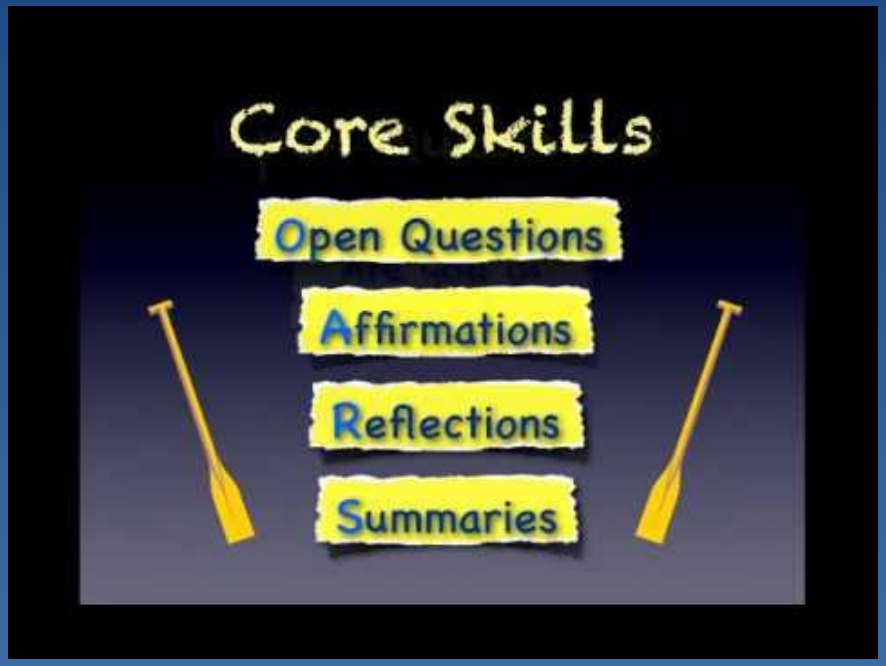
Consider these Qus in your first consult:

- "What are the greatest day to day challenges you face in managing your diabetes?"
  - Lets your patient know you value their lived experience
  - Gain understanding into their health beliefs, attitudes and real world
  - Prioritize their unique needs
- "What makes you smile?"
  - Identify personal motivators for engagement in diabetes self management
  - Identify potential risk for depression

Motivational interviewing

Components:

- The importance of change for the patient (willingness)
- The confidence to change (ability)
- Whether change is an immediate priority (readiness)



Motivational interviewing can contribute to improvements in self-management[1]

Meta-analysis data show that motivational interviewing can contribute to improvements in self-management abilities in patients[1]

- Motivational interviewing improved self-management of:
  - Diet control ($p < 0.00001$ vs. control)
  - Regular exercise ($p < 0.008$)
  - Glucose monitoring ($p = 0.001$)
  - Foot care ($p < 0.00001$)
  - Prevention and treatment of hyper- and hypoglycaemia ($p = 0.001$)

Short term (≤6 months) motivational interviewing also reduced HbA_{1c} ($p = 0.003$), but this advantage was not observed over 12-24 months ($p > 0.05$, not significant). No change in medication adherence was observed ($p = 0.07$, not significant).

1. Song D *et al. Int J Nursing Sci* 2014; 291-297.

COMMUNITY FACTORS

Community Environment

- Access to healthy foods
- Suitable exercise areas
- Affordable medications and supplies
- Accessible health information and care
- Ongoing follow-up

Culture & Family

- Cultural influences, not only relating to ethnicity but also customs, traditions, beliefs, and decision-making practices, affect engagement in diabetes-related health practices
- The family environment is largely where disease management occurs, linking traditional patient and community interventions
- Families need information, effective strategies, motivation, and behavioural skills to assist in the management of diabetes
- Important to involve families in clinical care and education throughout the patient's life with diabetes

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CLINICIAN
HEALTH SERVICE FACTORS

Clinical relationships

A better relationship contributes to greater engagement in diabetes self-management, which in turn contributes to better diabetes outcomes

We need to find a way to connect with and understand a patient's illness experiences and cultural values in order to provide better care and ease the difficult journey of illness

When patients do not value the relationship or have reduced confidence in their health care provider, they do not value and have reduced confidence in implementing the treatment recommendation

DEFINITIONS

- Cultural awareness: sensitivity to the similarities and differences that exist between two different cultures and the use of this sensitivity in effective communication with members of another cultural group

- Cultural safety: involves actions that recognise, respect and nurture the unique cultural identity of a person and safely meet their needs, expectations and rights. It means working from the cultural perspective of the other person, not from your own perspective

- Cultural respect :recognition, protection and continued advancement of the inherent rights, cultures and traditions of a particular culture.

Definitions (2)

- Cultural competence: becoming aware of the cultural differences that exist, appreciating and having an understanding of those differences and accepting them. It also means being prepared to guard against accepting your own behaviours, beliefs and actions as the norm.

- Personal cultural competence: the actions we personally take to expand our knowledge of other cultures and how we use that to shape service to those people. This is especially important in effective doctor-patient relationships.

Limitations (1)

- The idea that shifting and diverse cultures, the members of which do not all share identical beliefs or experiences, as something a health care worker can master is almost ludicrous
- This vision of cultural competency, while well intentioned, gives the impression that health care workers can reach an end point at which they have become culturally competent
- When a person imagines that they are culturally competent, they will have the mistaken impression that they are experts in their patients' culture
- This leads to providers interpreting their patient's symptoms and requests through a **stereotyped** view of **what they believe** the patient's culture to be.

Limitations (2)

- This translates into the tendency to generalize and identify an essentialized, static notion of culture that is conflated with racial and ethnic categories and seen to exist primarily among exotic 'Others.'

- With this approach, culture can become a 'list of traits' associated with various racial and ethnic groups that must be mastered by health providers and applied to patients as necessary

- Providers should recognize the individuality of patient's experiences and beliefs, even within the same culture

Limitations (3)

- There is a failure of cultural competency training to address the culture of providers, the culture of medicine itself
- By ignoring this fact and acting as if providers are coming from a place of normality, a viewpoint that contains no biases or assumptions, cultural competency can become an exercise in marking patients as different
- It has been argued that “many cultural competence efforts reinforce the assumption that…culture matters most in cases where patients are most different from an unmarked ‘mainstream’”

Jenks, A. C. (2011). From "Lists of Traits" to "Open-Mindedness": Emerging Issues in Cultural Competence Education. *Culture, Medicine, and Psychiatry , 35* (2), 209-235.

Kalamazoo Consensus statement

- Build clinician-patient relationship
- Open discussion
- Gather information
- Understand patient viewpoint

Framework for Discussion

- Solicit patient Agenda
- How does that sound to you? Concordance
- Verify Understanding
- Empathy – Reflect back your understanding of patient situation

Using Ramadan as an example

- I would like to talk to you about your health regimen during Ramadan.
- As you know, some patients choose to fast and others prefer not to fast. I would like to help you with your decision whether you choose to fast or not.
- I am not familiar with all alterations in diet, activity and medication use that occur during Ramadan but I would welcome your input.
- The decision to fast or not will be up to you. I will work with you whatever your decision is. I just want to make sure you have all the information you need.

RESPONDING TO PATIENT GROUP AT BANKSTOWN LIDCOMBE HOSPITAL

Why do Muslims Fast?

- 5 pillars of Islam form the foundations of faith and worship:

1. Shahada – declaration of faith
2. Salah – 5 compulsory daily prayers
3. Zakat – annual alms tax (2.5% savings) to poor and needy
4. **Sawm – fasting the month of Ramadan**
5. Hajj – pilgrimage to Mecca once in a lifetime for those who are financially and physically able

Spiritual Significance

- The Holy Month of Ramadan is a very significant time for Muslims all over the world
- Many Muslims look forward to this month in anticipation of the spiritual blessings it brings
- Having an understanding of the spiritual significance of this month to the patient can place the health practitioner in a much stronger position to gain the trust of the patient and enable honest and beneficial communication

Spiritual Significance

- It is believed that the first verses of the Muslim Holy Scripture - the Quran, were revealed during the month of Ramadan 1400 years ago
- For this reason it is also known widely as the “Month of the Quran”
- In addition, it is believed all good deeds are multiplied several fold during this month so it is a time devout followers will try to increase acts of charity, prayer, and attempt to refine their character

Exemptions




"… but whoever is sick or upon a journey, then (he shall fast) a (like) number of other days; Allah(God) desires ease for you, and He does not desire for you difficulty, and (He desires) that you should complete the number and that you should exalt the greatness of God for His having guided you and that you may give thanks." -Quran- 2:185

Pregnant Women**

Suckling Women**

Menstruating Women**

Mentally Impaired

* Should donate a meal to the needy
* * Should fast an equivalent number of days afterwards

Muslims who are exempt from fasting still insist on fasting in the month of Ramadan, including pregnant women with diabetes. Why?

- Women perceive themselves as fit to fast
- Pregnant women without diabetes often fast without any complications

ATTITUDES AND PRACTICES

Fasting among pregnant women with diabetes during Ramadan

- Standardised questionnaire conducted at 4 specialist centres in London
- 48 women, Mean age 32 years, 65% GDM, 31% T2DM
- 44% diet controlled, 25% on orals, 31% insulin
- 10% fasted during pregnancy
- 23% women who DID NOT fast had a history of hypo
- Immigrants and rural based women more likely to fast
- Husbands tended to discourage fasting when they felt women were endangering themselves
- Women were just as likely to consult their Imams as they were their health professionals

E. Hui, M. Reddy,V. Bravis, M. Rahman, D. Darko, M. Hassanein Int J Clin Pract, September 2012, 66

Muslim patients' expectations and attitudes about Ramadan fasting during pregnancy.

Lou A; Hammoud M. International Journal Of Gynaecology &Obstetrics. 132(3):321-4, 2016 Mar.

- Cross-sectional study targeting Muslim patients with active obstetric records (Detroit USA) during Ramadan 2013.
- Women aged 18-50 yrs approached July - Aug, and asked to complete a written survey on perceptions of fasting, influences on decision making, and healthcare expectations.
- 37 women completed the survey, 26 (70%) did not fast in their current or most recent pregnancy during Ramadan.
- 23 (62%) believed fasting was harmful to themselves, their fetus, or both
- 7 (19%) reported consulting others about fasting during pregnancy, with the most influential individuals being Muslim scholars, followed by family/relatives and healthcare providers.
- The most important characteristics desired in a physician included being respectful of Islamic beliefs and possessing knowledge about Ramadan.

STUDY AT BANKSTOWN LIDCOMBE HOSPITAL (RAMADAN 2014)

Attitudes to fasting during Ramadan with diabetes in pregnancy

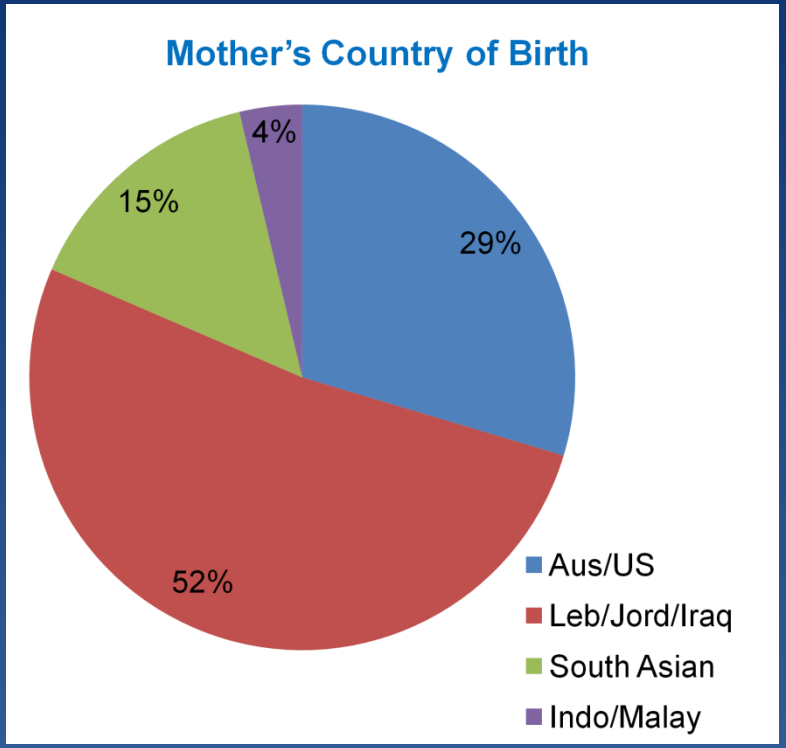
26.4% of the Bankstown population identify as Muslim (ie potentially fasting Ramadan).

Aim: To gain an understanding of the attitudes and actions of pregnant Muslim women regarding religious obligations and risks of fasting whilst pregnant, particularly if there is diabetes in pregnancy, and to use this information to develop guidelines regarding fasting for Muslim women with diabetes in pregnancy and their health providers.

Method: Prospective survey of self-identified Muslim pregnant women, recruited from our centre during the month of Ramadan 2014 with questionnaires administered during the diabetes antenatal clinic.

Demographics

- 29 completed surveys
- 86% women had gestational diabetes[GDM], 10% type 1 diabetes and 1 woman had type 2 diabetes
- Mean age 29 years
- 66% had completed Year 12 or above



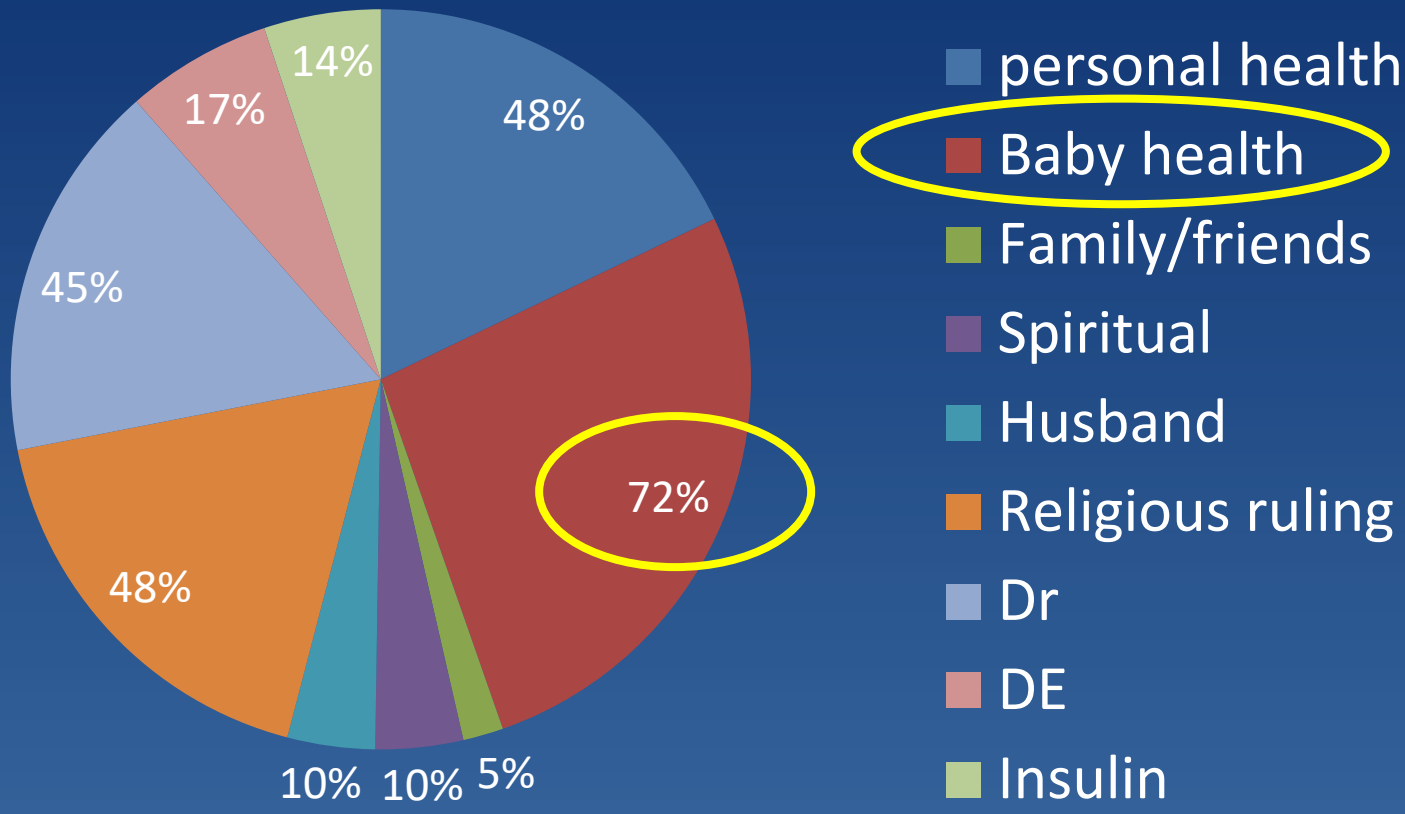
Results 1

38% thought abstaining from fasting was either not permissible from the religious viewpoint or were unsure.

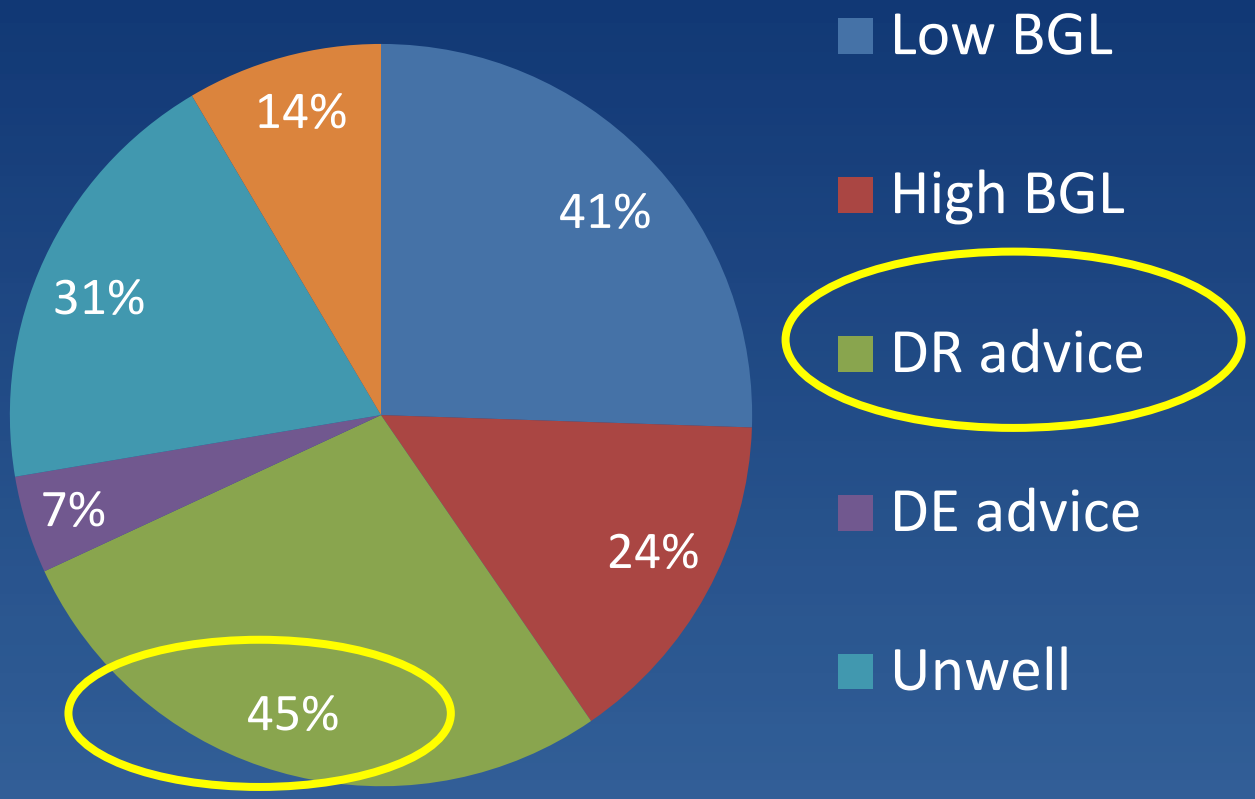
28% thought it was NOT permissible to do fingerprick glucose testing whilst fasting.

Over 50% stated they would fast with diabetes in pregnancy, while 93% said they would fast during pregnancy if they did not have diabetes

Results 2: Factors influencing the initial decision to fast



Results 3 : Influences on Breaking the fast



Advice from a doctor and experience of high or low BGL were the most common influences

Guidelines

- We developed 2 handouts, 1 for patients and 1 specifically for health professionals
- Patient handout has been simplified to Year 8-9 level readability and has been translated into Arabic.
- In 2015 we assessed feedback. All very positive, found it useful and agreed with recommendations
- In 2016 we made further modifications and received the Gold Tick endorsement from our institution, deeming it suitable by community partners

I have diabetes in pregnancy, what should I do during the month of Ramadan?

The Holy Month of Ramadan is a very significant time for Muslims all over the world. Many Muslims look forward to this month in anticipation of the spiritual blessings it brings. It is important to be aware, however, that you DO NOT have to fast during pregnancy and breast-feeding if there is any risk to mother or baby. **You can make up the fast at another time or pay atonement if unable to make it up because of a continuing medical concern.**

Although healthy pregnant women are exempt from fasting, studies from around the world have shown 45-90% still attempt to fast in Ramadan because they prefer to share the experience at that time.

Having diabetes in pregnancy can put you and/or your baby at risk, therefore it is strongly recommended you DO NOT fast. There are many other ways you can still celebrate and enjoy the blessings of Ramadan.

Types of Diabetes

Pre existing Diabetes: Some women have diabetes before they become pregnant and will ALWAYS be on insulin injections during pregnancy. It is strongly recommended they DO NOT fast. If you have pre-existing diabetes you should consult with your doctor for specific advice about your situation.

Gestational diabetes: Gestational Diabetes Mellitus, also known as GDM, is a condition that develops during pregnancy. As the baby and placenta grow, the body is not able to process glucose properly and blood glucose levels become too high. It is very important that every woman is tested for GDM and then follows the recommendations to reduce complications.
Many women can be managed by changing the way they eat and exercising, but some (up to 30-40%) may need insulin therapy.

Possible risks to you

- Hypoglycemia (low blood glucose) during the fasting period
- High blood glucose after the sunset meal (iftar)
- Dehydration

Possible risks to your baby

- Reduced growth if blood glucose levels are too low - Small baby
- Increased growth if blood glucose levels are too high - Large baby
- Poor nutrition for baby
- Early labour

I'm not on insulin, what should I do?

If you have GDM controlled with diet alone you may think there is no problem with fasting. However, during pregnancy there are many changes in your body that take place so there is enough food for your baby for 24 hours.

If you leave a long time between meals (eg fasting) this may put more stress on your body and on the baby. This is even more of a problem when Ramadan occurs during summer months when fasting is much longer.

If you still choose to fast, then you need to be aware of the risks and follow the advice of your doctor, nurse and dietitian.

You also need to agree to test blood glucose levels at home and be willing to break your fast if there is a problem.

REMEMBER: Testing blood glucose levels with a finger prick test DOES NOT break your fast and you can do this as many times a day as recommended.

Practical points

1. Glucose monitoring - this DOES NOT break your fast and must be done at all the recommended times and any time during the day where you may be feeling unwell, or have dizziness, nausea or other signs that may indicate low blood glucose .

2. You must **agree to break your fast** if any of the following problems occur:
- Blood glucose level [BGL] below 4 mmol/L during fasting hours
- You are feeling unwell
- Baby is moving less than usual
- You are not gaining weight as expected or you start losing weight.
- Your tests show increased ketones

3. You may be asked to **test ketones** (blood or urine testing) to see if they are high. If the ketones are rising this can mean there is not enough carbohydrate such as glucose to meet the needs of the pregnancy and that there is some breakdown of your fat to try to give the baby energy. **The baby's brain needs carbohydrate and can't use fat breakdown products.**

4. Diet: There is a risk of high blood glucose levels after the predawn and sunset meals if the meal portions are too large or if you are having too many dates or sweets which can be common at this time. Remember sweet drinks will also give you high BGL.

If the dietitian thinks your meal size is good but your blood glucose is still too high your doctor may start you on insulin.

5. Exercise: You still need to exercise but you may need to change when you exercise and how much you do. e.g. Walking 30 minutes 2 hours after the sunset meal. If you are in the habit of performing the tarawih (additional, voluntary prayer performed after the night (isha) prayer) this may form part of your exercise routine. Otherwise try to maintain other exercise as recommended.

Insulin controlled Diabetes

Using insulin may make it even more difficult to fast. However, if despite your doctor's advice and your religious exemption from fasting, you still choose to do so, then you will need to take much care and follow advice from your medical team very closely. Some points to consider:

If you are on **long acting insulin before bed** only:
- you may need to take this dose a little earlier than usual to account for waking up for an early pre dawn breakfast (suhur)
- the dose may need adjustment depending on your pre dawn (before suhur) BGL.

If you are on **insulin at meal times:**
- Make sure you keep recording the BGL 1-2 hours (timing to be according to the advice of your medical team) after the sunset meal (iftar) and after the predawn meal (suhur), because these levels will help determine your insulin doses.

Fasting is not obligatory for pregnant women especially if they have another medical condition such as diabetes where a long time without food and water may harm the mother or the baby.
The Grand Mufti of Australia has stated that if there exists any medical condition that may affect the quality of the environment in which the baby grows (ie inside the womb of the mother) then it is STRONGLY recommended the mother DOES NOT fast and the opinion of the treating doctor should be followed.

If you have any concerns or questions regarding the advice provided here, please discuss with your doctor, nurse or dietitian.

Patient Handout Diabetes Centre Bankstown-Lidcombe Hospital Revised June 2016

How has this changed our practice?

- All women who present for GDM group education are informed about the risks and recommendations around fasting during pregnancy
- Individual women who identify as Muslim are given the patient handout at the first visit and advised not to fast by the Diabetes Educator
- Advice is reinforced by the Doctor
- If women insist on fasting some specific advice is given as per the guideline and the decision to continue fasting is reviewed at each visit

Conclusions

- Most women choose not to fast during pregnancy
- Although they may not always consult healthcare providers, pregnant Muslim women do value their opinion
- Healthcare providers need to be confident and respectful in their discussions with Muslim patients and provide care on an individual basis

Current situation

- The medical system attempts to help physicians and other healthcare providers to understand and incorporate cultural beliefs through cultural competency.
- This approach tries to teach the main beliefs and values that each culture holds.
- Often, cultural competency results in the stereotyping of patients based on their assumed beliefs and alienates them by focusing on their differences

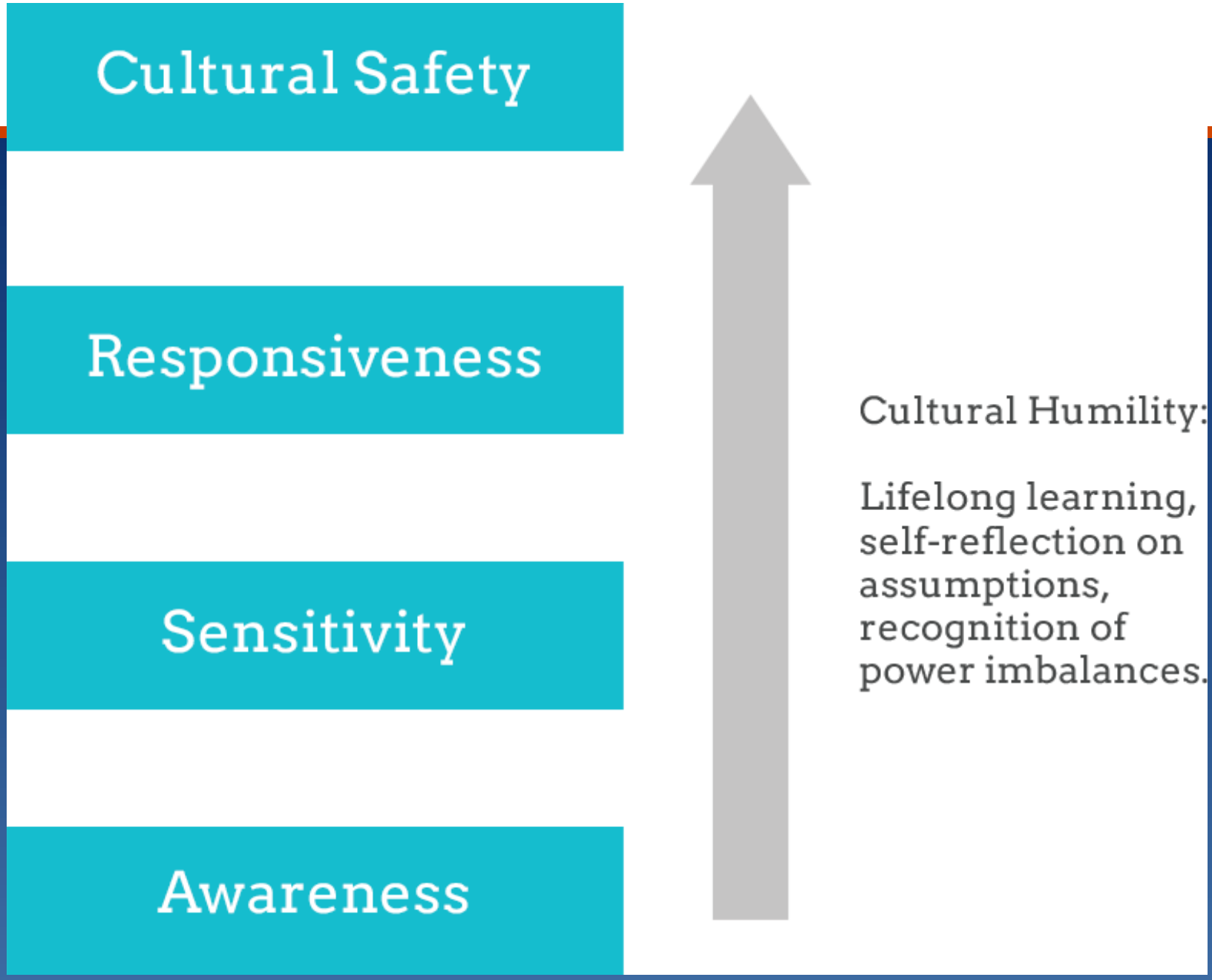
Cultural humility

"To be culturally humble means that I am willing to learn,"
- Joe Gallagher

Defined as a "process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners

It requires humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care

It is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities


Cultural Safety
Responsiveness
Sensitivity
Awareness
Cultural Humility:
Lifelong learning, self-reflection on assumptions, recognition of power imbalances.

Bridging the cultural divide

The first step is to simply be aware that everyone is a victim of unconscious biases

Once we come to this (often uncomfortable) realization, we must make a conscious effort to change our mindset

And make conscious decisions to not allow these biases to manifest

Practicing cultural humility is extremely important in this process.

It puts everyone on the same platform because there is no “minority,” “majority,” or “ethnicity” associated with it.

It takes away the need to know everything about a certain culture and encourages us to approach every patient encounter acknowledging that we will humble ourselves, learn what is important to the patient, and leave having learned something from the interaction.

The 5 Rs of Cultural Humility

- **Reflection** – approach every encounter with humility and understanding that there is always something to learn from everyone.

What to ask: What did I learn from each person in that encounter?

- **Respect** – treat every person with the utmost respect and strive to preserve dignity at all times.

What to ask: Did I treat everyone involved in that encounter respectfully?

- **Regard** – hold every person in their highest regard while being aware of and not allowing unconscious biases to interfere in any interactions.

What to ask: Did unconscious biases drive this interaction?

- **Relevance** – expect cultural humility to be relevant to the patient and apply this practice to every encounter.

What to ask: How was cultural humility relevant in this interaction?

- **Resiliency** – embody the practice of cultural humility to enhance personal resilience and globally focused compassion.

What to ask: How was my personal resiliency affected by this interaction?

Cultural humility

Correcting power imbalances

Incorporating the patient's perspective

Forcing self-reflection by providers

- These elements work together to make the patient a part of the decision-making process, rather than a bystander about whom decisions are made
- Through these components, providers are able to avoid the issues of stereotyping and focusing on the patient as the "other"
- By allowing the patient to guide discussion of cultural values and to help incorporate those values into the treatment plan, clinicians show that they respect those values and are able to respect the individual patient's beliefs, not a stereotyped version of the culture as a whole

Practicing Cultural Humility

Ask questions in a humble, safe manner

Seek Self-Awareness

Suspend Judgment

Express kindness and compassion

Support a safe and welcoming environment

Start where the patient is at

- Lisa Boesen