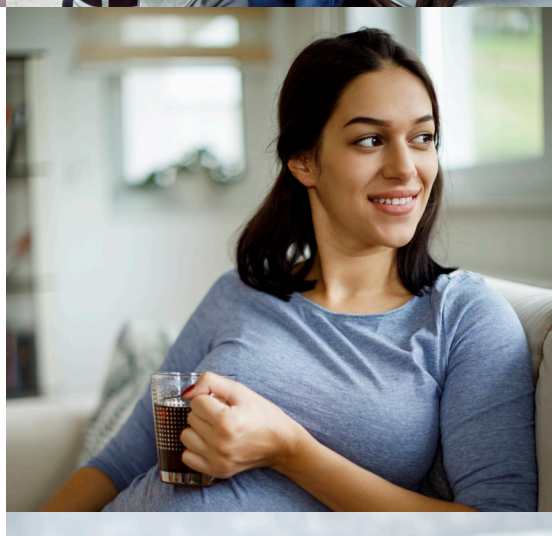



Diabetes in the Hispanic/Latino(a) Community






Module 1: An Overview

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This is the first of two modules exploring Hispanics/Latinos(as) living with diabetes in the US. The goal of this series is to raise awareness of health inequities and provide population facts, cultural insights, and potential solutions to assist health care providers in taking concrete actions to close Hispanic/Latino(a) health disparities.

This module explores cultures, spiritual and other beliefs, and perspectives around health, illness, and treatment along with other parallel facts.

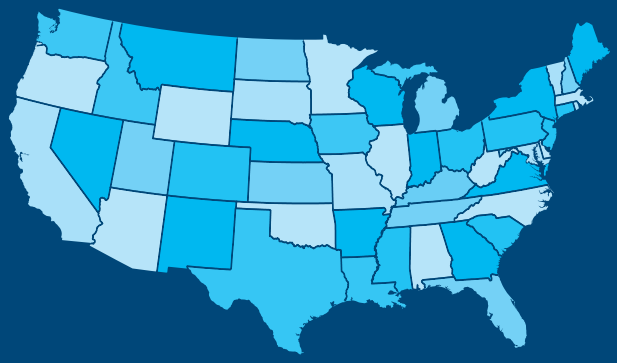
We invite you to integrate this information into your practice and share learnings with others who serve in a health care or health service role.

This module is not intended to be a comprehensive examination of health disparities and the numerous causal factors; rather it's meant to be a practical resource for those serving in a health care professional role.

Population and statistics

Diabetes has a staggering impact on the US population as a whole.

Diabetes in the US



34,200,000
people have diabetes
(10.5% of the US population)[1]

88,000,000
people 18 years and older have prediabetes
(34.5% of the US adult population)[1]

For those of specific races and ethnicities, the impact of diabetes is even more wide reaching. Often times health disparities adversely affect these populations, and this translates into worse health outcomes, higher health care costs, lost work productivity, and premature death. For Hispanics/Latinos(as) in the US, health disparities are far too common, impacting quality of life, longevity, economic opportunities, and biases. Hispanics/Latinos(as) are also more insulin resistant than non-Hispanic Latino(a) whites, putting them at greater risk of developing type 2 diabetes.[2]

Among adults of Hispanic/Latino(a) origin,[3]

Mexicans, at **14.4%,**

and Puerto Ricans, at **12.4%,**

have the highest prevalence of diabetes, followed by

Central/South Americans, at **8.3%**, and

Cubans, at **6.5%**

What is Latinx?

The term *Latinx* originally began as a "gender-neutral alternative" to *Latino* or *Latina*. In the Spanish language, nouns and some adjectives are considered masculine or feminine, whereas in the English language these are gender neutral. *Latinx* was coined by key figures in the United States to offer those who prefer gender neutrality or who do not identify as male or female to an alternative. This began to take off with younger, progressive individuals and politicians. However, it is still not fully accepted by the Latino community. According to a recent poll, the term did not resonate with up to 40% of Hispanic voters.[4]

We opted to use the traditional masculine and feminine verbiage in the content of these modules. However, we also want to bring awareness to the origin of the term and recommend that individual preferences be taken into account when addressing someone in the Hispanic and/or LGBTQ+ community.

Four diasporas

Assessment of the health status of the Hispanic/Latino(a) population in the US teaches awareness that Hispanic/Latino(a) ethnicity is not made up of a homogenous group of people. Moreover, in many cases, language and religion are often the only commonalities among the various Hispanic/Latino(a) subgroups. Hispanics/Latinos(as) are a diverse group that includes people of Cuban, Mexican, Puerto Rican, and South and Central American descent as well as those of other Spanish cultures and races. **Each population has its own history and traditions, but one thing they share is being at higher risk of type 2 diabetes (17%) compared with non-Hispanic Latino(a)whites (8%).**[5] **Although 17% is just an average for Hispanics/Latino(a) groups**, the chance of having type 2 diabetes is closely tied to background. For example, someone of Puerto Rican heritage, is twice as likely to have type 2 diabetes as someone of South American heritage.[5]

A diaspora is a scattered population whose origin lies in a separate geographic locale. Historically, the word *diaspora* was used to refer to the mass dispersion of a population from its indigenous territories, specifically the dispersion of Jews.

1.

US AND MEXICO

2.

CENTRAL AMERICA

1. US and Mexico

In 2016, there were nearly 58 million persons of Hispanic/Latino(a) origin residing in the US, representing 18% of the population.[6] **Projections reflect that by 2060, Hispanics/Latino(as) will number 111 million people in the US.**[7] Despite record immigration over the past two decades, 65.6% of Hispanics/Latinos(as) in the US in 2016 were born there.

Mexicans account for the biggest group of immigrants living in America, but the number of immigrants coming into the US has started to decline.[8] They primarily come from nine states: Zacatecas, Guanajuato, Michoacán, Oaxaca, Guerrero, San Luis Potosí, Hidalgo, Chiapas, and Sinaloa.

2. Central America

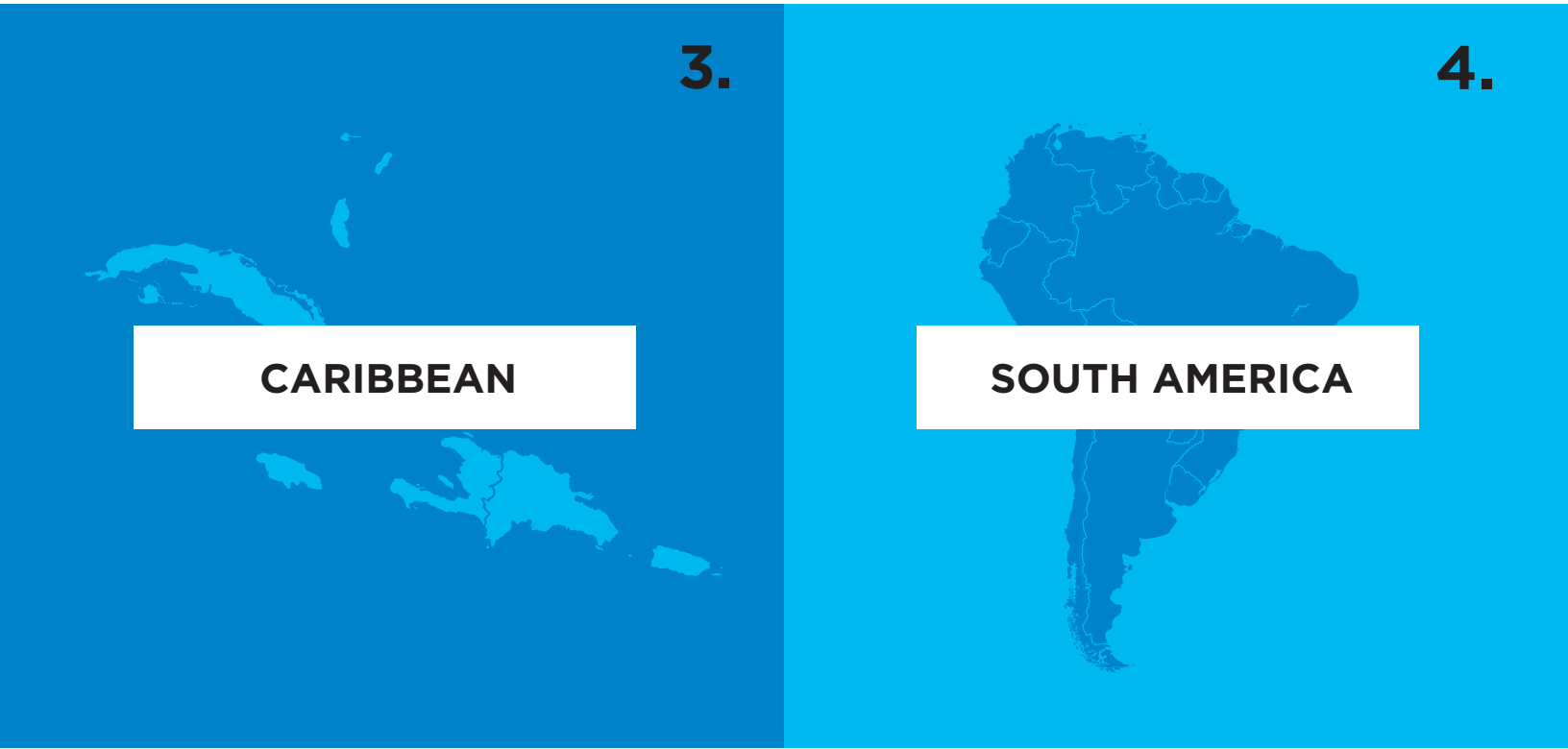
Central America lies between Mexico and South America and is made up of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. Most people throughout Central America are Mestizos (individuals with both indigenous and Spanish heritage). Additionally, dispersed throughout this region are Amerindian minorities, ranging from nearly half of the population in Guatemala to single-digit percentages in other countries.

3. Caribbean

The Caribbean, also known as the West Indies, refers to a geographical area and group of island nations situated in the Caribbean Sea; the Atlantic Ocean, North America, Central America, and South America surround it. The Caribbean islands include Cuba, the Dominican Republic, and Puerto Rico. In 2014, an estimated 4 million immigrants from the Caribbean settled in the US which is close to 9% of the 42 million immigrants within the nation. Caribbean immigrants came from five countries: Cuba, the Dominican Republic, Jamaica, Haiti and Trinidad and Tobago. According to 2010-2014 American Community Survey (ACS) data, Caribbean immigrants mostly settled in Florida (40%), New York (28%), and New Jersey (8%).[9]

4. South America

South America is made up of 12 countries: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay, and Venezuela.



DIABETES BACKGROUND

Diabetes background

More than 30 million people in the US have diabetes, and 1 in 4 are unaware they have it.[10] Meanwhile 84 million US adults have prediabetes, and 1 in 3 (90%) don't know they have it.[10]

Over their lifetime, adults in the US have a 40% chance of developing type 2 diabetes.[5] If you're a Hispanic/Latino(a) adult, your chance is more than 50%, and you're likely to develop it at a younger age.[5] Also, diabetes complications can be more severe, including higher rates of kidney failure, and vision loss and blindness.[5]

Perspectives on health, illness, and treatment

While diabetes is a global health epidemic, there are differences in the health, manifestation of illness, and treatment of diabetes in the various diasporas. Studies reveal that a significant number of Hispanics/Latinos(as) use home remedies or see traditional healers either sequentially or in tandem with conventional medicine practices.

Within the four diasporas, natural medical treatment may be preferred or used together with Western medicine practices. Some of the reasons may be related to one or more of the following: limited access to care, mistrust of health care providers based on historical interactions, concerns with managing one's own personal health, and lower health literacy. Natural or alternative medicine may be more commonly utilized by older generations than younger generations and by first-generation Americans versus subsequent generations. However, all beliefs should be assessed when creating treatment plans for each patient.

In Mexico, Central America and the Carribbean, the health of a person with diabetes can be affected by lack of education, low income, poor access to care, and location. Treatment for those living in the US is more progressive than in other countries. Diabetes management consists of proper diet and exercise, prescription medication such as metformin, and the administration of insulin.

However, treatment for Mexicans, Central Americans, and Caribbeans is sometimes not as progressive due to lack of medication availability, medication adherence, and knowledge of diabetic management.

Common remedies

Home remedies are an often overlooked component of health management among Hispanics/Latinos(as). In the US, remedies are commonly used in conjunction with biomedical medicine.

- **Prayer**
- **Garlic**
- **Prickly pear cactus pads**
- **Special teas from leaves and roots**
- **Lemongrass**
- **Lemon juice**
- **Vapor rub (eucalyptus)**

Hispanics/Latinos(as) may view illnesses, treatments, and foods as having "hot" or "cold" properties; the attribution of these properties varies by country of origin. Generally, "hot illnesses" are balanced with cold foods and drinks while "cold illnesses" are balanced with hot foods and drinks.

Examples of "cold illnesses":

- **Cancer**
- **Colic**
- **Empacho (indigestion)**
- **Headache**
- **Menstrual cramps**
- **Pneumonia**
- **Upper respiratory infection**

Examples of "hot illnesses":

- **Acid reflux or ulcers**
- **Anger**
- **Diabetes**
- **Diaper rash**
- **Hypertension**
- **Pregnancy**
- **Sore throat and infection**

SPIRITUALITY

Spirituality

Religion and spirituality is an important component to how Hispanics/Latinos(as) view themselves and manage their health. Among some Hispanics/Latinos(as), illness can be attributed to "God's will" or supernatural forces. This belief is more common among Spanish-speaking Hispanics/Latinos(as) than those who speak English. When illnesses are viewed as a punishment or the will of God, prayers and candles may be offered, resulting in a delay of obtaining health care services.

While some Hispanics/Latinos(as) may believe God has a plan for every person, they may also believe that individual actions play a key role. The term "la lucha" (the struggle or the fight) is an optimistic belief in the importance of self-reliance and taking an active role in personal health. "La lucha," in more general terms, is constant perseverance in the face of adversity and hardship Hispanics/Latinos(as) may face.

Additionally, some Hispanics/Latinos(as) believe in "susto," or a startling event that may cause separation of body and soul ("espiritu") and that may make the body more susceptible to illness. A car accident is one example. Some believe that certain illnesses are already present in the body, lying dormant or sufficiently resisted. When the body is weakened by "susto," the disease takes hold. Many Hispanics/Latino(as), particularly Central and South Americans, link the development of diabetes with "susto." However, it is important to note that "susto," is not believed to cause diabetes; rather, it "opens" the body or makes it more vulnerable to diabetes that may have already been present. Traditional treatments for "susto," may include special drinks made from water and herbs.

When we think about Hispanic/Latinos(as) addressing diabetes, cultural competency is key. Cultural competency is the ability of providers to deliver care that addresses the holistic needs of the person. Holistic treatment involves the whole person (mind, body, and spirit). Taking these things into account when treating patients who are Hispanic/Latino(a) can increase patient satisfaction. This is important because patient satisfaction can nurture provider/patient relationships and have a positive effect on patient outcomes.

Assessing for spiritual and religious practices is beneficial in understanding the lens through which the patient views life.

BARRIERS TO HEALTH CARE

Socioeconomic barriers

In an analysis of patients with diabetes, **23.9% of Hispanics/Latinos(as)** reported that cost was a significant barrier to health care compared with **8.2% of non-Hispanic/Latino(a)whites**.[11]

Access to health care

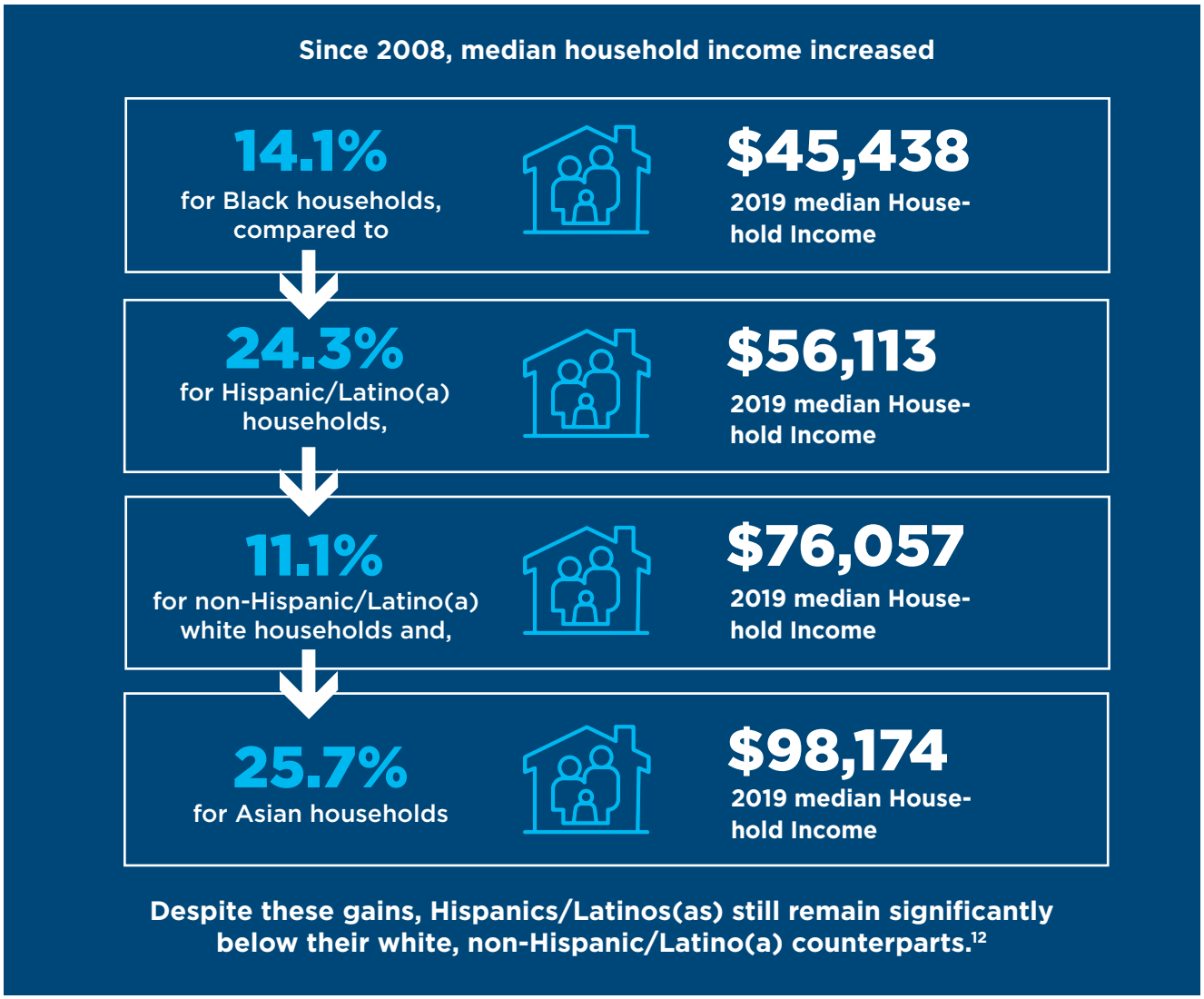
Low-income areas have limited access to resources and programs, and people living in these areas are less likely to seek care through educational programs.[13]

Language barriers

Further complicating access to health care is the fact that a significant number of Hispanics/Latinos(as) are not proficient in English. Additionally, many Hispanics/Latinos(as) prefer to conduct conversations in Spanish, although with a few exceptions medical services are rarely provided in Spanish. This language barrier affects interactions with health care providers and, therefore, quality of care[13]

Cultural barriers

The Hispanic/Latino(a) culture is rich in traditions, beliefs, practices, and attitudes, all of which influence perception and understanding of disease processes and treatment. It is important to explore these cultural factors to gain appreciation and insights into protective and motivating factors. Lack of sensitivity to these issues can create barriers to the implementation of high-quality health care. Hispanics/Latinos(as) also have more medication-related concerns than non-Hispanic/Latino(a) whites[13]



DELIVERING CULTURALLY-RESPONSIVE HEALTH CARE

Delivery of education: Cultural competency

Effective cross cultural communication builds trust and rapport over time increasing effectiveness of patient education. As providers* engage in cultural competency training and activities they become advocates for their patients. Patients who are engaged with their health treatment have less anxiety about treatment options, gain better understanding of their health, and are inspired to inquire about their health.

- Assess any barriers to the patient's understanding of education and/or material shared by asking open-ended questions (avoid yes/no or closed ended questions) Let the patient share how much they already know about the condition and how they perceive it. This may provide insight on literacy level and acceptance of learning more about the condition.
- Practice health literacy skills with the patient to ensure they understand. For example, have them read food labels and medication slips. You can also share or send visuals that may highlight key medical terminology in diabetes care for better understanding.
- Offer a thorough dietetic evaluation with a registered dietitian (RD) or a certified diabetes care and education specialist (CDCES), preferably with a professional who is familiar with your patient's cultural background. This can be done at the time of initial diagnosis (prediabetes or diabetes) and on an ongoing basis as needed.
- Learn how to engage your patients and address their social determinants of health. Up to 80% of a person's health is impacted by conditions and environments such as where they are born, grow, and their age. Providers can play a key role in identifying these needs for their patients.
- Be mindful of environmental conditions they live in, access to health care, and level of support (personal or professional) by administering screenings and assessments regarding these concerns. Community health workers at local hospitals and community centers can also serve as a level of support.
- Explore the challenges your patients face when it comes to acquiring the tools, lifestyle skills or habits needed to manage their condition. This will be helpful in determining each patient's needs.

To learn more about how to support your patients and be a catalyst to solving for their unmet needs, access Cigna's provider guide about social determinants of health: ***Addressing Social Determinants of Health within Your Practice***

***A health care provider may be a physician, pharmacist, nurse, counselor, community health worker, educator, and anyone who impacts a patient's health journey.**

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