

# **South Indians with Diabetes in New Zealand**

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# My Background

- My family and relatives
- Qualified as a nurse in 2002
- Self reflection: impact of healthy eating, attitudes and behaviours to health in the S. Asian population.
- From this I decided to conduct further research in this area.



# Research Title

## **FIJIAN INDIAN PATIENTS' WITH DIABETES IN NEW ZEALAND**

1. Knowledge/understanding/views/attitudes
2. Self management practices
3. Response to a culturally tailored educational intervention.

# Methodology

## *Phase 1*

- 15 Fijian Indians recruited from GPs
- Interviewed to answer research questions.

## *Phase 2*

- Phase 1 used to design session.
- 5 educated
- 16 family members
- Re-interviewed for evaluations

**Interviews in Fijian Hindi, audiotaped and transcribed in English  
Data analysis using general inductive approach. Interpretations confirmed with participants.**

# Phase 1 – Views and Attitudes

- Low concern for DM
- Newly diagnosed VS longer diagnosed
- Genetics, high sugar intake, stress and God.
- Lack of insight on body, diabetes and its complications.
- Insulin: Known as injectable drug.  
Sign of deterioration and dependence



# Phase 1- Self-care

Lifestyle changes difficult to maintain due context.

## ■ Diet:

- Large CHO portions (roti/rice or bread), avoid in sugary foods.
- Veges and salad are not considered as meal.
- Dinner often eaten late.
- Festive seasons: Celebrating with foods only way (Eid, Diwali).
- Family: Prepares/Shopping
- Common changes: low fat milk, margarine, oils, wholemeal bread.



# Phase 1- Self-care

## ■ Exercise

- not in lifestyle, least favoured, sign of deterioration, social status of women



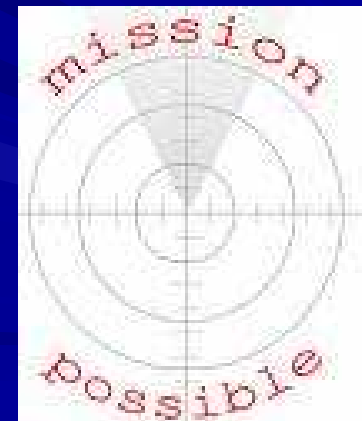
## ■ Lack of autonomy

- Reliance on HCP visits, bloods and meds
- Family: most lack of insight of disease and management.
- Diabetes Education: Lack of education, non seeking and unachievable.
- Effect of HCP: stereotyping/reinforce negative behaviours.

# Challenges

How do I :

- Teach people who have low literacy
- Fixation thinking pattern
- Low motivation to participate
- Guarded by traditions and norms.

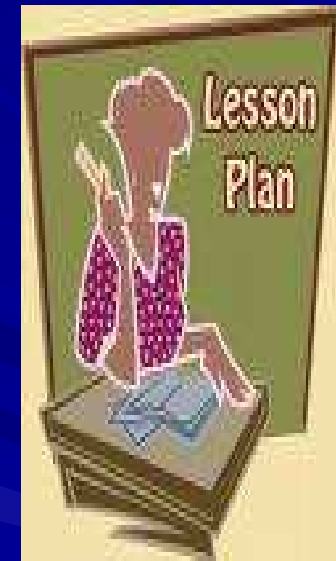


# Phase 2- Aims of Education

1. Raise awareness on our culture and health.
2. Improve understanding of participants and their family on diabetes.
3. Motivate participant to take control of their illness.

# Phase 2: Teaching Plan

- Our Cultural lifestyle and impact on health
- Diabetes
- Contributing factors (risk assessment)
- Complications
- Video presentation
- Physical Activity Vs Exercise
- Diet
- Role of family
- Medical Management and Monitoring



# Phase 2: Key techniques

- Simple/Interactive Activities (checklist, label reading test, video, reading handouts).
- Education assisted by family members.
- Visuals : Models, pictures, fat model, sugar models and scriptures from Holy Book.
- Accommodate for discussions and prayers.



# Phase 1- Feedback

## **Benefits of family participation**

*"My mother has diabetes but we didn't realise what she was going through and our role in helping her with her outcomes. I don't want her to suffer and also don't want to end up with the complications she is experiencing. Its quiet disappointing to learn how negligent our community. We can change our outcomes with lifestyle changes".*

*"My daughter in law did all the cooking at home and had never taken consideration about the effect of her cooking on me and the whole family who all have high blood pressure/Cholesterol and weight problems. With education she realized how critical her role is to cook healthy".*

## **Benefits of Indian Educator**

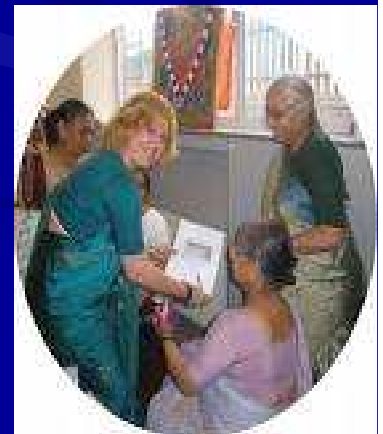
*"We know what to expect from education, e.g too much carbs (rice and roti), more veges/salads and exercise, but truth is we can't follow this. We appreciate the care NZ health system offers us here, in Fiji we die early because of our poor health system. Fact also is when non Indians educate us they really don't realize how hard it is to make changes. We feel intimated and lose our self-esteem when we fail to do what we are taught".*

## **Benefits of taking autonomy**

*"My foot is amputated and I'm partially blind because I never took my management seriously. I could have prevented or delayed my suffering if I had realized my responsibilities. We fall because we fail to respond and when we finally learn its too late"*

# Recommendations

1. Health initiatives/clinics for Indians.
2. Newly diagnosed to receive tailored education.
3. Prevention/screening initiatives for at risk SAs.
4. MOH to address Diabetes-CVD for SAs.
5. Need for SA educators to challenge for change.



# Aims of my role

1. Support diabetes care for SAs in the primary care setting.
2. Enhance diabetes care at ADC for SA.
3. Facilitate referral to diabetes clinic for complex needs.
4. Plan and support interventions for SAs.

# Developments

1. Raising awareness on SA.
2. Building relationship: GPs, nurses, NGOs
3. Promote referrals to ADC/SA Nurse.
4. On-call for advice.
5. Networks overseas (UK, Fiji and S. Africa).
6. Follow up DNAs.
7. Participate in workshops.
8. Community Clinic : 3kings and Mt Roskill.
9. Workshop days.

# Conclusion



1. Indians show inadequate understanding on diabetes
2. Key influencing factors for management is Cultural and family context.
3. Lack of Autonomy: Proactive from onset
4. Reliance on medications and HCP for management.
5. Lifestyle education should be flexible and achievable in their cultural/family context.

# Thank You



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