2017

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Type 2 diabetes in Native Americans: The influence of historical and cultural factors on incidence, prevalence, and strategies for patient education, disease prevention, and management

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Abstract

Type 2 diabetes (DM2) is virtually nonexistent among Native American, Alaska Native, and Canadian First Nations people prior to the 1950s. Due to historical, cultural, environmental, and psychosocial factors, Native people suffer disproportionately higher rates of DM2 than other populations. This literature review aims to examine the influence of these factors and investigate whether insight and knowledge into them, as well as culturally sensitive approaches to disease education, prevention, and self-management can be beneficial to providers working among Native communities. The results suggested that culturally sensitive approaches are indeed of value in promoting more effective care, and that lack of cultural sensitivity can present an obstacle.

Literature Review

The incidence and prevalence of type 2 diabetes among Native people continues to increase, especially in younger patients. More effective strategies in disease prevention, delay of onset, and disease self-management are needed in order to curtail this rising epidemic. CDC prediction: one in two American Indian/Alaska Native children born in 2009 will have type 2 diabetes in their lifetime unless the current trend is halted (McLaughlin, S., 2010).

Introduction

It has been well established that the prevalence of DM2 among Native peoples is the highest of any racial or ethnic group in North America, and the incidence continues to increase, especially among young adults, adolescents, and children. DM2 is now the fourth leading cause of death, and a major cause of disability and morbidity, including complications such as vascular disease, renal failure, blindness, peripheral neuropathy, and amputations. Disease self-management is crucial in preventing these complications. Genetic predisposition has been identified as a risk factor for the development of DM2 among Native peoples, but several variables also have significant influence, including environmental, historical, and cultural factors. Barriers to effective diabetes prevention and care have also been identified, including access to care, poverty, and cultural beliefs and practices, as well as healthcare provider’s lack of cultural sensitivity.

Statement of the Problem

The incidence and prevalence of type 2 diabetes among Native people continues to increase, especially in younger patients. More effective strategies in disease prevention, delay of onset, and disease self-management are needed in order to curtail this rising epidemic. CDC prediction: one in two American Indian/Alaska Native children born in 2009 will have type 2 diabetes in their lifetime unless the current trend is halted (McLaughlin, S., 2010).

Research Questions

What are some of the historical, environmental, and cultural factors that influenced the development of type 2 diabetes as a major health problem among Native communities?

Can knowledge and insight into these factors be helpful to the provider in developing a culturally sensitive approach to Native patients?

Is a culturally sensitive approach more accepted by Native patients, and how can it improve their self-management of type 2 diabetes?

Can culturally sensitive approaches be effective in creating effective partnerships between patients and providers, and that lack of cultural sensitivity can perpetuate miscommunication and patient distrust, an obstacle to effective care.

In success decreasing diabetes among Native peoples will be a long process, and perhaps must be measured one patient at a time.

Applicability to Clinical Practice

Based upon the studies reviewed in this paper, the evidence indicates that provider cultural competence, along with a culturally sensitive approach, are of benefit in providing effective primary care among Native communities, particularly in the management of a complex, chronic disease such as DM2. For providers working among Native communities, the following lessons gleaned from this literature review may be of great value:

Recognize the importance of cultural competence.

Learn the culturally accepted norms of communication, including body language and eye contact, and be patient.

Explore your patient’s beliefs and perceptions regarding diabetes.

Develop culturally themed approaches to disease education and self-management.

Partner with community tribal elders, family members, and lay educators and mentors.

Innovate—utilize Web based, culturally themed programs to help overcome obstacles to care, such as limited access due to distance.

Listen, or your tongue will keep you deaf.

References


Acknowledgements

Many thanks to my classmates for their comradeship, and to my family for their love, support, and patience during this journey.

Discussion

The evidence is clear regarding the emergence of DM2 as perhaps the most major health issue facing the indigenous people of North America, who now suffer disproportionately higher rates of disease and disease related complications than any other racial or ethnic group. Type 2 DM is a direct result of the colonization of North America and the subsequent loss of tribal lands and ways of life. In that regard, diabetes truly is “the white man’s disease.” The literature also reveals that the problem of DM2 is many faceted, with its roots in history, and compounded by many environmental factors, including geographic isolation, poverty, historical trauma, and lack of access to healthy food choices and medical care. The multiple forces that helped create and perpetuate the problem of DM2 among Native people are daunting obstacles to overcome, and will require combinations of government, Native communities, and healthcare providers. The studies reviewed for this paper indicated that at the provider level, culturally sensitive and appropriate interventions can be effective in creating effective partnerships between patients and providers, and that lack of cultural sensitivity can perpetuate miscommunication and patient distrust, an obstacle to effective care. Success in decreasing diabetes among Native peoples will be a long process, and perhaps must be measured one patient at a time.