Professional Development

Diabetes Educators as Cultural Translators

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Persons who differ from their health care providers in terms of race, sex, or socioeconomic status are likely to ask themselves three major questions when receiving diabetes care: Does this health care provider have goodwill toward me and have my best interests at heart? Does this provider have the professional expertise to help resolve my particular health care problems? Does this health care professional understand my life experiences and those of others like me?[1] Patients who perceive their provider to be an advocate, as well as competent and respectful, will view that provider as credible. Such relationships engender trust among people of different cultures. Health care professionals will have to be skilled and dedicated to cultivate such perceptions over time.

For the purposes of this article, the term 'culture' refers to individuals and groups with common origins, customs, and styles of living.[2] While culture may not always play a crucial role in the treatment of emergencies and acute conditions, cultural dynamics shape the process and outcomes of interventions designed to promote self-care behaviors.[3] Culture is especially relevant to the management of a chronic disease such as diabetes because of the disease's lifelong course and constant focus on culturally-embedded behaviors.

While certain health behaviors are known to be important for diabetes self-care, promoting such behaviors requires understanding all behaviors in relation to the cultural context in which they occur, a concept defined as *cultural relativity*.[2] Examining behavior in its cultural context can help to explain conditions that pose barriers to the translation of scientific knowledge into improved health care for persons with diabetes from minority cultures. Identifying barriers to health promotion may help educators understand why recommended health actions sometimes do not occur. These barriers can be defined as competing priorities (eg, issues of survival versus long-term health), environmental obstacles (eg, neighborhood crime, lack of resources such as transportation, child care, etc), and lack of knowledge and skills. Furthermore, the barriers to appropriate diabetes care are not only relevant to persons with diabetes, but also are relevant to health care providers and their delivery systems. For example, health care providers may not examine a client's feet at every visit for several reasons: there are too many other procedures to be done (competing priorities), there may not be enough time or there is no water to wash hands afterwards (environmental obstacles), or they may not know they should perform this examination or how to examine feet properly (lack of knowledge and skills). Identifying culturally specific obstacles to action on the part of both members of the health care team is a first step in intervention planning to overcome culturally specific barriers to diabetes care.

Diabetes educators can acquire the skills in understanding, communicating, and intervening that will help them mediate between the mainly Caucasian middle-class health care system and underserved populations with diabetes, which can include certain racial and ethnic groups, older adults, and economically disadvantaged persons. Awareness of the cultural history, traditions, and current norms of the underserved populations can help in the design and implementation of diabetes education interventions. No cultural group is homogenous, but by individualizing diabetes education messages for a particular client, effective education can take place on a one-to-one

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basis. More general diabetes education messages and intervention should be targeted to reach specific cultural groups.

The primary purpose of this paper is to highlight the role of diabetes educators in the translation of diabetes information across cultures, and the importance of culturally inclusive and linguistically appropriate approaches as key components in the effective delivery of diabetes education and care. We also will describe some of the diabetes care challenges facing many culturally diverse persons and discuss the role of the diabetes educator in helping individuals meet those challenges.

The Role of a Cultural Translator

Diabetes educators can be thought of as translators, making scientific knowledge understandable, relevant, and applicable to daily diabetes self-care. Diabetes translation has been defined as the "... systematic effort to influence human behavior so that new knowledge is utilized to optimize diabetes care." Diabetes translation must encompass all contexts that affect diabetes care (eg, psychological, social, cultural, financial, geographic, demographic, and health care).[4] The multiple roles of the diabetes educator, with required expertise in diabetes, in teaching functions,[5] in acting,[6] in philosophizing,[7] and in marketing education tools,[8] are all relevant to the role of cultural translation (eg, translating diabetes self-care information so that it can be applied successfully in culturally-diverse settings).

Diabetes educators maintain that education is an interpersonal experience[9] and for many persons the perceived quality of their diabetes care and education may be virtually equivalent to the quality of their relationship with their health care provider. Diabetes educators who are willing to advocate for the needs of their patients by such time-consuming tasks such as social referrals, letter writing, and counseling, may obtain credibility for themselves and sometimes even for the system they represent. Most importantly, such educators can earn the validation necessary to work within the infrastructure of culturally diverse communities.[10] Skills in community organization, when combined with earned credibility, can allow educators to serve as catalysts to mobilize individuals and communities to address diabetes care and the prevention of other health problems.

As a cultural translator, a diabetes educator can help to reduce stereotypic thinking among professional colleagues about persons from different ethnic and socioeconomic groups. Cultural translators are aware that when professionals feel superior to, or pessimistic about, the persons they serve, these attitudes are conveyed in subtle ways, including body language, tone of voice, and choice of words. A cultural translator can set a higher standard for communication in their health care system. Language or actions that fail to promote a positive image of a particular cultural group can be gently discouraged. When colleagues blame a patient or a group of patients for noncompliance, a cultural translator can help those colleagues identify the barriers to improved self-care (competing priorities, environmental obstacles, lack of knowledge and skills). Translators can help colleagues understand that the health care system itself often has failed to meet the needs of minority persons for relevant and appropriate diabetes care. A cultural translator who has credibility in both the majority and minority cultures can guide colleagues toward more effective communications, replacing mutual distrust with mutual respect.

Because everyone is intimately involved in his or her own culture,[11] educators need to evaluate the influence of their own cultural backgrounds in forming their current perceptions. Contemplating the inherent dignity and worth of all persons may help educators to avoid such pitfalls as condescension, stereotypic thinking, and ethnocentric approaches (viewing one's own cultural values and beliefs as inherently correct or superior) to diabetes care.[11] Educators acting as cultural translators must remain alert constantly to both verbal and nonverbal cues that communicate that the health messages they are delivering may be inappropriate, irrelevant, or patronizing. Diabetes educators can reduce potential barriers to diabetes translation by pilot testing programs, print materials, and audiovisual materials with their target audience and obtaining feedback that will help in the revision of these products.

Earning Trust and Respect in the Community

To establish a community health intervention, such as a diabetes education program, in a culturally diverse community, educators must identify and negotiate with community gatekeepers or opinion leaders (official or not), who can grant or deny entry into a community. To earn acceptance by these gatekeepers, cultural translators must demonstrate tact, a nonjudgmental and nonthreatening manner, and a genuine regard for the community. Volunteering to serve the community in non-health-related areas (eg, tutoring children or adults, political lobbying for resources, providing recreational items for children's sport teams) can help educators earn trust and credibility. Cultural translators should be careful not to commit resources over which they lack full control, simply because failure to deliver on promises can cause setbacks on the road to building trust. Small gestures consistently and sincerely made can sometimes have large returns for an educator seeking to be a cultural translator.[10]

Diabetes educators with a commitment to becoming cultural translators can enhance and demonstrate their respect for diverse cultures by learning about the historical rituals and norms of a particular culture. For example, in many cultures food has significant social and cultural meanings, often representing warmth, social acceptance, and security. Present-day food choices and preparation frequently reflect historical and traditional cultural practices. For example, traditional Southern vegetable dishes include prolonged cooking with animal fat (pig, chicken), reflecting a past that included constraints and mandates of slavery.[12] Being overweight is itself a culturally relative construct,[11,12] a fact that the height and weight tables used by most health care professionals fail to take into account. In some cultures, extra weight is considered attractive. Religious beliefs also play an integral role in the lifestyle of many people. Understanding the key religious tenants of a culture can help the educator better understand a client's view of health and self-care behaviors. Religious leaders/institutions can be powerful allies for translating

health-related messages about chronic diseases such as diabetes.[13]

The credibility of cultural translators also may be enhanced by participating in community activities (cultural festivals, parades). Some educators working among culturally diverse people like to wear indigenous jewelry or clothes, particularly if such items are gifts from clients. Honoring members of the cultural group by exhibiting pictures or displaying quotes is another way to show appreciation for the contributions of a particular culture. Cultural translators should always seek out unoffensive, creative means to show their solidarity with the client and the cultural community.

While much can be done to build trust and earn respect, educators still must acknowledge that some persons never will believe that a health care professional so different from themselves, in terms of social and economic status, can be fully trusted. Distrust may be exacerbated by feelings of powerlessness, and such deep-rooted feelings are not easily changed. Treatment offered by a health care system that some perceive as ethnocentric may seem irrelevant and ineffective to persons living in highly stressful situations amid violence and abject poverty. Building a trusting relationship among such persons will be slow and incremental.[10]

The Impact of Poverty on Diabetes Care

Disproportionately high rates of diabetes exist within the African American, Hispanic American, and Native American communities according to the Centers for Disease Control (CDC).[14-16] The CDC reports that about 3.6% of the African American population has been diagnosed with diabetes and the disease contributed to 22,000 deaths in this group in 1988. African Americans with diabetes annually suffer more than 9000 lower-extremity amputations, 3625 new cases of end-stage renal disease, 2800 new cases of blindness, and 428,000 hospitalizations. Long-term reduction in activity was reported by 691,000 African American persons in 1988. Among Hispanic Americans, almost 6% have diagnosed diabetes, compared with 3% of the general population. The extent of the burden of diabetes and its complications is unknown for this population. Although it is known that about 7% of all Native Americans have been diagnosed with diabetes, data are inadequate to provide a clear and accurate understanding of the extent of the diabetes burden for this population.

Some reports suggest that diabetes also burdens some Asian Americans disproportionately, but for this population and others, national data usually do not provide adequate designation of descent, and sample sizes in most national surveys are too small to provide stable estimates. A correlation exists between diabetes prevalence and socioeconomic status. A recent nationwide poll conducted by the Gallup Organization showed that households in the lowest economic group (less than $15,000 annual income) had the highest prevalence of diabetes.[17]

Many persons in the racial and ethnic populations known to suffer disproportionately from the burden of diabetes face stresses and challenges to basic survival that displace diabetes self-care and other long-term health concerns. Individuals living in underserved inner cities and rural areas deal on a daily basis with poverty, racism,[18] environmental hazards such as substandard and overcrowded housing,[19] crime, pollution, substance abuse, violence, and stress. Although chronic diseases such as diabetes are affected by all of these factors, for the individual, the demands of daily survival for oneself and one's family almost always will be a higher priority.

Good diabetes self-care is expensive, involves the commitment of resources for health care supplies (eg, blood glucose monitors and test strips), and requires diabetes education. Because these services often are inaccessible or are not covered by third-party payers, appropriate diabetes care may seem an unattainable commodity for economically disadvantaged populations. The chronic complications of diabetes, including renal failure, amputations, and retinopathy, often result in disabilities that further reduce the income of affected patients. Inadequate health care, combined with poor health and insufficient economic resources, becomes a self-reinforcing downward spiral. Furthermore, the future-time orientation of diabetes self-care may seem impractical to many economically disadvantaged persons who experience daily feelings of despair, vulnerability, and alienation.[19]

An ideology of despair may dominate the thinking of some persons living in precarious socioeconomic conditions. Expressions of fate or of God determining whether one lives or dies are common. The feelings of powerlessness associated with poverty are linked to disease.[20] In fact, some sociologists argue that income and class are more important than race in predicting health status. It is difficult, though, to determine precisely the relative impact of the biological, sociological, and economic factors affecting the health of persons with chronic diseases like diabetes who live in economically disadvantaged and environmentally stressful environments. It is certain, however, that poverty adds significantly to the difficulties of carrying out good diabetes care.

Words as Barriers and Bridges

Compelling examples of the gulf between the majority culture, which is the source of most health education messages, and many of the underserved populations that health education messages are intended to influence, are issues of literacy and language. With an estimated 23 million functionally illiterate Americans,[21] diabetes education materials must be written at levels appropriate for the individuals who need them rather than for the health care professionals who develop them. Social marketing principles can be used to help cultural translators develop materials for use among socially segmented populations, using culturally inclusive words and idioms that facilitate the acceptance and understanding of a health message. Understanding the vernacular specific to a particular culture (eg, persons without money or resources are "busted," and where one resides is often referred to as where one "stays" or where one "cribs" or "shacks" in various cultures) is needed when developing audiovisual mediums. Focus groups can be useful at several stages during the development from concept outline to the finished product.[22]

Diabetes Education and Personal Empowerment

Empowerment has been defined as "... [A] social-action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice."[23] In the context of diabetes education, empowerment has been redefined as "... an interactive process that enables persons with diabetes to acquire and enhance the social, problem-solving techniques and communication skills necessary to manage their own diabetes care in a variety of life situations."[24] This approach to diabetes care and education is a more appropriate model for racial and ethnic populations than is the more conventional compliance approach.[18]

With the compliance approach, clients are directed by health care providers to perform specific diabetes self-care behaviors and are labeled noncompliant if they fail to obey directions. The client's beliefs, expectations, and capability to perform treatment behaviors often are not given adequate consideration. The compliance approach to diabetes care and education may be especially problematic for persons from backgrounds where cultural values are quite different from those of the provider. First, because health care providers often are unaware of the cultural meaning of prescribed diabetes care regimens, the likelihood of noncompliance is significantly increased. Second, the compliance approach provides a contextual message that the health care provider is "... powerful and in charge" and that the person with diabetes is "... powerless, passive, and expected to be obedient."[23] This contextual message may be especially harmful to persons from minority cultures because it is likely to reinforce their sense of alienation and distrust of the health care system.[20]

The empowerment approach maintains that persons have the right to make informed decisions about their own diabetes care. They can be prepared for the role of self-directed care by learning about diabetes and its care and by exploring with the diabetes educator their own health-related values, needs, goals, and aspirations regarding diabetes care. Such exploration serves two important functions. First, it allows individuals to make more relevant and realistic decisions about their own goals for diabetes care. Second, it provides an opportunity for the educator to learn more about patients as persons and about the cultures from which they come. Empowerment is intended to result in increased self-efficacy and an enhanced ability on the part of the persons to achieve their own self-care goals.[22] Such a philosophy is consistent with a desire to see all persons learn to become more effective in meeting their health care and other personal and social needs.

One outcome of empowering persons to be autonomous decision makers is that they in turn can help lead other members of the community to positive action. Effective health education programs have employed community advocates or elders to promote health through physical activity, good nutrition, and smoking cessation. Appropriately chosen and trained indigenous persons who become health advocates and translators within their own communities engender a level of credibility and trust seldom achieved by outsiders. Diabetes educators can work to empower individuals and communities through the effective transfer of skills and translation of health messages, and by helping individuals gain control of the skills and resources necessary to manage their own health education interventions.

Facilitating the empowerment of persons from diverse cultures requires the expansion of the diabetes educator role to that of cultural translator. The ongoing and interactive process of sharpening skills, evaluating the effectiveness of health education strategies that are culturally relevant, and establishing trusting relationships with culturally diverse persons may be termed *progressive empowerment*. This dynamic and evolving process will enable diabetes educators to become increasingly effective in translating the technical concepts of diabetes care into culturally interpretable information for specific populations.

Conclusion

Diabetes educators who choose to function as cultural translators will be changing their scope of practice and are accepting an important public health responsibility to improve the diabetes care, health, and quality of life for individuals and communities. They will work with a community to determine what the particular diabetes education needs perceived by this community are, what educational strategies can this community become involved in, and what materials and personal resources already exist in the community that can be used to improve diabetes care. Succeeding in this role requires diligence, patience, risk-taking, and commitment. The educator also must realize that the health care system is a culture with its own rituals, languages, values, customs, and norms. The successful "translator" will be respected and credible in both cultures if he or she is capable of establishing communication links between the two groups. The educator who succeeds as a cultural translator will be making a real difference in the lives of people who are striving to participate in and benefit from the American dream. These educators seek to progressively empower persons while developing a knowledgeable appreciation for their rich cultural diversity. The educators' example, no less than their teaching, should be a positive power in translation. Their own life practices should be an illustration of an attempt at healthy living. It is their practice of the lifestyle principles they inculcate that will give their diabetes messages more merit. The educator continually is brought into contact with individuals who need strength and encouragement, and can help these individuals only to the extent of revealing a personal strength of lifestyle principles that triumph over high risk habits. If the educator fails in setting an example, persuasive words will fall on deaf ears.[25]

Diabetes educators committed to functioning as cultural translators for underserved persons and their communities are greatly needed. Although African Americans constitute 12% of the US population, they comprise only 3% of physicians, 4.5% of registered nurses,[26] and 3.2% of registered dietitians.[27] While 9% of the US population is Hispanic, only 3.4% of physicians, 1.6% of registered nurses,[26] and 1.4% of registered dietitians are Hispanic.[27] American Indians represent only 0.3% of registered nurses and dietitians,

while Asian or Pacific Islanders constitute 3% of American registered nurses[26] and 5.6% of registered dietitians.[27] These data indicate that the majority of diabetes care and education provided to culturally diverse persons now and in the near future will be provided by members of the majority culture here in the US.

Through knowledgeable translation and advocacy, diabetes educators may facilitate the development of a more appropriate and sensitive health care system, and contribute to the reduction of the risk factors, morbidity, and mortality that disproportionately burden certain populations. Achievement of diabetes objectives such as those set forth in *Healthy People 2000*[28] will be achieved only if appropriate translation methodologies and programs are developed and implemented at the grassroots level of high-risk communities throughout the United States.

References

1. Davis LE, Proctor EK. Race, gender, and class: guidelines for practice with individuals, families, and groups. Englewood Cliffs, NJ: Prentice-Hall, 1989.

2. Randall-David E. Strategies for working with culturally diverse communities and clients. Washington, DC: Association for the Care of Children's Health, 1989.

3. Cardnas P. Diabetes and Hispanic Americans (speech). Chicago: First Tape Inc, 1990.

4. Anderson RM. The challenge of translating scientific knowledge into improved diabetes care in the 1990's. Diabetes Care 1991;14:418-21.

5. Pichert JW. Strategies for effective patient teaching. Practical Diabetology 1987;6:1-4.

6. Istre SM. The art and science of teaching. Diabetes Educ 1989;15:67-76.

7. Anderson RM. Diabetes educators as philosophers. Diabetes Educ 1987;13:259-61.

8. Skyler J. Intensive insulin therapy: a personal and historical perspective. Diabetes Educ 1989;15:33-39.

9. Report of the Secretary's task force on black and minority health. Vol I, Executive summary. US Department of Health and Human Services, 1986.

10. Braithwaithe RL, Murphy F, Lythcott N, Blumenthal DS. Community organization and development for health promotion within an urban black community: a conceptual model. Health Educ 1989;20:56-60.

11. Kittler PG, Sucher K. Food and culture in America. New York: Van Nostrand Reinhold, 1989.

12. Wilson CR, Ferris W. Study of southern culture, University of Mississippi. In: Encyclopedia of southern culture. Chapel Hill, NC: The University of North Carolina Press, 1989.

13. Foege W. The vision of the possible striving for the fullness of life. The churches challenge in health (speech). Second Opinion 1990;13.

14. Centers for Disease Control. Regional variation in diabetes mellitus prevalence, United States, 1988 and 1989. MMWR 1990;39:805-9.

15. Centers for Disease Control. Prevalence and incidence of diabetes mellitus, United States, 1980-1987. MMWR 1990;39;809-12.

16. Report of the Secretary's task force on black and minority health. Vol II, Chemical dependency and diabetes. US Department of Health and Human Services, 1986.

17. Surveys show socioeconomic trends in diabetes hospitals. Data Watch 1991 Feb 10:44.

18. Anderson RM, Herman WH, Davis JM, Freedman RP, Funnell MM, Neighbors HW. Barriers to improving diabetes care for blacks. Diabetes Care 1991;14:605-9.

19. Bullough VL, Bullough B. Health care for the other Americans. New York: Appleton-Century Crofts, 1982.

20. Wallerstein N, Berstein E. Empowerment education: Freire's ideas adapted to health education. Health Educ Q 15:379-94.

21. Doak CC, Doak LG, Root JH. Teaching patients with low literacy skills. Philadelphia: JP Lippincott Company, 1985.

22. Basch CE. Focus group interview: an underutilized research technique for improving theory and practice in health education. Health Educ Q 1987;14:411-48.

23. Wallerstein N. Powerlessness, empowerment and health: implications for health promotion programs. Am J Health Promotion 1992;6:197-205.

24. Funnell MM, Anderson RM, Arnold MS, et al. Empowerment: an idea whose time has come in diabetes education. Diabetes Educ 1991;17:37-41.

25. White EG. The ministry of healing. Mountain View, Ca: Pacific Press Publishing Association, 1942:132-33.

26. Minorities and women in health fields. US Department of Health and Human Services, PHS, Health Resources and Service Administration/Bureau of Health Professions, 1990;HRSA-P-DV 90-93.

27. Bryck JA. Report of the 1986 census of the American Dietetic Association. J Am Diet Assoc 1987;87:8.

28. US Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives. US Department of Health and Human Services, 1990; DHHS publication no. (PHS) 91-50213.

The purpose of this department is to provide our readers with a forum to share ideas, insights, and individual expertise in a broad range of categories relating to professional development and growth. Authors are invited to submit manuscripts that address specific strategies and/or practical approaches relating to the responsibilities of the diabetes health care professional. Papers that creatively apply business, marketing, human resource development, leadership, and management skills to diabetes education are of particular interest. Manuscripts should be limited to 8 to 10 double-spaced pages and sent to Professional Development editor Gail A. D'Eramo-Melkus, EdD, RN, Yale University School of Nursing, 25 Park St, PO Box 9740, New Haven, CT 06536-0740.