This project was initiated and overseen by the EMR Diabetes Initiatives Steering Committee (DISG) with funding from DHHS regional office and support of the Inner East Primary Care Partnership.
Understanding the barriers and enablers to accessing diabetes education services, for people with newly diagnosed type 2 diabetes.

Community consultations with Mandarin, Cantonese and Vietnamese speaking communities and the Aboriginal and Torres Strait Islander community.

Background

Agencies across the EMR have agreed to work together to improve access and uptake of diabetes education for people with newly diagnosed type 2 diabetes in the EMR.

This report outlines the findings from community consultations that aimed to gain an understanding of the barriers and enablers to accessing diabetes education services, for people with newly diagnosed type 2 diabetes from identified high risk populations. The high risk groups included, Mandarin, Cantonese and Vietnamese speaking communities and the Aboriginal and Torres Strait Islander community.

The consultations involved focus groups and interviews with people with newly diagnosed type 2 diabetes from the identified communities and/or health care workers who are providing services to these communities.

This project follows on from the “Improving Access and Coordination of Diabetes Education in the EMR project which identified these groups as being at high risk and/or high prevalence in EMR. The report also identified that these communities face significant barriers in accessing services that provide support in reducing risk and or managing health issues.
Focus groups aimed to explore the information needs and service preferences of people with newly diagnosed type 2 diabetes.

Interviews with general practice explored current referral patterns for diabetes education, experience of current services and perceptions of what additional services might be needed.

Methodology

Bilingual health workers conducted the consultations with the Chinese and Vietnamese communities and general practice. Table one (page 6) provides a summary of these consultations.

Consultations in relation to Aboriginal and Torres Strait Islander community involved consultations with community specific organisations, and peak bodies and community health organisations working with the community.

Data collection and analysis

The interviews and focus groups were conducted in Vietnamese, English, Cantonese and Mandarin by the bilingual researchers, following the planned lines of inquiry. The researchers took notes and a thematic analysis approach was used to elicit meanings from collected data.

Interview schedules for the community groups and general practices were developed and used by the two researchers (see appendix one).

Key areas of exploration for the community groups and general practice were:
  - How, when and what services they use/refer too and if not why not?
  - Their experiences of current services?
  - What services would best meet their needs?
Methodology

RECRUITMENT – People with newly diagnosed type 2 diabetes

Mandarin and Cantonese speaking communities.
Focus groups were used with the Mandarin and Cantonese speaking communities. The focus groups were conducted by a bilingual dietician. A bilingual flyer was distributed via the professional networks of the bilingual researcher conducting the focus groups. Participants were offered an incentive ($20 gift card) to participate in the focus groups.

Vietnamese Community
Recruiting Vietnamese participants for focus groups was challenging as only one focus group could be organised. An alternative strategy of phone interviews was adopted. The National Diabetes Services Scheme (NDSS) mailed flyers to all Vietnamese people on their data base living in the EMR. Community members were asked to contact the researcher (a Vietnamese speaking diabetes educator) to arrange an interview. Participants were offered an incentive ($20 gift card) to participate in the focus groups.

Recruitment was time consuming and a variety of strategies were required to engage with different community groups.
**Methodology**

**RECRUITMENT – Health Professional consultations**

Flyers inviting general practitioners to participate in an interview were sent to General Practices known to work with the target communities via the Inner East Melbourne Medical Local (IEMML). Reimbursement for time was offered. No general practitioners' responded to the flyer.

A second strategy although time consuming was more successful. The two bilingual researchers involved in the community consultations were asked to conduct the general practitioner consultations. They sent invitations via phone, email and/or personal visits using established professional networks and were able to engage a few General Practices’ in the process.
The consultations included focus groups and phone interviews with community members and health professionals involved in providing diabetes related health care to the identified populations.

<table>
<thead>
<tr>
<th>Language</th>
<th>Community consultations</th>
<th>Health Professional consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandarin</td>
<td>3 focus groups – total 19 participants</td>
<td>General Practitioner (1) Service coordinator (2) Practice nurse (2) Diabetes Nurse Educator (2)</td>
</tr>
<tr>
<td>Cantonese</td>
<td>3 focus groups – total 14 participants</td>
<td>Practice nurse (2) Diabetes Nurse Educator (2)</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Individual telephone interviews (10) Focus groups (1)</td>
<td>General Practitioner (3) Practice Nurse (1) Diabetes Nurse Educator (2)</td>
</tr>
</tbody>
</table>

Table one: Summary consultations.
### VIETNAMESE COMMUNITY FOCUS GROUP AND INTERVIEWS – FINDINGS

<table>
<thead>
<tr>
<th>Themes</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health–information seeking habits</td>
<td>Vietnamese people with diabetes often employed self-education to gather diabetes management information via internet, friends and books. Most indicated the lack of information in Vietnamese as an issue.</td>
</tr>
<tr>
<td>Unaware of and unfamiliar with allied health service</td>
<td>There was a mixed response in relation to other services used, half indicated they had attended other allied health services, the other half indicated that they only saw their GP or attended Vietnamese specific groups and some indicated they were unaware of other services.</td>
</tr>
<tr>
<td>Referral pathway</td>
<td>GPs are the main referrers to diabetes education and allied health services.</td>
</tr>
<tr>
<td>Logistical challenges in service access</td>
<td>Lack of time and not knowing about services were reasons given for not attending other services. Others indicated that they felt able to look after themselves. Preference for programs in Vietnamese and in a familiar setting were expressed.</td>
</tr>
<tr>
<td>Use of interpreter and translated diabetes service</td>
<td>This group expressed desire for more information and groups in Vietnamese but did not comment on use of interpreters.</td>
</tr>
<tr>
<td>Ideal diabetes education for Vietnamese people with diabetes</td>
<td>Diabetes education via public health talk format in familiar locations was identified by many as desirable. Half of the interview group preferred a weekend program. Information on diet and exercise were seen as most important.</td>
</tr>
</tbody>
</table>
# Findings

## CHINESE SPEAKING COMMUNITY FOCUS GROUPS – FINDINGS

<table>
<thead>
<tr>
<th>Themes</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health–information seeking habits</td>
<td>Mandarin–speaking people with diabetes often employed self–education to gather diabetes management information. Cantonese–speaking people with diabetes were more likely to rely on friends for convenient health information.</td>
</tr>
<tr>
<td>Unaware of and unfamiliar with allied health service</td>
<td>Participants presented with lack of knowledge about diabetes allied health services, many claimed to have never thought of attending diabetes education.</td>
</tr>
<tr>
<td>Referral pathway</td>
<td>GPs are the main referrers to diabetes education however, many people with diabetes did not feel comfortable requesting a referral.</td>
</tr>
<tr>
<td>Logistical challenges in service access</td>
<td>Participants in all groups identified multiple logistical challenges in accessing health service and indicated that accessing a foreign health service is often stressful. Participants highlighted the lack of trust when entering an unknown health service.</td>
</tr>
<tr>
<td>Use of interpreter and translated diabetes service</td>
<td>Use of interpreter was not preferred and participants indicated that translated diabetes services do not meet Chinese people’s needs and were criticised for their lack of cultural relevance.</td>
</tr>
<tr>
<td>Ideal diabetes education for the Chinese people with diabetes</td>
<td>Participants described individual diabetes education as foreign from what they were used to. Diabetes education via public health talk format in familiar locations was the most preferred.</td>
</tr>
</tbody>
</table>
### GENERAL PRACTICE CONSULTATIONS – FINDINGS

<table>
<thead>
<tr>
<th>Themes</th>
<th>Descriptors – Chinese</th>
<th>Descriptors – Vietnamese</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice referral patterns to other services</td>
<td>General practice referral patterns are not clear from the consultations. Community workers described the Chinese people with diabetes as ‘hard-to-engage’ but it is not clear if this is influenced by GP referral patterns</td>
<td>All the general practices’ reported providing information to clients and referring on to diabetes education. One practice said they have Vietnamese allied health workers in the practice that they refer too. Most patients do not ask/seek out services, only attend other services if referred.</td>
</tr>
<tr>
<td>General Practice experiences of patients response to referrals</td>
<td>Service coordination for the Chinese appeared to be more complicated than use of language interpreters. Poor understanding of the health care system may also be a factor. Chinese usually attend diabetes education if told to by the GP.</td>
<td>Practices’ reported that most patients attend services that they refer them to. Practices reported that they receive feedback from the services and that patients are usually positive about the services they attend.</td>
</tr>
<tr>
<td>Services/support general practice would value</td>
<td>Language-specific diabetes education service at low or no cost was considered the most important modification when targeting diabetes education at the Chinese community.</td>
<td>Language-specific diabetes education service at low or no cost most important. Mobile service that can visit people at home. The practice that has allied health in the practice reported this model works well and could be replicated by others.</td>
</tr>
</tbody>
</table>
Engagement is supported by:

- Partnering with Aboriginal Organisations – developing culturally appropriate/programs together.
- Delivering programs in established community groups.
- Offering general health and wellbeing focused programs open to every one.

ABORIGINAL AND TORRES STRAIT ISLANDER CONSULTATIONS – FINDINGS

EACH and Darebin Community Health have seen a gradual increase in the number of Aboriginal and Torres Strait Islander people seen at their services over the last 5 years. Both attributed this to, strong organisational support and investing time and resources in engaging with the community.

In 2014, 2.3% of EACH clients identified as Aboriginal or Torres Strait Islander, the community is estimated to represent less than 1% of the EMR population.

Successful engagement strategies were those where the organisations partnered with Aboriginal organisations. For example EACH has a strong partnership with Mullum Mullum, the local Aboriginal Gathering Place. EACH Aboriginal Health staff work closely with Mullum Mullum, delivering programs in the community and organising health check days for the community at EACH. The health checks provide an opportunity to introduce the community to other services that EACH provides and for community to meet “check out” staff.

Darebin reported similar experiences, finding that community members don’t come to programs or visit allied health staff unless they know other people in the group or know the staff member. Staff members attending community groups and developing programs with established community groups has seen community groups referring and accompanying members to Darebin. The Darebin Aboriginal health workers also plays a key role in supporting access. Darebin diabetes educator also works with VAHS diabetes clinic, and cross referrals ensure community members get access to a range of services.
ABORIGINAL AND TORRES STRAIT ISLANDER CONSULTATIONS – FINDINGS

Diabetes Australia Aboriginal Health program staff reported that the programs they have seen working best in the community are those that offer flexible appointment structures, work with established groups to deliver programs rather than set up a new group/service. Community members are reluctant to attend programs/services if they think they are the only Aboriginal people there.

Programs that focus on the whole of the community and on wellbeing rather than ill health are more acceptable.

The Eastern Health Aboriginal Case Management Service operating at Healesville has over 800 people in their program, many with diabetes, their experience is that most of their clients prefer not to travel out of the area so access to specialist services is limited, cost is also a barrier. Community members do attend the Diabetes Educator at Yarra Valley Community Health as links have been established by the program and community members are familiar with the service.

They estimate that over half their clients see a local GP rather than an Aboriginal specific medical service.

The Eastern Health Aboriginal Case Management Service reported they have little interaction with Eastern Health diabetes services.

Aboriginal people are over represented in ED presentations and 4x more likely to be hospitalised with diabetes.

1. DHHS Koolin Balit: Victorian Government Strategic Directions for Aboriginal Health 2012–2022
Language and lack of familiarity with services is a key barrier.

Chinese and Vietnamese speaking communities prefer to see health professionals that speak their language, use of interpreters is a barrier.

Chinese and Vietnamese speaking communities

Language barrier

The Chinese and Vietnamese speaking communities indicated that language is a barrier for them in accessing services. They expressed a strong preference for seeing health professionals that speak their language and some indicated that use of interpreters is a barrier for them.

General practitioners indicated that they prefer to refer to health professionals that speak the clients language as the client is more likely to attend.

Familiarity with the service

The Chinese and Vietnamese speaking communities indicated a preference for accessing services in familiar settings such as community groups.

Not being familiar with the services available was indentified as a barrier for the Chinese and Vietnamese speaking communities. A reluctance to engage with a service if you are not familiar with the people working in the service was reported for all groups. This was also true for general practitioners in relation to referral to services.
General Practice is a key source of diabetes information, care and referral. General Practice are the main source of information and referral for the Chinese and Vietnamese speaking communities. General practitioners indicated they are happy to refer to other services and most clients will attend if referred to an appropriate service but finding suitable services (health professionals that speak the clients language) is difficult.

Interventions that focus on the individual and are condition specific may not align well with community expectations/or concepts of health and wellbeing.

Preference for Community Talks

The Chinese and Vietnamese speaking communities indicated a preference for community talks in familiar settings. Interventions that focus on the individual and/or are condition specific may not align with community expectations or concepts of health and wellbeing. It maybe that community talks provide a more acceptable way for the community to “check out” health professionals before they engage with them on a individual basis.
Aboriginal and Torres Strait Islanders

Familiarity with the service

Partnering with Aboriginal organisations is key to engaging with the community. Aboriginal people are reluctant to attend a service if they think they are the only Aboriginal people attending the service, taking services to already established community groups addresses this barrier.

Community health services have been able to increase aboriginal participation, by proactively engaging with local Aboriginal organisations, building trust, developing joint programs and identifying appropriate referral pathways.

General practice

Many Aboriginal people attend their local GP for diabetes care contrary to the belief held by some that that most Aboriginal people attend Aboriginal specific health services. Access to specialist services may be restricted as community are reluctant to travel too far to access services, cost may also be a barrier. Not being familiar with or comfortable accessing specialist services may be a further barrier for some.
Use a community development approach to tailor program information and delivery format to the needs of specific communities.

Improve access to health professionals that speak Chinese and Vietnamese.

Consider role of IDEAS clinic for improving access to specialist services for Aboriginal Community.

- Community lectures/forums in familiar surroundings is the preferred method of getting information about diabetes for all groups. It may also be that this format is more appropriate culturally as there is less focus on the individual and allows broader community participation. Community Health could also use this to introduce services and staff addressing other barriers such as lack of familiarity/trust of service.

- Improving access to health professionals that speak their language is important for the Chinese and Vietnamese speaking communities as use of interpreters can be a barrier.

- Partnering with local community groups to engage and deliver services is crucial.

- Explore with Aboriginal community groups the appropriateness of IDEAS clinic for the Aboriginal community. Given the high risk for complications and hospitalisations for the Aboriginal community and the limited access to specialist services the IDEAS clinic could be an effective way to provide more comprehensive and coordinated care.
The previous mapping exercise identified that engagement with all community groups in relation to community diabetes education services is very low.

It was estimated that less than 8% of the people with newly diagnosed diabetes in the region are accessing local community diabetes education services. Although numbers were small, other cultural groups in the catchment were fairly proportionally represented as a percentage of the total population.

Almost half of the referrals were from General Practice and were for diabetes education.

This would suggest that whilst services have found it challenging to engage with the community groups that were the focus of this report, there are broader issues than language and cultural appropriateness that are limiting community participation in diabetes education in the formats that it is currently offered.
Appendix one: EMR Type 2 Diabetes Consultations Interview Schedule

Interview Schedule for consumer focus groups

Aim

Explore the information needs and service preferences of, people with newly diagnosed type 2 diabetes from Mandarin, Cantonese and Vietnamese speaking communities including:

- How, when and what services they use and if not why not?
- Their experiences of current services?
- What services would best meet their needs

How, when and what services are used and if not why not?

When you were first diagnosed with diabetes

1) What information did the doctor give you about the condition?
   a) Did the doctor give you information about diet, exercise and other things you could do to help control the condition
      i) Was this in written form or verbal
      ii) How useful did you find the information
   b) Did you seek out information yourself
      i) If yes what information did you look for/from where/how helpful was it?

2) Did the doctor refer you to any other services and/or did you seek out other services
   a) If yes
      i) what types of services

Experience of current services?

3) Have you attended other services/programs for diabetes if yes how helpful was it
   i) if no why not?
4) What things have been most helpful for you in managing your diabetes?

What services would best meet needs?

5) If we were setting up diabetes programs to support people with diabetes from your community to learn about their condition and how to manage it?
   i) What things do you think should be discussed in the program
   ii) What other things do you think need to be considered in planning the program- [include prompts such as timing, venue
   iii) Would you attend such a program – if yes why if no why not
   iv) What is the best way to let the community know about this program/motivate them to come to the program?
Interview Schedule for Health Professional

Questions

6) When you first diagnose a person with type 2 diabetes, do you give the patient any information about the condition?
   If yes:
   - what type of information, is it in Vietnamese
   - Is it provided in written format

7) Do you routinely refer patients to education services?
   If yes
   - what types of services
   If no – why not

8) Do your patients request information or to be referred to education?

9) Do you find your patients independently seek out other services?

10) When you refer patients to education services in the region do they attend?
    If yes
    - Do you receive feedback from the service?
    - Are patients happy with the services?
    - Do you think the services provided help the client manage their diabetes?
    If no – why not

11) Are there changes to current services you think are needed to support people with diabetes from your community to learn about their condition and how to manage it?

Areas to explore if the GP does not include in response
   What things do you think need to change?
   What other things do you think need to be considered in planning the programs- [include prompts such as timing, venue
   Would you refer to such a program/service – if yes why if no why not
   What is the best way to let the community know about ours services/motivate them to come to programs/services?
Appendix Two: Improving Access and Coordination of diabetes education in the EMR

Summary of Community and General Practice Consultations with Chinese and Vietnamese Community.
Appendix Two: Improving Access and Coordination of diabetes education in the EMR

Summary of Community and General Practice Consultations with Chinese and Vietnamese Community.
Methodology

In order to explore the diabetes self-management journey of Chinese (Cantonese- and Mandarin-speaking) people with type 2 diabetes and understand their pathway of diabetes education service access, participants of interest were invited to a one-hour focus group. The participants of interest were: Cantonese-/Mandarin-speaking people with self-declared type 2 diabetes for preferably less than 5 years and have no experience of structured diabetes education. The study adopted a qualitative phenomenological line of inquiry and focus group questions were around the topic of lived-experience of disease management and habits of gathering of health information (see appendix for focus group questions).

Recruitment

A bilingual flyer was developed to recruit suitable participants from the community (see appendix for a copy of the flyer). The flyer was distributed via professional network including the Victorian Chinese Worker Network and the Carrington Health Chinese Friends of Health, posted up on noticeboard at various Chinese community organisations and public libraries, and circulated among Chinese senior citizen clubs. Potential participants were encouraged to ring the bilingual researcher directly when eligibility was checked, then confirmed participants were allocated to one of the scheduled focus groups. As an incentive to participation, each participant was presented with a $20 Coles gift card at the end of focus group.

Data collection and analysis

The focus groups were conducted in Cantonese or Mandarin by the bilingual researcher (TC), following the planned lines of inquiry. Data collection continued until theoretical saturation was achieved. All focus groups were tape-recorded and re-listened to by the researcher for data analysis. Thematic analysis approach was used. Quotes from participants are used in this report to illustrate the truthfulness of data. All quotes have been translated to English by the researcher.

Results

A total of six focus groups were conducted: three in Cantonese and three in Mandarin. Majority of the participants were recruited at various Chinese senior citizen clubs where the focus groups were conducted respectively. Other interested participants from the community were invited to the focus groups held either at Carrington Health or MonashLink Community Health Service (Glen Waverley).
Demographics of participants

A total of 33 Chinese people with diabetes in the Eastern Metropolitan Region of Melbourne were consulted. Their age ranges from 50 to 94, with majority in their 60-70. Their diverse backgrounds, varying in country of origins, history of diabetes diagnosis and management, enhanced the richness of the data collected. Table 1 summarises the demographics of the participants.

Table 1: Demographics of focus group participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Cantonese-speaking (n=14)</th>
<th>Mandarin-speaking (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male-to-female ratio</td>
<td>2:12</td>
<td>6:13</td>
</tr>
<tr>
<td>Country of origin (China-to-Hong Kong ratio)</td>
<td>3:11</td>
<td>19:0</td>
</tr>
<tr>
<td>Diagnosis of diabetes (&lt;5years-to-&gt;5years ratio)</td>
<td>3:11</td>
<td>13:6</td>
</tr>
</tbody>
</table>

Key themes

Data analysis identified six major themes that emerged from the qualitative data. Table 2 summarises the themes and their descriptors.

Table 2: Themes and descriptors emerged from data

<table>
<thead>
<tr>
<th>Themes</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health-information seeking habits</td>
<td>Mandarin-speaking people with diabetes often employed self-education to gather diabetes management information. Cantonese-speaking people with diabetes were more likely to rely on friends for convenient health information.</td>
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<td>Participants presented with lack of knowledge about diabetes allied health service, with many claimed to have never thought of attending diabetes education.</td>
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<td>Referral pathway</td>
<td>GPs are the main referrers to diabetes education however, many people with diabetes did not feel comfortable requesting for a referral.</td>
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<td>Logistical challenges in service access</td>
<td>Chinese people with diabetes faced multiple logistical challenges in accessing health service. Accessing the foreign health service is often stressful. Participant highlighted the lack of trust of the health service when entering the unknown.</td>
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</tr>
</tbody>
</table>
Health-information seeking habits

The researcher found many of the participants, especially the Mandarin-speaking people with diabetes, were of very high educational levels. Some claimed to be retired professors at university, highly skilled professionals and government officials. More importantly, they presented with good knowledge of diabetes self-management. It was reported that Chinese (Mandarin-speaking) have strong self-education culture. Many told the researcher that they actively gathered diabetes care information from books, newspapers, overseas television programs and mobile phone apps every day.

On the other hand, Cantonese-speaking people with diabetes were more likely to rely on convenient health information source. It was reported that they mostly gathered information from their circle of friends informally. When they faced with diabetes management query, they were likely to leave it rather than seeking clarification. Many participants also reported receiving diabetes management written information from their general practitioners (GPs), however, as these written materials were in English, people usually threw them out after they left the clinic.

When participants were asked if they accessed the mainstream information sources, including reading the Diabetes Australia newsletters, attending National Diabetes Week events, they told the researcher they did not know about these and not find them attractive due to language barrier.

Unaware of and unfamiliar with allied health service

Many participants consistently reported that they have never thought of consulting or seeking support from allied health practitioners for their diabetes. One participant said:

\[\text{It has never crossed my mind. I kind of know there are dietitians around but it never occurred to me that I need to see one.}\]

Almost all people with diabetes had a poor understanding of the diabetes healthcare team. While some claimed to have seen a ‘dietitian’ at diagnosis, they reported having a foot assessment or being given a glucometer by the ‘dietitian’. Previous research suggested that such confusion between diabetes professionals could be contributed by the diabetes healthcare system in Asia where allied health professionals were rather uncommon, and people with diabetes usually received the entire diabetes education from the nurse only\(^1\).

For those who appeared knowing about allied health services for diabetes management, they indicated not knowing how to access the service, privately and at community health service.
Referral pathway
The GPs were highly respected in the Chinese community. Most of the participants who had been to structured diabetes education were referred by their GPs at diagnosis. However, diagnosis was not that clear for many participants. While some reported that their GP never really told them about a definite diagnosis, many others were sharing their stories of being diagnosis with diabetes at the medical check-up for migration and such diagnosis was not followed-up. Their GPs possibly had assumed these people had already received diabetes education in China.

Participants did not know they could request for referral to diabetes allied health service. Even with this knowledge, one participant said:

*My GP is very busy. I feel uncomfortable asking for a referral, especially requesting a Chinese-speaking professional. It means he has to dig through his book to find one. Then some professionals might have a Chinese surname but don’t speak Chinese. It is just too hard.*

Some participants suggested that promotion of diabetes education service at the reception of GP clinics and pharmacies would allow them to engage the diabetes education service themselves.

Logistical challenges in service access
While language and transport barriers have been repeatedly identified to be major barriers to service access by all migrant groups, the participants in this study also highlighted additional challenges faced. One lady described her challenged experience in attending a health service.

*You have to understand, ‘Carrington Health’ or ‘MonashLink’ mean very little to me. In Hong Kong, all health services share the same logo, a red cross, so when we find a community clinic, it is obvious. Also I can trust that I am here to see my health professionals. Looking at this logo with all the hands in the air (the MonashLink logo), it can be a gym or a shop selling bread.*

It was more than the fear of stepping into a health service. This participant highlighted the lack of trust of the health service when entering the unknown. She then went on discussing that it would be ideal to put a health-related sign on the door.

Furthermore, another participant pointed out that locating the health centre was stressful. With limited English and being new to the country, going anywhere outside his daily routine was difficult. To complicate the issue, entrance with poor signage often contributed to more stress.
Use of interpreter and translated diabetes service

When the researcher explained the diabetes care system in Australia and discussed the availability of interpreter during service access, she was surprised to learn that the presence of an interpreter during individual diabetes education session was a barrier rather than an enabler. One participant said, pointing at her elderly father sitting next to her:

_He doesn’t like having so many people surrounding him. He would rather not attend. I said to him that he could learn more about better controlling of his diabetes but he said no. Every time I suggest him to see a doctor or health professional, the first thing he asked is if he or she speaks Chinese._

Some participants with adequate English skills described their experience of attending either mainstream diabetes education, or translated public talks on diabetes. They reported to have gathered some healthy lifestyle information, which however, was of little cultural relevance. They ended up having to do self-learning from Chinese books.

Ideal diabetes education for the Chinese people with diabetes

Participants were asked to describe the ideal model of diabetes education targeted at the Chinese community, it was reported, consistently across all focus groups, that they would like to see more diabetes talk in the community. While it might address the convenient information-seeking habits of the Cantonese-speaking community, large-group talk / lecture was repeatedly mentioned as the preferred format of diabetes education. One lady pointed out:

_I can see it is great that in Australia we can consult the dietitian individually but we are not used to this model. We prefer public talk. Then if we need tailored advice, we can then see you individually in the clinic._

Although the content of public talk would be general and its focus might be increasing awareness, greatly limiting its impact on individuals, such format is more in line with the collectivist-orientated culture. Also, this outreaching service will bring the diabetes education to where the community is and in a familiar approach. The participants advised that these talks should focus on dietary management as it is a common concern for people with diabetes.

Another innovative service emerged from various discussions was a small-group intervention, at the weekly senior groups or at the health centre, where people with diabetes are regularly invited to participate in diabetes education collectively. Many said that the focus group format of a round-
table discussion about diabetes would be helpful for clarifying management doubts with the health professionals and asking more individual-tailored questions.

Lastly, special request was made for low or no cost, and provision of written education materials in Chinese to meet the cultural needs of self-education. This service should also be best promoted at the GP clinics and pharmacies.
References:


For more information:

Tammie Choi  (tammie_choi@hotmail.com)
Methodology

In order to explore and understand the referral pattern of diabetes education of local health services working with the Chinese (Cantonese- and Mandarin-speaking) people with type 2 diabetes, participants of interest were invited to a 30-minute interview. The participants of interest were: healthcare professionals involved in initiating or coordinating the referral of diabetes education for Chinese people with type 2 diabetes. Initially the project was designed to target specifically on interviewing general practitioners (GPs), however, it was proven to be challenging. The participants of interest were then modified to draw information from other professionals involved in the referral process, i.e. practice nurses in GP clinics, service coordinators and clinicians. The study adopted a qualitative phenomenological line of inquire with interview questions designed to capture participant’s experience in working with the Chinese people with diabetes (see appendix for interview questions).

Recruitment

Purposive sampling was adopted. The researcher (TC), who is also a community dietitian, recruited participants via her professional networks. Invitation was sent to local general practices and community organisations either verbally via telephone or written invitation via email. An interview appointment, either over telephone or face-to-face, was then made.

Data collection and analysis

The interviews were conducted in English, Cantonese or Mandarin by the bilingual researcher (TC), following the planned lines of inquiry. Data collection continued until the network of contact was exhausted. The researcher took notes in English during all interviews, which was collated and analysed. Thematic analysis approach was used to elicit meanings from collected data.

Results

A total of seven telephone or face-to-face interviews were conducted: one GP, two service coordinators, two practice nurses, and two diabetes nurse educators (DNEs). These health professionals were working in various settings including private GP clinics, community health centres, Primary Health Network (PHN) and the Royal District Nursing Service (RDNS). This diversity contributed to broader commentary on the topics discussed and enhanced the richness of the data collected.
**Key themes**

Data analysis identified three major themes that emerged from the qualitative data. Table 1 summarises the themes and their descriptors.

Table 1: Themes and descriptors emerged from data

<table>
<thead>
<tr>
<th>Themes</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese people with diabetes are ‘hard-to-engage’</td>
<td>Chinese people with diabetes were commonly described as a ‘hard-to-engage’ community. Service coordination for the Chinese appeared to be more complicated than use of language interpreters.</td>
</tr>
<tr>
<td>Chinese people are unfamiliar with the healthcare system</td>
<td>Chinese people are not familiar with the local healthcare system, contributing to poor understanding of the needs to access allied health service. However, the Chinese respect and trust the GP a lot, and they usually attend the diabetes education service if the GP told them to.</td>
</tr>
<tr>
<td>What could make diabetes education more attractive to the Chinese?</td>
<td>Language-specific diabetes education service at low or no cost was considered the most important modification when targeting diabetes education at the Chinese community.</td>
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</tbody>
</table>

**Chinese people with diabetes are ‘Hard-to-engage’**

Chinese people with diabetes were referred to a ‘hard-to-engage’ community, especially by mainstream professionals. The interviewed service coordinator at the PHN described her role in the central intake system coordinating Allied Health referral requests for the local GPs. This service coordinator told the researcher that there were hardly any Chinese referrals. Similarly, the DNE at RDNS described a recent service improvement project within the organisation to address the low service usage by Chinese community, however the strategies employed did not seem to work.

A practice nurse also shared that it seemed effortful for the Chinese people with diabetes to attend diabetes education session when they had to arrange transport and language assistance from adult children. A service coordinator said ‘It was a family affair!’ from the initial contact as many Chinese people with diabetes were not confident in answering the phone and would leave adult children’s mobile as primary contact, yet the adult children could be too busy with work and did not pick up the phone during working hours. The complexity continued when arranging the diabetes education appointment as adult children needed to be available to provide transport and sometimes translation. The service coordinator reported that some just dropped the idea of attending the service as it was too complicated.
Chinese people are unfamiliar with the healthcare system

As allied health service is rather uncommon in China, the Chinese community is used to gather diabetes self-care information from only the GPs. This has sometimes become a barrier. A practice nurse reported an incident when the patient declined a podiatry referral as he did not understand the needs. Also the China diabetes annual review system appeared to be ingrained into many of the Chinese. They appeared reluctant to take-part in more frequent reviews for diabetes, and multiple diabetes appointments with different allied health professionals seemed even more overwhelming.

The strong respect to the GP was reported as common in the Chinese culture. Many interviewees said that GPs were almost ‘God-like’ to the Chinese. When a referral was recommended by the GP, they usually made an effort to attend the diabetes education service.

What could make diabetes education more attractive to the Chinese?

Language-specific diabetes education was described as the most important in attracting the Chinese clientele. The two practice nurses at different clinics, as well as the interviewed GP, consistently reported that most people would request for a diabetes education delivered in Chinese. Other than addressing the language barrier, the sharing of common culture was seen as foremost important. A service coordinator of a health service reported that the Chinese referrals had increased drastically since the employment of a bilingual diabetes clinician.

The other important enabler is low or no cost. The interviewed GP told the researcher that the Enhanced Primary Care (EPC) plan had made the referral process a lot easier and the diabetes education more attractive. The GP said that the Chinese community has a low awareness of diabetes education and its importance, therefore, they are less likely to pay an out-of-pocket cost to a service they did not understand why they need it.

For more information:

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DIABETES ACCESS PROJECT: VIETNAMESE INTERVIEWS AND FOCUS GROUP SUMMARY

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Method:

The National Diabetes Services Scheme (NDSS) mailed interview flyers to all Vietnamese people on their data base living in the EMR. The contact person on the flyer was a Vietnamese speaking diabetes educator who scheduled interview times with each person. Interviewees were given a $20 gift voucher for their time. This was advertised on the flyer.

10 people met the project criteria and were interviewed. The criteria was – living in the EMR, diagnosed with Type 2 diabetes within the past 5 years, and from a Vietnamese background.

Demographics of interviewees

- 4 were male, 6 female
- 8 were aged over 55 years, 2 unknown
- 9 had resided in Australia for more than 20 years, 1 for less than 3 years
- 9 were diagnosed for 5 years or less (6 of these were 3 years or less) and one for 6 years
- 4 had attended diabetes education and 6 had not – 3 of the 4 had attended a one on one program and 1 a community program. 3 of these 4 had been diagnosed for 3 years or less.

Question 1 – information provided by GP

To manage patients’ diabetes, GPs most commonly provided information about diet (7) and exercise (5) and purchase/use of a blood glucose meter (3). Information was given in a range of formats including verbally (3), written (3) and booklet (3). Most often the information was given in English. 3 interviewees mentioned the lack of Vietnamese information about diabetes. GPs also provided information about other services such as an endocrinologist (1), dietitian (2) and diabetes nurse/educator (2). In 2 cases the GP prepared a care plan and sent referrals. 2 people were not given any information or booklet. 6 people looked up information themselves including on the internet or asking friends.

“My doctor told me to go to pharmacy - buy meter. I check my blood sugar. I see dietitian to talk about foods. My doctor told me to do exercise. No book, just verbal. I think it was good but that was all I was told.”

“No programs. I was not told to attend any programs. If there is program in Vietnamese then I think it’s very good because I want to know more and how to look after myself.”

Question 2 – GP referrals to other services

5 interviewees reported that their GP referred them to other services. All 5 were referred to a dietitian, 3 to a podiatrist, 2 for an eye check and 2 for diabetes education.

“It was very good because they taught me how to look after myself and what foods to eat.”
Question 3 – attendance at other programs

4 interviewees attended other diabetes programs. 1 saw a diabetes educator and 3 went to information sessions. Of the people who did not attend programs, 2 said they weren’t told, 1 said they had no time, and 1 was happy with support provided by their GP. 3 people said they look after themselves.

“The diabetes educator taught me how to check my blood sugar, exercise. They are all good for you if you have diabetes.”

Question 4 – most helpful in managing diabetes

9 interviewees said that learning about diet and food was most helpful in managing their diabetes, 6 mentioned exercise and 2 mentioned blood sugar checks.

“I think exercise is important and check your blood sugar. You also have to be very careful with your food.”

Question 5 – content and type of future diabetes education programs

Most of the interviewees said that information about diet (7) and exercise (6) were most important in any diabetes education program. Some (3) also said that information about blood glucose checks is important.

Half of the interviewees preferred a weekend program but some (3) mentioned that as they were retired a weekday program would be suitable. 3 people said the program could be offered anywhere while only 1 mentioned a community venue as being important. 7 people said they would definitely attend such a program and 3 said it would depend on the location, time and language.

9 people said a program could be promoted through a letter. Radio was mentioned by 2 people and newspapers were mentioned by 2 people. These responses may have been skewed as the interviewees were advertised by letter.

“Does not matter where or when, people will go if they think it’s good for them to know.”

“Yes I definitely attend programs. Vietnamese speaking is important as we can’t understand English”
Focus Group Findings

The Vietnamese focus group comprised of 5 people aged over 55 years: 4 women and 1 man who all live in Whitehorse area and are all Vietnamese. Only one person diagnosed less than 5 years ago. 2 more than 10 years and 2 more than 20 years ago. The group was conducted with a Vietnamese interpreter and English speaking facilitator.

The GP was the main source of information and follow up for this group. The GP provided the diagnosis and gave information at least verbally about how to manage their diabetes. In some cases the GP also referred to other specialist services if needed such as specialist, optometrist, podiatrist, diabetes education and dietitian.

Participants who attended the diabetes education at Richmond Community Health Centre found this service useful to help them manage their diabetes.

Participants also found written information in their own language useful and the session provided by their local Indochinese elderly group every year was also good to remind them.

Generally it was felt that the GP alone was not enough.

Future education sessions preferred are those offered at their Indochinese group to reduce transport issue and in their own language. They should include information about exercise, diet and food.

Note that this group only had one participant who was diagnosed in the past 5 years. All others had been diagnosed more than 10 years ago.