Understanding lived experiences of Aboriginal people with type 2 diabetes living in remote Kimberley communities: diabetes, it don't come and go, it stays!

What is the issue?
What is it like for Kimberley Aboriginal remote community people living with diabetes?

Why was this study done?
To listen to the stories of patients with diabetes. For example, how do they manage their diabetes and medicines? What supports do they have? What can be done to make it better?

How was this study done?
Thirteen (13) Aboriginal adult patients from two (2) remote communities shared their stories by yarning with Aboriginal Health Workers/Practitioners (AHW/P) and doctors. Medical records where looked at to list the diabetes medicines used and to find out how many adults in these communities had diabetes.

What did we find out?
Three (3) out of 10 adults in the communities had diabetes.

Patients who yarned with us had been living with diabetes from 9 to 33 years and would like support from their Elders, family, community, clinic, shop and other service providers to care for themselves.

Recommendations for action
- Need milimili (picture books) and movies to tell us what diabetes is: *"It didn't really hit me 'til I started watching them pictures"* (patient).
- AHW/P to assist patients with their diabetes from first being told they have diabetes to medicine changes and their own care plan: *"There have been a lot of changes in my medications from month to month... it's just tiring me out"* (patient).
- Patients and clinic staff to understand each other better to support patient needs: *"We need someone who will sit with us on a weekly basis to talk to us. Not just fly in and fly out"* (patient). *"Gets you more understanding. You learn a lot from asking them questions"* (AHW/P).
- Yarning with patients before medical talk is important: *"Shocked at how differently the participants responded to the AHW-led yarning approach to interviews compared with clinic consultations. They were so open and honest"* (non-Indigenous doctor).
- Family, community, clinic and other services need to work together to offer better support: *"There's no support, there's nothing. . . no programs here for well-being"* (patient).
- The clinic, community and store need to work together to support people with diabetes: *"People tell us what you're supposed to eat and what you're not supposed to eat but you gotta try and go and find it. There's nothing there in the shop"* (patient).
- Share knowledge of good diabetes foods in the shop and on country: *"I'm also learning off the old people how they do it"* (patient).
- Everyone needs to understand diabetes and support each other: *"Sometimes when you talk to family and friends they think that diabetes is just an ordinary little thing that comes and goes and I like to tell them it don't come and go, it stays!"* (patient).

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If you have any questions or comments please contact: Julia Marley by email julia.marley@rcswa.edu.au or phone (08) 9194 323.