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Immigration and Diabetes:
a little-known reality

In the Canary Islands, the increasing arrival of immigrants, many from Africa, has highlighted the challenges faced by health care centers in treating people with diabetes or those at risk of developing it.

Diabetes mellitus is a chronic metabolic disease that has reached epidemic proportions worldwide. According to the International Diabetes Federation, more than 537 million adults suffer from this disease[2], and its incidence is particularly high in regions with vulnerable populations, such as migrants exposed to multiple risk factors. One example is the conditions they face during migration and upon arrival at their destination—lack of access to medical care, malnutrition, and chronic stress—all of which can worsen or trigger the disease[4]. In each medical consultation, it becomes increasingly evident how lifestyle changes after migration, such as a more Westernized diet and decreased physical activity, increase the risk of type 2 diabetes mellitus.

In the Canary Islands (Spain), where a significant proportion of immigrants arrive in an irregular situation, integration into the health care system is mainly hindered by lack of accessibility. Although Spain has a universal health care system, care for undocumented individuals faces limitations that vary by autonomous community, and misinformation about health care rights exacerbates exclusion.

Currently, diabetes requires continuous care, medication, and multidisciplinary follow-up; therefore, this becomes a costly and complex challenge for those living in vulnerable situations. Often, the care for immigrants with diabetes is limited to managing acute crises (especially when there is a significant language barrier) rather than adopting a preventive and educational approach, further worsening poor health outcomes and complications.

As health care professionals, we must not forget that migration is inherent to humanity; it involves changes and losses. The migration process affects physical, psychological, and social health. Diabetes in the immigrant population is, therefore, a complex challenge that requires culturally adapted health care, focused on the needs of each patient.

Primary care consultations are often the first point of contact an individual has with the health care system. Therefore, it is essential to recognize the barriers that migrants face in accessing proper diagnosis and treatment.

BARRIERS TO ACCESSING HEALTH CARE

Immigrants, especially undocumented individuals, face significant difficulties in accessing health services. These barriers include:

1. Language and communication:
Many people do not speak Spanish, making it difficult to understand and follow medical instructions.

2. Lack of knowledge about the health care system:
Newly arrived patients often do not know the procedures for accessing services (e.g., obtaining a health card, managing appointments, and prescriptions).

3. Stigma and discrimination:
Fear of rejection or discriminatory treatment may discourage immigrants from seeking care. For patients with diabetes, these barriers can delay diagnosis and hinder proper disease management, increasing the risk of serious complications such as neuropathy, nephropathy, and cardiovascular diseases.

IMPACT OF MIGRATION STRESS ON DIABETES

Stress is a worsening factor for diabetes. Immigrants often face high levels of stress due to:

1. Previous trauma: Many migrants flee from violence, extreme poverty, or armed conflicts in their home countries.

2. The migration journey: Traveling to the Canary Islands, often in inhumane and dangerous conditions, causes significant physical and emotional stress.

3. Uncertainty and social exclusion: Upon arrival, migrants face challenges such as unemployment, lack of housing, and the threat of deportation, which worsens chronic stress.

Chronic stress not only makes diabetes management difficult but can also directly contribute to insulin resistance and poor glycemic control. Therefore, health care services must incorporate strategies that address both the clinical and psychosocial factors that worsen the disease. »

DIABETES IN THE IMMIGRANT POPULATION IS, THEREFORE, A COMPLEX CHALLENGE THAT REQUIRES CULTURALLY ADAPTED HEALTH CARE, FOCUSED ON THE NEEDS OF EACH PATIENT

CULTURAL BARRIERS

Managing diabetes in the immigrant population requires a culturally sensitive approach. Factors such as traditional health beliefs, dietary habits, and perceptions of chronic illnesses significantly influence disease management. For example, in some African communities, traditional diets may include foods with a high glycemic index, such as refined flours or simple sugars, whose consumption may increase during adaptation to Western eating habits. Additionally, religious practices, such as fasting during Ramadan in the Muslim community, pose additional challenges for glycemic control. Many patients prefer to follow these practices even when health risks exist.

In such cases, health care professionals must adapt their recommendations to respect these beliefs without compromising diabetes control. The lack of knowledge about the disease in some communities also complicates management. In certain contexts, diabetes may be seen as a sign of weakness, leading to hiding the diagnosis and avoiding seeking help. Therefore, health education should be a priority, with culturally competent professionals who can communicate messages adapted to each cultural group.

THE ROLE OF NUTRITION IN DIABETES MANAGEMENT AMONG MIGRANTS

The dietary transition that migrants experience while adapting to host country diets is another key factor in diabetes prevalence and management. In their home countries, many follow more balanced dietary patterns, based on natural foods with lower consumption of processed products. However, upon arrival in the Canary Islands, access to healthy food may be limited by economic, cultural, and availability factors. Migrant families with limited resources often rely on cheaper, less nutritious foods, such as ultra-processed products rich in trans fats and added sugars. This dietary shift, combined with reduced physical activity due to precarious employment or social isolation, increases the risk of type 2 diabetes mellitus and makes disease management more difficult.

As culturally competent professionals, we must address this issue by promoting nutrition education programs that consider the cultural and economic particularities of the migrant population. For instance, incorporating recipes adapted to their culinary preferences, using accessible ingredients, and promoting cooking methods that minimize glycemic impact.

As a nurse in a Canary Islands health center, I have witnessed how comprehensive care, combined with cultural unders-

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» tanding and a commitment to health education, can significantly improve quality of life.

Creating multilingual educational materials and using interpreters are essential tools to overcome language barriers in our daily practice.

Currently, the health care system faces significant challenges due to service saturation and the lack of specialized resources to care for this population. To improve health care, we should:

• **Strengthen human and material resources:**
Increasing the number of health professionals and providing specific resources in primary care can improve care for immigrant patients with diabetes.

• **Develop intercultural training programs:**
Training professionals in cultural competencies will help them better understand the needs of this population and adapt their interventions.

• **Promote community participation:**
Involving migrant communities in designing and implementing health programs can improve acceptance and effectiveness.

• **Expand support networks:**
Creating collaboration networks between non-governmental organizations, social services, and the healthcare system can provide more comprehensive support to immigrants with diabetes. A strategy that has proven effective in similar contexts is the development of community programs that actively involve immigrants in the prevention and management of diabetes. These initiatives, in collaboration with local associations, can act as a bridge between migrant communities and the healthcare system. A practical example would be the creation of support groups for diabetes patients and healthcare professionals, where experiences can be shared, questions answered, and self-care promoted. These meetings not only reinforce knowledge about the disease but also foster a sense of belonging and empowerment in people who often feel invisible in their new environment. The main objective of these networks is to "strengthen inclusive policies and ensure that economic, cultural, and language barriers do not hinder access to health care. D

CONCLUSIONS

Diabetes is one of the many health challenges faced by immigrants, but its effective management can serve as a model for addressing other chronic diseases in vulnerable groups.

To achieve this goal, we must promote greater awareness and training among health care professionals in intercultural competence to provide quality care, regardless of patients' origin, culture, or religion.

"Immigration is a reality we cannot ignore," and "every consultation can be a small step toward more inclusive and humane care."

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