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Education in diabetes in multicultural settings:

the role of the intercultural mediator

In diabetes consultations, there is something one learns over time: explaining well is not always enough. Clear guidelines are provided, educational materials are delivered, recommendations are repeated, etc., and yet this often does not translate into real changes in daily life.

Diabetes is not managed with information alone. It is managed through understanding, support, and therapeutic education that makes sense to the person receiving it. And that "making sense" is not the same for everyone.

When working in settings where different cultures coexist, this becomes even more evident. Not everyone understands illness in the same way. Language does have an influence, but it is not the only factor. Beliefs, dietary habits, personal history, and, in many cases, everything involved in a migratory process also carry significant weight.

This is where a key question arises in daily practice: **how does cultural diversity influence diabetes management in clinical consultations?**

Diabetes treatment is largely based on self-care. This means constantly making decisions: what to eat, how to organize meals, when to take medication, or how to interpret a glucose reading.

However, to make decisions, one must first understand. And this is where differences begin to emerge. Some individuals experience diabetes as something temporary, something that will disappear over time. Others associate it with emotional or family-related situations, or even with explanations linked to spirituality. Dietary habits, the use of traditional remedies, and perceptions regarding drugs also vary considerably.

Added to this is the reality faced by many of the people we care for: processes of change, uncertainty, financial difficulties, or lack of support. All of this directly influences how a chronic disease such as diabetes is managed. Every individual arrives with a personal history, and that history shapes both how they care for themselves and how they understand care. When these aspects are not taken into consideration, small misunderstandings begin to appear, which over time evolve into adherence problems.

Sometimes it is assumed that the patient has understood what has been explained. However, this is not always the case—not because they are unwilling, but because they interpret what they hear according to their own references: their culture, their understanding of health, and their previous experiences. As a result, the same recommendation may carry completely different meanings. Once this becomes evident, the way one views the consultation changes. The focus shifts away from "compliant or noncompliant" and toward seeing the person as a whole. That is when care begins to acquire greater meaning.

Because it is not enough to know a great deal about diabetes. It is also necessary to listen more carefully, observe more attentively, and adapt proposed interventions. Over time, one understands that cultural diversity is not a difficulty, but rather a reality that requires working better. It is also an opportunity to rethink how education is being delivered, to question assumptions, and to focus on something that is sometimes forgotten: the relationship built with each patient.

Faced with this reality, another important question emerges: **how can genuine understanding be facilitated in diabetes consultations?**

This is where intercultural mediation becomes especially important. It is not simply about translating words, but about helping what is being said make sense for both parties. In practice, the mediator acts as a bridge. They help the patient understand what is being proposed, why it is important, and how it can be applied in daily life. At the same time, the mediator enables healthcare professionals to better understand the individual in front of them: their beliefs, habits, and the real difficulties that may be influencing their care. This significantly changes the dynamics of the consultation.

It allows recommendations to be better adjusted and prevents misinterpretations. Many times, what appears to be disinterest or lack of involvement is actually a lack of understanding or a different way of perceiving illness. There is something clearly noticeable when working in this way: trust. When individuals feel that their reality is being taken into account, their attitude changes. They become more involved, ask more questions, and participate more actively. Care then begins to form part of their lives, not as an obligation, but as something meaningful to them.

Currently, the intercultural mediator within the health care system in Spain continues to be a useful figure, although still insufficient- »

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» ly integrated. In some healthcare centers, this role is used and makes an evident difference, whereas in many others it depends on isolated projects.

In a disease such as diabetes, where a large part of management depends on the individual, improving communication is not a minor detail. It is a key component. Therefore, **intercultural mediation should not be understood as something occasional or exceptional, but rather as part of a way of working that is better adapted to current realities**.

To move toward intercultural therapeutic education, it is necessary to incorporate specific strategies into daily practice:

•Use clear language, avoid technical terminology, and, whenever possible, involve an intercultural mediator.

- Actively explore the patient's beliefs and adapt education to their cultural framework.
- Adjust dietary recommendations to the patient's culture and preferences, avoiding the imposition of rigid models.
- Listen without judgment, integrate safe practices, and explain treatment in an understandable manner.
- Confirm understanding through open-ended questions or techniques such as "explain to me how you would do it."
- Reinforce therapeutic education based on its practical usefulness in daily life.

These are simple actions, but they have a real impact on adherence and diabetes control. D

CONCLUSIONS

- Cultural diversity directly influences how diabetes is experienced and managed.
- Therapeutic education must be adapted to the reality of each individual.
- The intercultural mediator facilitates communication and improves adherence.
- Working with the patient's environment and community strengthens self-care.
- Humanizing health care improves both clinical outcomes and the patient experience.

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